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## Using this document to submit your DSRIP Project Plan Applications

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

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

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



## Domain 2 Projects

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

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

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

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

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

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



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

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

**1. 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 community needs assessment (CNA) and actuarial data from Catholic Medical Partners' Medicaid managed care contracts indicate that the rate of potentially preventable inpatient admissions (PPIA) admissions is 16.5 per 1000 and the rate of potentially avoidable readmissions is 5.92 per 1000. Our commercial contract rates for PPIA are 6.66 per 1000 and our potentially avoidable readmissions are 1.78. This actuarial data highlights the opportunity that CPWNY has to improve the quality and reduce unnecessary admissions. The majority of the PPIA and readmissions for the Medicaid population are for chronic health conditions. Additionally, the rate of ER visits is approximately 681 per 1000, 50 % of which are considered avoidable based on NYS data and best practice research. There is observed variation across our geography but all regions have significant opportunity to improve. The CNA also found that Medicaid beneficiaries report problems in gaining access to primary care and less than optimal coordination of care. Providers noted high rates of "no shows" in the clinical office and ER staffs report many ER visits could be more efficiently and effectively treated in the ambulatory setting. It is noteworthy that a greater numbers of patients were attributed to our regional PPS's based on level III attribution including urologists, ophthalmologists and surgeons; more than on Level II primary care attribution. These observations from our cost and utilization data plus the CNA present a significant challenge for our PPS. Not only is more PCP access necessary but break through interventions are needed to improve coordination of care, and more proactive interventions are needed to improve overall



patient engagement and reduce no show rates. Published HEDIS data for the WNY Medicaid population shows that this group lags behind the commercial population in the following areas which will be addressed by our DSRIP projects: 1. behavioral health acute and continuation phase, 2. management of cardiovascular disease –cholesterol control, 3. flu vaccination, and 4. prenatal care in the first trimester. To close the gaps identified in our CNA, CPWNY will expand our IDS capabilities using Crimson Population Health Manager and increase our analytic staff to support our clinical transformation. Management of change and performance based contracting require strong data and analytics capabilities to support direct care staff and overall management. We will redeploy and retrain staff displaced due to declining hospital utilization and also recruit new personnel into newly created positions to achieve success. More specifically, Sisters of Charity Hospital (SOCH)/CMP will rapidly engage our PPS partners in identifying our patient population. We will stratify patients by need and by clinical practice. Our stratification will include but not be limited to: 1. Patients without a PCP. 2. Patients with a PCP but not meeting clinical goals for preventive or chronic illness. 3. Patients with chronic health conditions including Behavioral Health. 4. Patients with significant social & economic barriers to health – economic risk (i.e. homeless). 5. Patients in need of Palliative Care. Currently SOCH/CMP Project Management Team uses a stratification system based on Hierarchical Clinical Condition (HCC) coding and builds patient registries to monitor utilization and quality for the high risk population. This system is used to identify patients with the greatest burden of illness, and to focus practice efforts on providing the extra support to patients at risk for hospitalization. SOCH/CMP Project Management Team will use this method in our CPWNY IDS and our population health tools to identify the Medicaid patients. Once patient data is analyzed, SOCH/CMP Project Management Team will use our regional leadership team to work with the clinical office, health system and our community organizations to meet our process and outcome goals.

- 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.

The Community Partners of WNY (CPWNY) PPS has a comprehensive and accountable provider network of over 1000 physicians, a major health system with urban and rural partners, a certified Health Home, community based Behavioral Health providers and major community organizations including Catholic Charities and the Urban League. CPWNY will expand the existing workforce to support Medicaid beneficiaries and design outreach and follow-up initiatives to improve patient engagement. The Project Management Team will use the data warehouse (MedInsight) and Crimson Population Health software to identify patient needs and the reporting and analytics system will produce practice specific reports on quality of care and hospital utilization. SOCH and CMP have been using these reports and know they will be effective in engaging clinical office leadership in making improvements in our CPWNY IDS. The majority of our practices have received rapid cycle improvement training following the Institute for Healthcare Improvement (IHI) model of improvement, and the SOCH/CMP Project Management Team will continue to provide this training with a specific focus on care management for prevention and for improving care to the high risk population. The Project Management Team will add additional components of training on best practices by using community health workers to reduce social and economic barriers to care. Currently, we have over 65% of our PCP practices at PCMH Level III. Approximately ninety (90%) of our practices have electronic health records and are actively engaged in implementing interoperability using the direct method via secure e-



mail. In addition we have a hospital to homecare transition team that visits high risk patients within 48 hours of discharge to ensure ambulatory follow up and reduce the potential for readmission. We will expand these resources and integrate with our community collaborators to achieve our DSRIP goals.

- 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.

The top four challenges in our IDS are as follows: 1.engage providers to expand access and use community organizations to support clinical care and services 2.Integrate community health workers and clinical teams 3.improve EHR functionality, interoperability and reporting by integrating claims and EMR data 4.Staff training in proactive, patient-centered care. CPWNY will mitigate these challenges using registry and reporting systems to identify patients in need of interventions and use our mobile care management and regional lead teams to engage the provider community. Improving and reducing “no shows” will require creating linkages between clinical practices and community health workers so that CPWNY has active follow up. Improving interoperability, data and reporting will be a task delegated to the regional training teams and we will assess each practice’s competencies and design intervention plans to achieve 100% lean interoperability over the next 2-3 years. The Project Management Team will expand the existing training teams and create training modules in the areas of patient centered care, best practices in preventing unnecessary admissions, CCD data interoperability, rapid cycle improvement and team based care. Achieving early success and rewarding results will require CPWNY to set reasonable expectations and ensure that the practice teams have the support needed to show early success. Sisters of Charity Hospital has a culture of accountability (responsibility with results) and we will leverage this to drive results in the CPWNY PPS.

- 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.

CPWNY PPS and Millennium PPS have worked together since early August to coordinate our planning and projects. We have conducted a joint CNA with UB Regional Institute and P2 Collaborative. For this broad project we have jointly been working with HealthLink, our Regional Health Information Organization, on interoperability, reporting, consent and data governance. We anticipate this type and level of collaboration will continue.

## 2. System Transformation Vision and Governance (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.

Catholic Medical Partners, who will be contracted to serve as Project Management, has extensive experience in risk based contracts that reward improvements in quality and utilization. CMP's CMS Shared Savings results were positive. CMP ACO reduced hospitalizations per 1000 by 26%, emergency room visits by 13%, CT scans by 10% and ambulatory care sensitive conditions by 15%. Improving quality in the following areas: patient experience, patient safety, and prevention, at risk population for CAD, CHF, IVD diabetes and hypertension. Our PPS strategy and action plan will build on CMP's CMS Shared Savings and Commercial managed care risk contracting experience and success in our contracting and improvement initiatives. The DSRIP outcome and process goals will create new challenges and opportunities for improvement. Mitigating social and economic barriers and the corresponding health care disparities will require new solutions and IDS support. Existing partner IDS infrastructure will need to be expanded and tailored to improve clinical care and service. The quality of care will improve through improving access and patient engagement, improved coordination of care, better exchange of reliable and valid data, improved provider performance reporting, adherence to best clinical and operational practices, and a culture of accountability built on the values of the common good. Culture is the key component to creating a high performing health care system and creating the administrative and operational support that can be used by practitioners to better serve the population. The CPWNY strategy is as follows: 1. Utilize Physician leadership and accountability in the clinical office, at the regional level and at the board governance level. 2. Strengthen the capacity of the PCP's clinical office to meet the needs of the population including: the integration of Behavioral Health and Palliative Care, proactive and chronic care management, and coordination of care with institutional, ambulatory and community partners. 3. Accelerate interoperability and the integration of EMR data and claims data to improve clinical reporting and practice performance including linkage and participation with the RHIO. 4. Expand patient consent for the RHIO. 5. Create a business model based on achieving margin or incentive payments for improved clinical care and service effectiveness and efficiency. Leadership at the board level will guide CPWNY strategy and decision making, oversight and implementation of our DSRIP improvement initiative. We expect the building of a more accessible and reliable care system will require the division of our PPS service areas into sub-regions. Each sub-region will have a leadership team with a PCP lead, a care management lead, a community service coordinator and a practice transformation specialist. This leadership team will be operationally accountable for our initiatives in distinct geographic areas. This model was selected to improve access to clinical and community services in close proximity to the target population. This team will provide the necessary support to the clinical practice and address gaps in continuity, access, and performance in the region. Health care delivery is an interactive process between care givers and patients. The Project Management Team will build clinical office capacity at the primary care level to meet the individual needs of the population. We will build capacity by integrating behavioral health and palliative care in the clinical office, by building reliable and timely referral relationships among providers and by addressing the preventive and chronic needs of the population. Our staffing component will be expanded to include care coordinators for each patient and a team of social workers, pharmacists and nutritionists available to make the individual interventions necessary to close gaps in care.



Patient engagement is foundational to our improvement agenda. Value based contracting is dependent upon giving provider data on quality, utilization and cost. Currently, SOCH and Catholic Medical Partners provides its network physicians with the following: 1. Semi-annual avoidable admissions and readmission data. 2. Quarterly quality of care reports on the CMS 33 quality metrics: 2.1. CAD/IVD (LDL screening and control, appropriate medication use). 2.2. CHF (Use of appropriate medication). 2.3. Diabetes (Control of HbA1c, LDL, BP; Tobacco use; Aspirin use). 2.4. Preventive Care (Influenza; Pneumococcal; Tobacco use; BMI measurement; Breast, Cervical and Colorectal Cancer Screening; Screening and treatment for Depression and Hypertension). 3. Patient Experience of Care Report – SOCH/CMP data and analytics system uses both claims and EMR data. MedInsight / Crimson Population Health tools will support our regional teams such that they will be able to bring actionable data to our practices. These reports will guide our management and oversight of the PPS and our incentive programs.

- 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 CPWNY PPS governance strategy is designed to engage partners, promote competency and reward performance. The governance charter delineates a broad representation on the Executive Governance Body (EGB) which is empowered with board oversight and management of CPWNY DSRIP project plans. The EGB is supported by 3 committees comprised of individuals with expertise in finance, data/IT and clinical performance. The majority of the EGB and its committees have demonstrated success working in integrated delivery systems. The EGB will set forth roles and responsibilities, a comprehensive performance expectations, distribution of funds (project support/ bonus), clinical and data sharing responsibilities, and dispute resolution. Governance strategy milestones include partner completion of education and training (knowledge and competency), process evaluation, change and development (transformation), performance evaluation including competency/integration/clinical evaluation (aligned with project metrics). CPWNY will integrate the organizational, clinical and utilization goals for the PPS partners into SOCH/CMP’s current integration program and by doing so share expertise and establish common expectations for performance on each metric for PPS partners’ contractual arrangements. SOCH/CMP have been developing a high performing health care system with a distributed network for the past 8 years and have achieved success in improving triple aim metrics. Our strategy is designed to enhance and expand this IDS success, to contract with health plans based on a percentage of premiums, and demonstrate that CPWNY PPS can create a 2-3% margin as an IDS, while improving quality. It’s expected that SOCH/CMP’s current success with a Population Health Business Model will reinforce the importance of the CPWNY PPS initiatives to partners & vendors. Success will enable CPWNY PPS to continue transformation to a high performing health care system with the skills, knowledge and ability to assume full clinical and financial risk for population health.

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

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient



population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

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

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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding for the development of the practices throughout the network, as well as for the additional required IT investments. Technology and a skilled workforce is paramount to our strategy for improving the coordination and integration of different services. Many of the practices do not currently have the physical capacity, nor some of the technology infrastructure to support their new roles. Even those with certified EHR's are not able to meet the interoperability demands that are needed to coordinate the care throughout the continuum. There is the possibility to shift some of those practices on EHR's not meeting the needs to other technology that does.

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
<input type="checkbox"/>	<input checked="" type="checkbox"/>



**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.

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

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

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

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



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



### 2.b.iii ED Care Triage for At-Risk Populations

**Project Objective:** To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

**Project Description:** Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

**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. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
  - a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
  - b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
  - c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
  - a. Patient navigators will assist the presenting patient to receive a **timely** appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
  - b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
  - c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. Use EHRs and other technical platforms to track all patients engaged in the project.



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**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 WNY Community Needs Assessment revealed that Western New York performs worse than NYS as a whole for Medicaid ED care and overuse. The region has an observed rate of Medicaid potentially preventable ED visits 8% higher than the state as a whole. Chautauqua County in particular stands out with a risk-adjusted rate 46% higher than the state average. Within WNY, Medicaid patients have the highest rate of ED use, with 45% visiting an ED for care in the past year. On the other hand, primary care is underutilized, as WNY has a 28% lower primary care practitioner (PCP) visit rate than the statewide average, and a lower percentage of Medicaid beneficiaries with a PCP visit in the past year. The Medicaid PCP visit rates for Erie and Niagara Counties are 30% and 29% lower than the statewide rate. Community survey respondents in all five PPS counties listed “Access to Care” as the most critical need for health care in their community, and surveyed patients indicated that they would rather go to urgent care or an emergency room because it is quicker and they do not need to wait for an appointment. Based on the findings of the CNA, CPWNY will meet the needs of the community through the expansion of resources including our health homes, patient-centered medical home primary care practices, patient navigators and Community Care Teams. These teams are multidisciplinary care management teams that support the state’s highest need residents by providing individualized care plans, intensive care management, in home visits, health coaching, and beneficiary engagement with appropriate community resources. These teams are ED/hospital based and will be engaged for all Medicaid, dual eligible and uninsured patients who present in the ED based on specific criteria. Along with expansion of services will be significant provider and patient education.

- 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 project will target two specific overlapping patient populations: (1) Frequent ED users (defined as individuals with 4 or more visits per year) and (2) Persons with behavioral health and substance abuse issues, who form a particular sub-population of frequent ED utilizers. The project will be implemented in phases. The initial focus will target the six Catholic Health System emergency departments, some of which are located where the highest concentration of Medicaid members reside (zip codes 14218 and 14220). During this first year, the remaining five emergency departments will be set up virtually with additional resources deployed in subsequent periods. For example, at Bertrand Chaffee Hospital, CPWNY PPS will deploy a virtual care management



program, via electronic connectivity with “real time” care management staff until additional staff is recruited, trained and deployed.

- 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.

Necessary resources for the project include: (1) broadened access to primary care with emphasis on patient centered medical homes (current resources plus expansion), (2) the development, procurement and deployment of patient navigators (needed community resources to be developed), and (3) additional clinical resources including RN Case Managers and Social Workers to all participating EDs. The normal protocol for patient ED presentation will remain intact; care management intervention to primary care services will be provided as an augmentation of immediate treatment and stabilization. (1) Access needs to be evaluated from the perspective of the beneficiary—many have limited transportation options and often people cannot leave work for an appointment without losing pay or putting their job at risk. This will include the incorporation of: (a) Medical and Health Homes. Patient Centered Medical Homes and health homes (current resources) typically have extended hours (weekends and evenings), same day appointments, and continuity with one provider. In some models, patient navigators schedule appointments at patient centered medical homes for frequent users. Currently, approximately 60% of patient population in SOCH and Catholic Medical Partners IPA are part of a Patient Centered Medical Home. There is minimal advancement of PCMH with our rural partners. Resources will be needed to enhance PCMH in these areas using existing resources of Clinical Transformation Specialists with additions to the staff. (b) Alternative Primary Care Sites. Given that two-thirds of emergency visits occur after business hours (weekdays 9 am - 5 pm), identifying primary care sites and /or urgent care centers available after business hours is one strategy for improving appropriate access to health care services. This may include electronic access to primary care appointment calendars for direct scheduling as well as data sharing through connectivity through the RHIO, HealtheLink. 24/7 nurse help lines are needed as well to improve healthcare access for the Medicaid population. Some offices do have this in place but will need to be expanded to the small independent practices /rural area partners. (c) Interoperability of outpatient, inpatient, and ER is necessary. Use of existing staff with enhancement of staff numbers to be put in place will be needed ASAP. (2) Patient navigation is rooted in a simple premise. If barriers to timely healthcare access are eliminated, and patients are supported throughout the healthcare continuum, healthcare outcomes will improve. These barriers are often broader than most realize. They include more commonly discussed issues such as financial constraints and lack of medical insurance. Yet they also include less obvious, but equally paralyzing, factors. These are the emotional, cultural, communication and logistical barriers that cause people to disengage from the healthcare system, neglecting preventive care or chronic disease treatment. The best healthcare advances mean nothing if a patient misses their appointments because of child care issues. A cost effective resource for community or payer organizations, provider facilities, in at-home care settings, and organizations serving Medicaid populations, lay patient navigators can connect the care team around the patient and augment the work of physicians, nurses, care managers and social workers. For disadvantaged patients, patient navigators forge person-to-person connections on a patient’s own terms, connections that have historically been missing for many. (3) The following available assets can be mobilized



to implement this project, but must be augmented: an ED care triage program, and partnerships between participating EDs and community primary care practitioners (with an emphasis on PCMH providers).

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

Challenges and anticipated issues are: 1. The design, development of the patient navigator position/role is a relatively new concept in health care delivery particularly in the ED setting. There are no formal training programs in our existing academic institutions. Our plan will be to establish an educational/training curriculum which will encompass basic foundational health care concepts with a focus on connectivity with appropriate and timely primary care services. This person will be partnered with care management staff at all ED settings to enhance coordination of care. 2. Policy, protocols and clinical pathways standardization among our partners may be a challenge as the goal would be to assure/provide consistency in care and reduction of practice variation. Our plan to address this will be the promotion of our multiple electronic platforms in terms of uploading key documents, templates, clinical pathways that will alleviate/reduce variation. We will also implement fast track decision provider committees relative to policy, procedure and clinical guidelines to promote standardization. 3. Cultural and language needs of patients that exist in pocket areas of the Community Partners of WNY service area (zip codes 14218 and 14220) and our ability to meet those needs. Our plan to address this issue is to insure that cultural competency training is in place, especially for the patient navigator. Hiring patient navigators who are of the same culture and linguistic abilities will be promoted. 4. Coordination of care is a problem for the health care community. IT interconnectivity needs are a priority. Our plan will be to explore possibilities with our partners that close this gap.

- 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.

Community Partners of WNY and Millennium have worked together since early August to coordinate our planning and projects. We have conducted a joint CNA with UB Regional Institute and P2 Collaborative. We have agreed on six (6) similar DSRIP projects and are working with HealthLink, our Regional Health Information Organization, on interoperability, reporting, consent and data governance. ED Care Triage for At-Risk Populations is one of those six projects. We expect coordination will be accomplished through the sharing of data across the region (i.e. ED alerts), coordinated care management, utilizing shared knowledge of community interventions and use of best practices.

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

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



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

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

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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

To support electronic access to primary care appointment calendars for direct scheduling. Improved data sharing via HealtheLink. Improvements to community assessments; tools for patient navigators; guidelines for risk stratification; patient registries for tracking and reporting.

a. 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
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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



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

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

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

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

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

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
  
- b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



## 2.b.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 regimens. 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](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.

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

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

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



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

According to the Community Needs Assessment (CNA) Community Conversations, one of the most common negative experiences in healthcare is the lack of continuity in care. Providers interviewed also echoed the sentiment of lack of continuity and technology infrastructure across health care settings. Enhancement and expansion of the current SOCH/Catholic Health System Care Transition program for the Medicaid population will provide coordination of care between providers and amongst transition settings. The CNA provides insight to areas of impact by expansion of the existing Care Transition program: The current Potentially Avoidable readmissions rate is 5.8/100. A 25 % reduction would amount to 511 fewer readmissions or a goal rate of 1,238.4. Wyoming, Niagara, and Orleans counties are currently 80% above the goal rate (as high as 2289/100,000); WNY has a higher rate of hospitalizations for both adolescent and adult diabetes complications than NYS with Erie, Niagara, Cattaraugus, and Orleans performing worse than NYS. Erie County also showed higher rates of admission for congestive heart failure. Each of our counties have higher cardiovascular disease (CVD) mortality rates than New York State, with Niagara and Chautauqua reaching rates of over 300 per 100,000. Care Transition programs are about engagement of the patient /care giver in disease management programs to prevent complications which can affect hospitalization rates; WNY has a disproportionately large at-risk (health care needs, health vulnerability) population for five demographic groups: households without a vehicle, individuals Age 65+, single parent households, individuals in poverty, and African Americans who traditionally experience barriers to quality schools, good paying jobs and safe housing. Evidence supporting the success of Catholic Health's existing Care Transition program includes a comparison of patients enrolled in the program compared to eligible patients who declined enrollment. Data from 2010-2012 indicates a lower 30 day re-hospitalization rate for patients enrolled in the program. 2010 indicated a 6.60% re-admission rate compared to 9.04% readmission rate for those patients eligible but not enrolled; 2011-7.01% vs. 9.91% , 2012 results were 5.67% for vs. 13.96 and 2013 were 5.7% vs. 10.7%. Our partners and Medicaid patients will benefit from the enhanced Care Transition Program.

- 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 is Medicaid patients admitted to the hospital with a high risk for re-admission to the hospital who meet two or more of the 8 BOOST criteria. Medicaid patients will be identified while in the hospital through the use of a TARGET assessment 8P scale developed by Project BOOST (Society of Hospital Medicine). The "P" items on the assessment tool include: Problem Medications; Punk/Depression-presence of depression either in screening or in history; Principal diagnosis and/or co-morbidities of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, cancer and stroke; Polypharmacy-number of medications as well as medications that increase the likelihood of adverse events post hospital discharge (66% of patients have at least 2 prescriptions); Poor health literacy-inability to teach back; Patient support-absence of caregiver or limited/lack of social supports; Prior hospitalization in the past six months; Palliative care-patients who have chronic disease management/symptom control needs. The program will begin where the highest concentration of Medicaid members visit, Mercy



Hospital of Buffalo in Erie County, while setting up programs in Niagara, Chautauqua and Orleans. A large proportion of Medicaid members reside in zip code areas 14218 and 14220 and those areas are nearest to Mercy Hospital. Our Community Needs Assessment indicated a high proportion of individuals at risk for re-hospitalization due to the prevalence of diabetes, CHF, cancer, stroke, COPD with co-morbid conditions, as well as behavioral health needs and lack of social supports. Individuals with low socio-economic status often have poor health literacy and therefore do not understand the instructions provided upon hospital discharge. Understanding of their disease state and compliance improves for this population when there is a visit in their own home with review by a Care Transitions Nurse/Coach trained to work in a culturally competent manner in the patient's own environment.

- 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 will expand on the current program's success. Community Partners of WNY will utilize current assets and resources to help achieve the goals of this DSRIP project. CPWNY will engage partner hospitals and home care agencies and expand the number of Care Transitions Nurses/Coaches as well as provide augmented training for healthcare providers and new Care Transitions Nurses/Coaches. Addition of social workers and patient navigators will enhance our ability to reach out to complex patients. Catholic Health Home Care's Health Home, has been recognized as one of the most successful Health Homes in New York State. It is anticipated that many patients eligible for Care Transitions will benefit from a linkage to the Health Home for ongoing Care Coordination to prevent unnecessary readmissions. Care Transitions patients will also be connected with Care Coordinators in primary care offices to continue to provide telephonic follow up and monitor compliance with primary care visits and disease management. Standardized protocols and tools will be utilized and are assets to the program. Standard protocols include but are not limited to: engagement by a Care Transitions Nurse/Coach with the patient upon admission to the hospital (gain trust and assess specific needs such as language, cultural needs as well as access /transport issues); completion of pre-discharge patient medication reconciliation and review of patient education tools to effectively prepare patients and caregivers for hospital discharge; scheduling follow up patient appointments within five to seven days of discharge from hospital; home visit by Care Transition Nurse/Coach within 48-72 hours of patient discharge from hospital to reinforce and expand on the information provided in the hospital pre-discharge and provide continuity for the transition to the patient's community based setting; medication reconciliation by pharmacist with communication to providers; patient education materials and self-management tools/motivational interviewing; personal health record; series of structured telephone calls with a Care Transitions Nurse for 30 days post hospital discharge ideally at 2, 7 and 14 days post discharge to reinforce results at prior visit and determine changes, progress in meeting patient goals and to answer patient questions and concerns; modeling behavior for how to handle common problems and/or next encounter or visit; community-based support for Health Home enrollees by Health Home Care Coordinators; ongoing PCP office Disease Management Nurse coaching; referrals to managed care plan Health Coaches where available; Collaboration with Health Care Plans and their services where applicable as well as social services departments in partner counties. While the Care Transitions Program will be structured with workflows and standardized tools, the specific content and format may vary by



patient and visit to meet the patient, caregiver and situations specific needs. Resources would need to be enhanced for the Community Partners of WNY and community resources embraced such as home care, patient navigators (to be developed), use of Catholic Charities for social issues, to name a few.--- Medical Director (existing resource): 0.5 FTE; Health Information Technology Specialist (added): 1.0; Director/Manager of Program (existing resource): 1.0; Clinical Pharmacist (added): 2.0; RN Care Transition Nurse/case management: (added to existing for all counties): 4.0; Social Worker (added to existing positions for all counties): 3.5; Patient Navigator/Community outreach worker (new positions): 3.0.

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

Challenges anticipated with this program are: changing care processes at transition touch points that will be addressed with informational meetings and key successes of existing program; Provider buy in to order or speak to patient about the program -The approach is to use our local physicians to work with other physicians in their area regarding the program; Lack of standardization of electronic medical records that inhibits the transfer of information - Need to purchase a communication tool /or integrate EMRs so that coordination of care can occur without added burden.; Lack of financial support from all managed care plans to pay for these services-The DSRIP grant will financially enable the expansion of this program. Poverty was described in provider interviews as a pervasive overriding issue driving health care need. Nearly a half million individuals in the region live in or near poverty, and are concentrated in Erie and Niagara counties. Poverty status impacts financial capacity to access health-promoting resources such as vehicles, computers, healthy foods, preventive care copays and more. -Community outreach or patient navigators can meet patients where the patient wants, such as at the church, library or call the patient. Refusal from patients to accept the program. The refusal rate for Care Transitions Programs averages at approximately 38%. -The use of Patient Navigators/Community Outreach Workers should increase the acceptance rate.

- 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.

Community Partners of WNY will work with the other PPS that has overlapping service areas through periodic collaborative meetings to discuss issues and share solutions.

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

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

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



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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

Support the integration of electronic medical records and communication tools.

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Brooks Memorial Hospital	Medicaid / Interact Program	2015 Q1		Collaboration with Chautauqua County Health Network (CCHN) to reduce readmissions using Interact Program

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

**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



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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.ii Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services

**Project Objective:** This project will use telecommunication to create access to services otherwise not accessible due to patient characteristics, travel distance or specialty scarcity.

**Project Description:** Patients may not have access to needed healthcare services due to patient characteristics, travel distance, and/or specialty scarcity. With the emphasis that NYS has placed on EHR and HIE connectivity, as well as other advances in telehealth, these needed services can now be made available to more patients. Telemedicine is using interactive telecommunications equipment to support direct, active communication between providers and patients. This telemedicine project is meant to address home-based telemedicine for chronic disease management and/or specialty scarcity, such as services for AIDS/HIV, adult psychiatry. Implementation will be intended to meet an unmet service need; this project is not intended to be a convenience service for the member or provider where access is otherwise available.

Telemedicine capabilities have been used to increase primary care provider and other medical personnel's expertise through programs such as Project Echo ([echo.unm.edu](http://echo.unm.edu)). Modeling of Project Echo, where appropriate, is encouraged.

**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 telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.
2. Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).
3. Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.
4. Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.
5. Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.
6. Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.
7. Use EHRs and other technical platforms to track all patients engaged in the project.



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**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.

Access to care was the answer 30% of the time to the CNA patient survey question “what do you believe is the most critical need for health care service in your community.” Telemedicine will be employed to address two manifestations of this gap reported in the CNA. The first is shortages of specialty care physicians and the second is access to care exacerbated by transportation issues. The CNA reports “capacity is a key issue across primary care, specialist care, and mental and behavioral health care” and shortages of specialty care physicians in Western New York (WNY) are a significant barrier to access in both urban and rural areas. The CNA concludes that telemedicine “was noted in rural focus groups as an opportunity to expand access to a limited rural provider network.” The CNA says, “areas with the most severely low proximities to specialty care providers lie within rural counties.” According to the CNA, four acute care facilities outside the Buffalo metropolitan area agree that if shortages in certain specialties could be met remotely using telehealth, care delays will be reduced and local coordination of care will improve. This will reduce total costs and readmission rates. The specialty fields most often cited in the CNA with shortages are Intensivists, Behavioral Health, Neurology and Infectious Disease; others include vascular, cardiology, endocrinology, and maternal fetal medicine. To address this gap the telemedicine project will provide remote consults with specialty physicians initially focused on the ICUs of rural acute care facilities, as well as, emergent behavioral health for participating acute care facilities. The CNA says inadequate transportation has a negative impact on access to care and is “a pervasive issue for people seeking health care” that results in patients often not getting the primary care and follow-up care they need. Further, the CNA reports, by comparison to other areas of the state, outside of NYC, WNY has a greater percentage of households without a vehicle and that concentrations of poverty and patients who lack access to transportation are in both urban and rural areas. To mitigate this gap, telemedicine technologies will “co-locate” specialty care with primary care reducing the need for multiple appointments. The project will also employ telemonitoring and mobile health tools to monitor targeted patients in their homes, rapidly identifying sudden changes in health and reminding them of appointments or treatment plan components, including medication regimens. The acute care component will benefit 720 attributed beneficiaries with 828 teleconsults, plus additional patients not attributed to the PPS and other non-Medicaid patients in year one. The non-acute setting component of the project will become operational in year two and is expected to benefit 6,000 beneficiaries by year five.

- 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.

In acute care environments, this project will benefit patients: ● admitted to the ICU of each of the five PPS partner hospitals in Cattaraugus, Chautauqua, Niagara, and Orleans counties; ● Medicaid patients who present at any of 11 PPS partner emergency rooms in need of behavioral health services; ● Medicaid inpatients at a PPS partner facility in need of behavioral health services, including patients for whom behavioral health is a primary diagnosis and those with comorbid conditions. It will include patients currently attributed to this PPS and the community in general. The primary care and remote monitoring component of the project will focus on patients with conditions representing the highest rates of preventable hospitalizations and the highest number of ER visits among the Medicaid population for the PPS acute care providers in 2013, as reported in the CNA, including diabetes, COPD, asthma, congestive heart failure, and/or behavioral health needs. Focus on these chronic illnesses is informed by the Salient NYS Medicaid System data regarding Medicaid chronic conditions which shows disproportionate representation among beneficiaries attributed to the PPS compared to the general Medicaid population. The focus will be directed to beneficiaries receiving services at one of six large primary care facilities in the PPS including 9th Street Clinic in Niagara Falls, St. Vincent Health Center and Mercy Comprehensive Care Center in Buffalo, Orleans Community Health Primary Care in Albion, Springville Primary Care, and WCA PCC.

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

All acute care Community Partners of WNY partners have participated in an FTC grant to develop a dedicated healthcare high speed secure broadband network which will be deployed to support this project. This project will leverage established local relationships of the Community Partners of WNY partners and incorporate specialty care expertise from turnkey national vendors to meet local gaps through a collaborative and flexible “hub and spoke” model providing remote care consultations. This will include accessing needed expertise from among over 750 CMP specialty physicians. In addition, the project will leverage the already established behavioral health programs of PPS partner, WCA Hospital. The projects mobile health component will utilize existing community resources of PPS partners including developed home care programs of Catholic Health, patient transportation services of MASH and EMS organization, Rural Metro, to leverage combined clinical and logistical expertise. The mobile health program will require the acquisition of and training on telemonitoring equipment for both patients and clinicians to monitor chronically ill patients remotely from a central location and dispatch the appropriate level clinician when needs arise. This will require a team to support operations, deployment and training, as well as, field support (total of nine in the first year and 13 in year five) and Medical Triage Teams (four NPs in year one to seven in year five, 42 LPN/Paramedics in year one to 70 in year five). It is anticipated that some of these needs will be met by redistribution and retraining of currently employed personnel. Our plan to augment the call center program will require evaluation and implementation of cell phone and home computer applications that will enhance patient compliance with medication regimens, physician appointments and other recommended care. This will use the same support, deployment and training resources noted above.



- 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 challenge to assess technology and compatibility issues; will be mitigated, in the acute care environment, by incorporating the services of turnkey vendors, and using equipment owned & maintained by the vendors who will provide remote consultations to supplement local providers. High per consult charges for individual PPS partners is a challenge given relatively low volumes. Consult volume will be aggregated for the PPS leading to volume discounts. Provider resistance to telemedicine may be a challenge addressed by engaging them in conversations that identified telemedicine as a solution to a community need. We will develop protocols requiring utilization of available local physicians before using vendor physicians & will use a hybrid model so local physicians can choose to join vendor's panel of experts. Vendor physicians will provide consultation & care recommendations while patients will be under the care of local physicians. The challenge of physician licensure/credentialing will be addressed by choosing a vendor that handles these issues. The challenge of needing standard protocols will be met by having PPS partners approve the standard service protocols of the vendor and their consent and confidentiality standards to meet gov't requirements. The mobile health program will require a physical center, hiring/training of staff and evaluating/acquiring equipment. It will require training providers and patients. Integrating Community Paramedicine will require changes to NYS Community Paramedicine regulations. To help, PPS partners will work together to leverage our expertise: those with established home care for working with patients at home; those with displaced health professionals who could be redeployed; our EMS partner for dispatch expertise and to facilitate regulatory changes. We have addressed issues of defining participating providers & delineating hub & spoke designations with an active project team of PPS partners that continues to work together to evaluate vendor proposals and develop an implementation plan. We will leverage our relationship with local Medicaid Managed Care providers to develop sustainable strategies for authorization/payment and expect that our plan to expedite implementation through use of turnkey vendors will provide greater opportunity to evaluate efficacy and produce measureable outcomes that will justify sustainability.

- 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.

No other PPS in our service area has proposed a telemedicine project so no direct coordination for program design and delivery is required. Coordination benefitting Medicaid patients will occur because patients are targeted by health status and facility where they seek services, not by the PPS to which they are attributed. Therefore, coordination will occur for reporting and funding of services provided to patients not attributed to our PPS.

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

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



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

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

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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The capital funding required to build and support the telemedicine program is directly linked to: (a) supporting the workforce outlined in this application, and (b) building the information technology architecture enabling the effective use of telemedicine technologies featured in this program. Workforce Office Infrastructure: The Medical Triage Team program requires a centralized call center supported by software similar to EMS dispatch capabilities. The capital required to construct the physical space accommodating between 20 to 30 personnel is estimated at \$200,000 including workstations, telephones, headsets, computers, cabling, etc. The operating budget for leased office space of approximately 4,500 square feet is estimated at \$136,000 per year including CAM, janitorial, and utilities. The cost of the medical triage call center system is estimated at \$100,000 and is based on a typical Medtronic EMS dispatch system that would be customized for our purposes. Enabling IT Architecture – To be developed in conjunction with PPS and vendor partners.

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?



<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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 requirements and patient engagement progress in the project.

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



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

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



## Domain 3 Projects

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

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

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

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

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

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

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

*A. PCMH Service Site:*

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



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

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

### **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.

ECMC and BryLin Hospital are currently used for our mental/behavioral health (M/BH) inpatient admissions. Also, our ambulatory network includes 152 psychiatrists. The Community Partners of WNY has five NYS-licensed comprehensive community-based Behavioral Health Providers. Our primary care practice sites who have agreed to participate in this project have either achieved or begun the process to become a NCQA level 3 PCMH or Advance Primary Care Model by Year (DY) 3. Sisters of Charity Hospital Project Management Team has risk-based Medicaid managed care contracts; their actuarial data for 2013 shows a Mental Health admission rate of 6.74 and a Substance Abuse rate of admission of 8.42 per 1000. These are dramatically higher than the commercially-insured population that show a MH admission rate of 2.27 per 1000 and a SA rate of 1.0 per 1000. For the first six months of 2014, the MH rate for our Medicaid population increased to 7.16 per 1000 and the substance abuse rate to 10.12. Outpatient visits for the same period are also increasing. The CNA demonstrates major MH conditions driving utilization are depressive disorders and the major clinical conditions driving SA are alcohol and mixed drug abuse. The most recent HEDIS data show 51% of patients remained on anti-depressants for the acute phase of treatment. After six months this dropped to 34%. Follow-up 7 days after



hospitalization showed 28% of patients not meeting this HEDIS standard, and at 30 days 17% had not had a follow-up visit. Data on diabetes and cardiac care for the target population show additional disparities in management of these two conditions. This data shows serious gaps in care and opportunities to make improvements. The PPS will address the 4 key disparities listed above including: 1. High rates of BH admissions 2. Patient compliance with medication recommendations 3. Continuity of care issues following discharge 4. Early identification and management of chronic behavioral and physical health conditions. Utilizing the Four Quadrant population-based planning framework for the clinical integration of health and behavioral health services our strategies include: 1. Building SBIRT for both MH and CD into patient's annual PCP visit and having referral agreements between PCP and BH providers with rapid access and collaborative care plans. In some practices with higher Medicaid populations we will co-locate a BH provider in the clinical office with psychiatric backup support. 2. Improving patient education, engagement and medication compliance with embedded nurse care managers in PCPs. 3. Proactive Community Health Worker follow-up to all patients discharged from a BH inpatient facility who do not follow up within 7 days, and active follow-up of 2 days for patients with multiple BH admission history. Implementing the Collaborative Care Model with integrated nurse care managers in BH settings linked to a PCP in a team approach to monitor patient outcomes and make interventions to improve medication compliance, cardiac care, HTN management and DM care. The PPS will use registries and EMR reporting to stratify patients and engage the practice in overall population improvement.

- 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 intervention are all Medicaid patients seen in the PCP setting for an annual visit, patients who are prescribed anti-depressants, and patients transitioning from inpatient BH settings to home or a community setting. Additionally, Community Partners of WNY will identify/target patients in our BH settings with gaps in best practice standards for health care in the areas of DM, BP control and cardiac care.

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

Community Partners of WNY will utilize our current network to develop PCP screening tools for early identification and formal/written referral agreements between PCP and BH providers to improve early intervention. Team-based BH interventions will be emphasized, using qualified MH and SA counselors with reliable back-up from pharmacists, psychiatric NPs and psychiatrists for medication management, referral accountability following hospitalization, and to improve access. We will use EMR-secure messaging to improve communications and reduce information exchange gaps that diminish continuity of care. Sisters of Charity Hospital/CMP Project Management Team will establish BH education to expand patient education regarding BH signs and symptoms and reinforce the importance of adherence to medication protocols. Patients who miss their



appointment will have active follow-up via geographically-based CHW teams. Secondly, we will place nurse care managers in the BH setting who are trained in providing proactive case and care management to patients. Community Partners of WNY has an active embedded care management program in PCP clinical settings and this PPS will expand this to the BH setting in five of our community-based comprehensive BH partners: Horizon Health Services, Spectrum Human Services, Catholic Charities-Monsignor Carr, Child and Adolescent Treatment Services, and BryLin Behavioral Health. The care managers will be trained in best practice care and case management and will use registries to close gaps in medical care for our target conditions.

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

The CNA noted that only 13% of the PCPs in our region are safety net providers and that, of the PCP practices, only 21% are PCMH. The Community Partners WNY network has over 300 PCPs and in addition 450 midlevel practitioners. We have been attributed 58,000 patients. Our network is geographically distributed, our practices serve the Medicaid population based on our health plan contracts, and over 65% are PCMH-certified. PCP clinical offices will be challenged to develop BH protocols and integrate them into their workflow. There will also be challenges in staff training and determining what level of BH can be managed in the PCP office. The Community Partners WNY strategy will be to design PCP specific interventions that either utilize embedded staff or are virtual – namely, based on referral, access and information exchange agreements backed up by a team of pharmacists and psychiatrists. The PPS population health business model and our success will enable us to implement BH integration effectively. The PPS has conducted pilot BH/PCP integration with success, and has presented PCPs with specific training in effective Pain Management with an emphasis on addiction prevention.

- 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.

Community Partners of WNY and Millennium have worked together on the integration of BH and PCP and plan to collaborate throughout implementation.

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

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



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

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

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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

Renovations to primary care and behavioral health offices to enable co-location of services. IT infrastructure to support patient registries; stratification of patients; reporting; protocol development.

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Lakeshore Behavioral Health	Health Home	7/1/2014		Provide care management to high risk individuals with chronic conditions

- 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.

Health Home: The health home provides care management services to qualified Medicaid recipients. The DSRIP project "Integration of Primary Care and Behavioral Health Services" builds upon a foundation of care management offered by the Health Home. The DSRIP goes further in ensuring that all Medicaid recipients with mental illness have access to high quality primary care.

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

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

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

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



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



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

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

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

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

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

*Improve Medication Adherence:*

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



*Actions to Optimize Patient Reminders and Supports:*

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

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

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

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

Overall, Western New York has a 24% higher incidence of cardiovascular disease than the rest of New York State. Some of the most significant concerns for cardiovascular health were seen in Niagara County, which was ranked in the bottom quartile for prevention metrics, and performed worse than the state on hospital admissions for all categories of cardiac-related chronic disease including angina and ischemic heart disease, congestive heart failure, coronary atherosclerosis, and hypertension. Western New York has higher rates of heart attack hospitalizations and obesity, particularly in Erie, Niagara, and Cattaraugus counties. Niagara was also ranked in the bottom third for prevalence of heart failure, and WNY as a whole was ranked last in the state for angina without procedure. According to the CNA the WNY region has 32.7% prevalence of high blood pressure compared to 26.8% state wide. Erie, Niagara and Chautauqua counties performed worse than the state on admissions for patients with hypertension, with Erie and Niagara showing rates of over 200 per 100,000. Erie County also showed higher rates of admission for congestive heart failure. Cardiovascular disease is the leading cause of hospitalization and death in every county of New York State. The goal of this project is to slow the progression of cardiovascular disease, improve patient outcomes and reduce ER visit/hospital admissions. The project will utilize a cardiovascular care management program which includes provider and patient education,



implementation of care management processes and protocols, a care management team (pharmacists, dieticians, social workers, etc.), use of coordinators to provide patient assessments including risks and barriers, self-management techniques including assessing readiness to change, adherence to treatment plan, lifestyle modification, confidence and conviction. Also included is linkage to community based programs/resources with follow-up.

- 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 Medicaid and uninsured patients >18 years attributed to the PPS in Erie, Niagara and Chautauqua counties with a cardiovascular disease diagnosis. The target population is estimated to be 12,707 individuals.

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

In keeping with the Million Hearts Campaign, adopting a heart healthy lifestyle, receiving timely evidence based care and prescribing appropriate medications are included in the cardiovascular care management program developed by Sisters of Charity Hospital/CMP Project Management Team. The chronic disease self-management program of the Stanford Model will also be implemented throughout the PPS to promote patient engagement. The current assets and resources that can be mobilized to achieve the project goals include national evidence based clinical guidelines adopted by for the diagnosis and treatment of congestive heart failure, coronary artery disease and hypertension in ambulatory and community care setting. Another asset is office based electronic health records (EHRs) that enable the practice to create condition specific patient registries identifying patients with "Gaps in Care". Existing resources (the Care Team) include: (a) the clinical transformation team, which supports EHR implementation, maximizes EHR use in the medical office by developing patient registries, and facilitates the use of RHIO, enhancing complete patient health information, (b) social work resources, (c) pharmacist resources, (d) registered dieticians and (e) office based nurse care coordinators. Care coordinators initiate a patient assessment including risks and barriers, self-management techniques including assessing readiness to change, adherence to treatment plan, lifestyle modification, confidence and conviction. The Care Team follows up on referrals to community based programs. Sisters of Charity Hospital/CMP Project Management Team has web based and in person training programs for care coordinators and materials to leverage across the PPS. Sisters of Charity Hospital/CMP Project Management Team developed a web based "tool kit" to perform an assessment, including health literacy, language/translation needs, and readiness to change. The tool kit provides self-management tools and shared decision making resources for patient engagement.

- d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include



issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Some of the challenges anticipated include reaching, engaging and motivating the adult Medicaid patient population in managing cardiovascular disease. Education level is an underlying factor with the lowest rates of high school completion in Buffalo, Niagara Falls and the Southern Tier. Transportation and housing issues exist and may negatively impact patient engagement in seeking healthcare. Community Outreach Workers along with social workers, will provide home visits with linkage to community resources such as legal aid, food banks, transportation, and provide blood pressure monitoring without charging copays. The Health Home will provide integrated services in one setting for patients needing home care services. PCMH practices will provide open appointment access. Tobacco Cessation services will be provided by the NYS Quitline using the 5 A's approach since 49% of Medicaid population are smokers. Patients will be referred to nutritionists at community settings for education and budget meal planning promoting hypertension and cholesterol control. Pharmacists can assist with promotion of once-daily regimens or fixed-dose combination pills. Patient reminder systems will be expanded and enhanced with secure text messages for blood pressure checks, lab work and office appointment reminders. The PPS will provide ongoing competency training for all staff and patients on proper BP monitoring techniques. The PPS will dedicate IT resources to drive improvement in the management of cardiovascular disease through data integration and system interoperability.

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

The PPS will collaborate with regional health plans and other PPS in our service area through project leads, meetings and a toll free hotline.

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

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

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

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

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



will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

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

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

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

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

Capital funding will be required to provide an electronic medical record to practices currently using paper charts, to upgrade existing office EHRs to ensure interoperability and/or consistent data capture for quarterly quality metrics, develop patient registries for cardiovascular disease in the practice, enable alerts and reminders to close gaps in care related to the management of coronary artery disease, hypertension and congestive heart failure.

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?

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



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

### **Project Selection**

For this project, one of the following three project models can be selected. Please indicate which of the three will be chosen:

- Model 1: Implementation of Nurse-Family Partnership program model for pregnant high risk first time mothers.
- Model 2: Establish a care/referral network based upon a regional center of excellence for high risk pregnancies and infants.
- Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.

### **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 revealed numerous gaps in prenatal, maternity, and early childhood preventive care. Adolescent pregnancy rates are very high in WNY. Erie County ranks at the 25th percentile for preterm birth among comparable counties; Niagara is at the 0 percentile. Erie, Chautauqua and Cattaraugus rank in the bottom quartile for maternal mortality versus comparable counties. The WNY maternal mortality rate is 26.8 per 100,000 births, compared to 20.6 statewide. Based on Medicaid PQI, Erie and Cattaraugus are in the bottom quartile for preventing pediatric disease hospitalizations. Well-child visit rates (0-15 months) for all counties fell well below the statewide average. As for emergency visits, the rate for falls among children aged 1-4 was substantially higher (516 vs. 504) than the state rate. CNA data reveal numerous Medicaid-specific gaps. Medicaid low-birthweight rates for both Erie and Niagara are 10.2% compared to WNY (9.6%). The Medicaid rate of high-risk pregnancy is 12.7% for Erie, compared to 10.9% for WNY. It was determined that the evidence-based home visitation model, Nurse-Family Partnership (NFP), is the best model to address these gaps; working with women who are identified as qualified participants (first time high-risk Medicaid moms) will help to address socioeconomic issues contributing to unplanned pregnancy, poor birth outcomes and lack of prenatal and pediatric care. To be successful, strong service linkages will be established with physicians and community service programs, primary care centers, OB clinics and FQHCs in Erie and Niagara County to create a referral system for early identification of women who are or may be at risk. Qualified homecare nurses with a passion for serving the target population will be hired; they will be supported by social workers who can connect patients to appropriate agencies, classes and resources. Staff hired will be representative of the cultures and languages spoken by the target community. Staffing will be provided 7 days/week, including office hours, with emphasis placed on continuity of nurse home visitor assignments, staff training in coaching/outreach, and partnering with other community providers, particularly Community Health Workers, to reinforce continued engagement in the planned home visiting services. Because the Nurse Family Partnership (NFP) limits its focus to first-time Medicaid moms, we will focus on good preventive practices, including coordination with health providers for thorough prenatal and early child care. NFP results show improved spacing of subsequent pregnancies, improved parenting, reduced childhood injuries, and better preparation for preschool. Referral agreements will be strengthened with Catholic Medical Partners physicians and care coordinators, as well as other prenatal care providers and local supportive services including substance abuse, mental health, domestic violence, nutrition services, and other health and social services agencies. A quality oversight committee will be established with broad provider representation. Program participants will be tracked through the use of an EHR supported by McAuley Seton Home Care's Maternal Child team.

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

The target patient population to be impacted by this project is the Medicaid-eligible population of women of childbearing age who become pregnant for the first time in the counties of Erie and Niagara. McAuley Seton Homecare's Maternal Child team will implement NFP programing focused on the high risk areas in these counties, working within the restrictions of its homecare



agency reach and licensure governed by NYS. Expansion to Chautauqua and Cattaraugus Counties will be reviewed for development in year three. Estimated target population for Erie and Niagara Counties is 2,500 first time moms annually whose payer is Medicaid. Because the Nurse Family Partnership model has strict limits as to the number of patients that can be enrolled in a program, we have identified a population of 300 patients that will be actively engaged by Demonstration Year 4.

- 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.

Current assets are McAuley Seton Home Care’s Maternal Child Team, comprised of 7.5 Registered Nurses and a Clinical Manager, providing 6,526 home visits annually to a primarily low-income, vulnerable population with complex needs. The Maternal Child unit’s breastfeeding support team is the largest in WNY, with 5 International Board Certified Lactation Consultants. The population served by the McAuley Seton Maternal Child Team resides mainly in the City of Buffalo and inner suburbs, and includes large populations of African Americans, Native Americans, Hispanics, Somalis, and persons of Middle Eastern descent in addition to Caucasians. McAuley Seton Home Care has sponsored its Maternal Child team for the past 15 years. Our current home visits include a complete physical and social assessment of mother and baby within 24 hours of referral. The nurse communicates closely with primary and pediatric physicians regarding their assessment and follow-up recommendations. Education materials are reviewed, taking into consideration patient literacy and education levels. Linkage is made with community and social service agencies. The experience and competence of the Maternal Child Nurses is key in achieving positive outcomes. In addition to our Maternal Child Program, McAuley Seton Home Care also provides Early Intervention Services to pre-school children in Erie County. Catholic Health has also been operating a “Centering Pregnancy” model and prior to that a Parenting program that mimicked the Centering philosophy. Our OB site at Sisters Hospital has been providing this care model for nearly 2 years. Over 50 women have been in this program and 100% went full term/did not need the NICU for the care of their babies. It has been a very big success. Given Catholic Health’s track record and its desire to implement the Nurse Family Partnership program, we remain committed to enhance our current evidence-based programs and establish this new program to provide yet another level of care for women in need and their families. Additional community resources are available through long-term partners such as Buffalo Prenatal-Perinatal, Buffalo Public Schools, Erie County Health Dep’t, East Hill Foundation, Oishei Foundation, Health Foundation of Western and Central NY, Horizon Health Services, March of Dimes, WNY Public Health Alliance, and Catholic Charities WIC program. These organizations encompass the full breadth of community services from providers of prenatal care, family planning, substance abuse, mental health, domestic violence, nutrition services, child protective services and other health and social services. All have been instrumental in support of the Centering Pregnancy program. Numerous community resources however are still needed and funding will help address these gap needs. Given that NFP program requirements are exactly prescribed and require absolute fidelity to the model, McAuley Seton will be required to pay the necessary fees, including Program Development



Startup Fee, Data Transmission Setup Fee, tuition for initial education session & administrator orientation, and Dyadic Measurement staff training necessary to implement the feeding scales.

- 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 first challenge concerns staffing; the supply of nurses meeting experience/educational qualifications may be limited. Related is the potential for nurse turnover. These will be addressed by enlisting aid from Catholic Health HR, with its innovative “Talent Network” approach. Another challenge involves slow program acceptance by referral sources. The PPS must convince referring and collaborating agencies of the NFP’s importance, and obtain their commitment. This will be addressed by leveraging relationships developed during the DSRIP implementation process. Informal linkages can and will be nurtured into formal alliances. It may be a challenge to identify affordable and easily accessible services/resources to which NFP clients may be referred. Related issues include securing motivation/time from community leaders to participate, and follow-through on community collaborator commitments. Again, our relationships with community agencies participating in DSRIP will ensure prompt resolution. Internal challenges include prioritizing day-to-day tasks and unexpected client issues to ensure the schedule is followed. Adherence to the program’s model elements for admissions, visit frequency & supervision must be monitored. The NFP must be able to remain in control of client intake functions so caseloads are balanced & manageable. Another issue will be the preventing IT interruptions. All these can be mitigated via education. NFP managers/staff will be educated in NFP best practices and encouraged to network with other NFP programs nationwide, and the national NFP office in Denver.

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

The two area PPS’s have collaborated extensively resulting in the joint decision to select two different models to serve the broadest segment of the WNY population. Community Partners WNY has chosen the focused NFP model while the ECMC PPS will pursue community health worker development. The PPS, including McAuley Seton Home Care, has and will collaborate closely with all maternal and child health providers, other home visiting agencies, as well as all major local health and social services providers. Irrespective of the PPS affiliation of these providers. Sisters of Charity Hospital, Catholic Medical Partners and Catholic Health System have an extensive record of regional collaboration which has continued throughout the PPS development process.

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



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

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

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

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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The Nurse Family Partnership has a very prescriptive requirement of resources needed for their staffing model and programs. Each of the Nurse Home Visitors, as well as the Nurse Supervisor, will require a laptop computer that can be brought to home visits in the field. The Administrative/Data Support person will require a desktop computer. Other new office equipment required includes two locking 2-drawer filing cabinets for storage of confidential records. In general support of the program, the Nurse Home Visitors will require digital cameras to record the appearance of their patients, and cellular telephones to communicate with one another and to the McAuley Seton Home Care project office from the field. The program will also require clinical supplies, including blood pressure cuffs, stethoscopes, thermometers, disposable measuring tapes, pregnancy calculators, baby scales, pediatric pads to measure length, bags to carry this equipment, and luggage carriers to transport heavy and/or cumbersome items.



- 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?

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

According to an article by Morrison, Dietrick, Ladwig, et al, on average, Medicaid patients who received palliative care incurred \$6900 less in hospital costs during a given admission than a matched group of patients who received the usual care. Within Western New York,



only 15 % of the Medicaid population utilized palliative care services in an 11 month period. This reflects an opportunity for significant improvement. The community needs assessment (CNA) indicates that the leading cause of death is Cardiovascular Disease followed by Chronic Obstructive Pulmonary Disease (COPD) or other conditions of the lung. Overall, Western New York has a 24% higher incidence of cardiovascular disease than the rest of New York State. Some of the most significant concerns for cardiovascular health were seen in Niagara County, which was ranked in the bottom quartile for prevention metrics, and performed worse than the state on hospital admissions for all categories of cardiac-related chronic disease including angina and ischemic heart disease, congestive heart failure, coronary atherosclerosis, and hypertension. The most seriously ill patients incur the highest costs – in 2009 the sickest 5% of patients in the United States accounted for greater than 50 % of health care spending, with a large proportion spent in the last year of life, often on hospital and /or ICU care. . Disease and disability become more prevalent during the later decades of life, directly bearing on health care need and consumption. Poor health can also create barriers to health care. Almost one out of six individuals across the region, about 243, 400 in all, are age 65 and up. The majority live in Erie county (59%) but comparatively high proportions live in Niagara, Chautauqua, and Genesee counties. There is at least one hospice service location in every county. Catholic Medical Partners, the Project Management Team for CPWNY PPS, currently has approximately 60% of its practices recognized as NCQA Level 3 Patient Centered Medical Homes (PCMH). Community Partners of WNY will work with current assets of Sisters of Charity Hospital, Catholic Medical Partners, Catholic Health home care/hospital palliative care program and the local Hospice Programs. Current assets include registered nurses, social workers and others who work collaboratively to identify and address the needs. As more patients are identified, staffing will be expanded proportionately.

- 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.

Geographically, target populations will be identified in the following order: in Erie County will be within the first 6 months; in Niagara County during the second 6 months and in Chautauqua County over the next 6 months. This project will be fully implemented within 2 years. The target population is patients with cardiovascular diseases and COPD as identified in the CNA and will be identified within PCMH practices with the largest Medicaid population. Additionally, patients living at home or in alternative settings like assisted living and long term care will also be focused upon. Social needs will be identified and addressed within the context of individual cultural and ethnicity beliefs and on chronic illness, interventions on symptom management/pain control and the dying process.

- 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 programs have established staff to patient ratios that will be utilized for the implementation of this project. Current assets that are mobilized include physicians, registered nurses, social workers, spiritual care staff and other community outreach staff. Proving support for meaningful discussion within the PCMH practices will start the process on an outpatient basis rather than after an admission to the hospital, thereby decreasing hospital admissions. Existing staff will be utilized and additional staff will be added incrementally based upon the volume of the identified target population. Community resources needed will be Hospice and Palliative Care Certified Clinicians, home health aides, assistive devices to maintain home living, faith community support, social services department case workers and care managers. Additionally, initial and on-going training will be provided by partner organizations for the PCMH offices via webinars.

- 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 challenge is understanding the word Palliative Care by both the target population as well as groups of physicians and other care providers. Palliative care has been associated with “death” and not the care of the living in attainment of quality in everyday life. Plan to overcome this perception: phone call campaign as well as a faith based approach in communities, libraries, shelters, clinics and food pantries. Other challenges include the continued growth of PCMH office which will be addressed via the use of the clinical transformation team from the Sisters of Charity Hospital Project Management Team. All interventions will be culturally and ethnically sensitive so insure the competency of the staff addressing issues with patients.

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

There is no plan to coordinate with other PPS as this is not a collaborative project. That said, CPWNY partners have been working on a community wide approach to palliative care through workshops and provider meetings and we expect this collaborative work will continue.

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

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



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

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

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

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

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

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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



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

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

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

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

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

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



## Domain 4 Projects

### 4.a.i Promote mental, emotional, and behavioral (MEB) well-being in communities (Focus Area 1)

**Project Objective:** This project will help to promote mental, emotional, and behavioral (MEB) well-being in communities.

**Project Description:** The best opportunity to improve the public's mental health and prevent its development from manifesting is the delivery of preemptive interventions. This project focuses on increasing the use of evidence-informed policies and evidence-based programs pertaining to the healthy development of children, youth, and adults.

- Increasing evidence indicates that promotion of positive aspects of mental health is an important approach to reducing MEB disorders and related problems.
- The 2009 IOM report concluded that the promotion of mental health should be recognized as an important component of the mental health spectrum, rather than be merged with prevention.
- MEB health serves as a foundation for prevention and treatment of MEB disorders.
- A developmental, interdisciplinary approach to MEB health promotion will affect homes, schools, workplaces, and communities.
- Child and youth development research should be synthesized from a State MEB health well-being perspective, and assessed to identify opportunities for action.
- Research indicates that focusing on positive child and youth development policies has the potential for the greatest return on investment

**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. Identify and implement evidence-based practices and environmental strategies that promote MEB health. A menu of interventions is found on the Prevention Agenda website accessible via the following:
  - Website: ([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))



- Section: Promote Mental Health and Prevent Substance Abuse Action Plan, Interventions for Goal 1: To promote mental, emotional and behavioral (MEB) well-being in communities
- 2. Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health.

### 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 CNA identified gaps in MEB services related to binge drinking, depression, marijuana use, obesity, and suicide. WNY ranked in the bottom third of NYS regions promoting mental health and reducing substance abuse. WNY had a higher rate of suicide deaths (11.4%); almost double the NYS goal (5.9%). 40% of Medicaid patients indicated that mental/physical health affected the ability to perform daily activities. Erie (24.1%), Niagara (22.4%), and Cattaraugus (24.5%) have high rates of adult binge drinking compared to the NYS objective (13.4%). WNY adults reported the highest past 30-day binge drinking rates in NYS (22%). Buffalo Public School (BPS) data shows the number of students who tried marijuana is higher than the NYS average (9.7% reporting use before age 13 compared to NYS average of 7.6%). 22.8% reported using in the last thirty days compared to NYS (20.5%). Women residing in Buffalo have a higher percent of low birth weight babies (10.5%) compared to the NYS average (8.2%). OMH data shows WNY suicide rates as 5.84/10,000. Other reports indicate 6.7% of US adults have depression and 11% of adolescents have a depressive disorder by age 18 (NIMH). Factors contributing to this include poor mental health/substance abuse and other physical health and environmental factors. Early age of onset and alcohol use patterns are risk factors predicting future binge drinking. Two school districts indicate high rates of early initiation of alcohol use. BPS (14.9% before age 13) and Lancaster (48% by grade 12). Students reported high 30-day usage rates (BPS; 25.7% and Lancaster; 48%). Research shows that decreases in perception of harm and social disapproval of marijuana correlate with increases in use. 67.3% of high school students referred in Erie County interventions reported “no” or “slight risk” associated with marijuana. Erie (29), Niagara (28) and Cattaraugus (27) Counties have high rates of obesity compared to NYS rate of 23/10,000. Physical inactivity will be addressed as a risk factor to impact obesity in WNY. Physical inactivity is apparent



in BPS. Studies show 42% of students watch television for 3 or more hours a day (30.6% NYS level). 20% of students did not participate in physical activity for 60 minutes for the past 7 days (NYS; 13%). Binge drinking will be targeted to impact low birth weight babies. Alcohol has known teratogenic effects on developing fetus, causing Fetal Alcohol Syndrome (FAS)/ disorders such as low birth weight in babies of women who drink alcohol while pregnant. FAS rates in Buffalo are 3.75/1000 births, three times the national average. 24.5% of sexually active BPS students reported drinking alcohol/using drugs before their last sexual intercourse. Sexually active BPS students who do not use a condom has risen 15% in three years. Risk factors targeted to combat the rates of suicide/depression include low self-esteem, poor coping skills and lack of emotional support in youth. Stigma associated with mental health/lack of education need to be addressed due to higher than average WNY suicide rates. Depression is known to be one major risk factor for suicide. Substance abuse/mental health stigma is a national issue. Studies show only 25% of adults 18-24 believe someone with a MEB disorder can recover; 42% believe they can be as successful at work as others; and 54% believe that treatment can help those with a MEB disorder. Only 26% agree that people are sympathetic toward those with these conditions. Associated risk factors will be targeted through evidence-based practices to address MEB gaps specified. Project partners have relationships in all 8 county school districts/communities. CPWNY partners currently deliver evidence based programs to address each of the identified risk factors such as binge drinking, depression, inactivity, etc. The plan is to expand existing programs to other high risk areas identified in the CNA.

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

The target population was selected based on geography, demographics, and high-risk conditions that have the greatest potential for successful intervention, behavior change and cost avoidance/cost reduction. It includes individuals with the risk factors identified in the CNA: substance abuse, binge drinking, obesity and child and adolescent depression, adolescent/adult substance abuse, adult depression, and adolescent/adult suicide risk as identified in the CNA, school and community data sources. The targeted population resides in all eight WNY counties, and specifically in urban, first ring suburban and rural areas, and addresses the changing demographic mix in our region and includes specific Spanish and Arabic language groups.

- 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 CPWNY PPS partners have engaged the Mental Health Association (MHA) of Erie County and the Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA) to take the lead as the partners on this project to promote MEB across the eight-county WNY region. The team of collaborators are well-positioned to deliver high-quality programming in WNY due to their current partnerships in the WNY schools and communities. Collaborators include mental health and substance abuse providers, and MHAs and Substance Abuse Councils in all eight WNY counties. The MHA and its vendors have established programs that are SAMHSA-approved, including Mental Health First Aid, Too Good for Violence, Ripple Effects, Compeer, and Wellness Recovery Action Plan. These programs are currently being utilized in the WNY area and have a



proven track record to reduce the suicide and depression risk factors identified in the CNA. ECCPASA and its partners have experience administering many evidence-based, SAMHSA-approved programs which address the risk factors of binge drinking, substance use, obesity and low birth weight babies identified in the CNA. These programs include Too Good For Violence/Drugs, An Apple A Day, Building Skills and Project Northland, Teen Intervene, and Project CHOICES. Other evidence-based programming includes parent awareness forums, student assistance prevention counseling, media campaigns, Fetal Alcohol and Drug Effects, and Environmental strategies. Newly proposed SAMHSA approved programs include Wellness Outreach at Work, and an evidence-based practice (Switch What You Do, View, and Chew).

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

We anticipate many challenges with this initiative. A primary challenge is to effectively overcome the stigma mentioned in the CNA associated with substance abuse, addiction and mental illness. In order to do so, we will engage a professional PR and media consultant to develop a region-wide campaign to raise awareness, address stigma, and generate positive change. Another challenge is gaining access in various school systems with demanding State Education requirements related to the Common Core Standards and student benchmarks. In order to ensure engagement with the schools and mitigate this problem, the partners will align program initiatives with the State Education Department requirements and work with school administration to ensure proper program implementation time. In addition, some WNY community leaders and organizations fail to fully appreciate the magnitude of MEB problems and to see their role in effectively solving them. We will face this challenge by actively engaging these leaders to give them a better understanding of their responsibility for bringing knowledge and evidence-based prevention to their communities to promote positive outcomes such as healthy decision-making and positive behavior changes. The final barrier identified in our CNA includes cultural and language barriers associated with the changing demographic mix in the WNY area as a result of immigration. Our partner agencies have developed relationships with community experts to overcome this obstacle as evidenced by their demonstrated success with the targeted populations.

- 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.

Community Partners WNY and Millennium, the two PPSs serving WNY, have been working in partnership along with a comprehensive group of approximately thirty agencies located throughout the eight-county region. It is expected that this level of collaboration will continue and expand.

- 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.

1. 1/15/15 - Identify roles and responsibilities and accountability of each partner. 2. 2/1/15 - Prioritize the delivery of programs based on need/community impact and accessibility. 3. 2/1/15



- Identify outcome metrics and report requirements. 4. 3/1/15 - Identify how the DSRIP initiatives will increase the number of people receiving services.

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

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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?

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Mental Health Association of Erie County	Medicaid	12/1/2015		To provide peer support services through the Child and Family Support Program
Compeer	Medicaid	12/1/2015		To initiate: Empowerment Services & Peer Supports, Psychosocial Rehabilitation and Family Support Training
WNY Independent Living Mental Health Peer Connection	Medicaid	current		Provide relapse prevention programming utilizing the Wellness Recovery Program



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
EC Council for the Prevention of Alcohol & Substance Abuse	Population Health Initiative Program	2015	2017	TO address population health & health disparities in WNY

- 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.

MHA & Compeer do not currently offer any billable services through Medicaid, however as noted above MHA has initiated the application process to provide Medicaid billable services. Therefore, the DSRIP project will assist in expansion of current services in alignment with its project goals.

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

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

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

- a. Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.
- b. Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



#### 4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2)

**Project Objective:** This project will promote tobacco use cessation, especially among low SES populations and those with poor mental health.

**Project Description:** Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use alone results in an estimated 25,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer (including lung and oral); heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.

The economic costs of tobacco use in NYS are staggering. Smoking-attributable healthcare costs are \$8.2 billion annually, including \$3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in \$6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health. This project is targets decreasing the prevalence of cigarette smoking by adults 18 and older by increasing the use of tobacco cessation services, including NYS Smokers' Quitline and nicotine replacement products.

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

1. Adopt tobacco-free outdoor policies.
2. Implement the US Public Health Services Guidelines for Treating Tobacco Use.
3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
4. Facilitate referrals to the NYS Smokers' Quitline.
5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
6. Promote smoking cessation benefits among Medicaid providers.
7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
8. Promote cessation counseling among all smokers, including people with disabilities.



### Partnering with Entities Outside of the PPS for this Project

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

Entity Name

### 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.

Tobacco use remains the leading preventable cause of morbidity and mortality (Reference: SGR report, Bureau of Tobacco Control Independent Evaluation Report). WNY has some of the state's highest smoking rates. Our counties (Erie, Niagara, Chautauqua and Orleans) are among the worst ten, with 2009 smoking rates of 26.6%, 27.1%, 26%, and 29.9%, respectively. (Data from NYSDOH, 2008-2009) This amounts to nearly 300,000 current adult smokers in five counties within the catchment area for this proposal (based on 2010 Census population). Among those surveyed for the WNY Community Needs Assessment, smoking rates were much higher in Medicaid and uninsured populations (49% and 48%, respectively), compared to only 16% among those with employer-based insurance. (WNY CNA, p. 18) Approximately half of all smokers have a high school diploma or less (Who's Quitting in New York, 2011, p.3). While overall NYS smoking rates have dropped between 2003 and 2011, particularly among those with higher education and income, rates remain unchanged for those with less than a high school education, household incomes less than \$25,000 per year, and those with poor mental health. WNY counties have lower incomes and education levels compared to New York State as a whole, thus bearing a disproportionately large share of the burden tobacco places on public health. While preventing youth from starting tobacco use is an important public health goal, helping current smokers quit will result in larger more immediate health gains (Youth Prevention and Adult Smoking in New York, 2011, p.7), which is why this program focuses on smoking cessation. Evidence-based treatments for smoking cessation, such as counseling and pharmacotherapy, increase the chances that quit attempts are successful; however, most quit attempts by smokers are unaided and do not use evidence-based approaches (Who's Quitting in New York, 2011, p.20-25). Many community resources exist to help smokers quit smoking. We propose to augment the programs below in order to boost their reach and utilization among smokers, which will result in improved health and decreased hospitalizations. We focus on three NYS-funded programs: 1) The Opt to Quit program with the NYS Smokers Quitline; 2) the Health Systems Change program; and 3) the Advancing Tobacco Free Communities initiative (more details below). These programs reach smokers through their healthcare providers (#1 and #2) as well as from grassroots efforts in low income multiunit housing complexes (#3).



- 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.*

Through the Opt to Quit and Health Systems Change programs described below we will identify smokers through physicians' offices. The Advancing Tobacco Free Communities effort will identify smokers living in the multiunit housing properties we have identified to work with. We have a particular focus on Medicaid beneficiaries in poor mental health; however, the programs we propose to expand reach the broader population but provide additional tools to help those who need more help quitting smoking.

- 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.

We will expand 3 assets to support this initiative. Roswell Park Cancer Institute (RPCI) holds the contract for the DOH-funded Smokers Quitline (NYSSQL), providing phone and web-based cessation support and medication to 100,000 New Yorkers each year. Client volume is traditionally driven by DOH anti-tobacco media, but NYSSQL has programs to foster referrals from providers directly to NYSSQL for services. The flagship referral program, Opt to Quit (OTQ), works with providers to enact systems change such that each patient's tobacco use is identified at each visit. Patients are referred to NYSSQL for contact regarding the quit process, and offered Quitline services, unless they opt out. All patients identified as tobacco users are automatically referred to cessation services unless they decline. OTQ is gaining momentum with providers (including in WNY) generating 800 referrals to the NYSSQL each month or ~10,000 per year (about 10% of client volume). We propose to recruit additional providers to participate in OTQ by adding a staffer to educate them about program benefits, and an IT person to facilitate data transfer from the provider to NYSSQL and patient reports back to the provider. Initial efforts will implement OTQ among collaborating PPS partner organizations, including those primarily serving Medicaid and patients with disabilities. The providers would be educated in PHS Guidelines for Treating Tobacco Use. This would also provide an opportunity to work toward increasing Medicaid and insurance coverage of tobacco dependence treatment and medications, and a platform for creating health insurance benefits for prescription and OTC cessation meds. Second, RPCI holds a DOH contract to foster Health Systems Change (HSC) in Federally Qualified Health Centers and clinics primarily serving persons with mental health comorbidities in 8 WNY counties. HSC exclusively focuses on populations with high smoking rates and serves populations with diverse health needs by providing more 'boots on the ground' to change providers' systems by automating the identification of tobacco users and their referral to evidence-based cessation treatments. This could involve adoption of OTQ or some other referral program such as the less tech-driven 'Fax to Quit', where providers manually refer to NYSSQL via fax. HSC is in its first year so recruitment has just commenced; we propose to expand this existing asset by adding a staff person to enhance efforts made to educate providers about the program. Because HSC makes changes at the systems level, successful program adoption by providers will result in significant patient yields into smoking cessation treatment services. This would provide an opportunity for providers, assisted by their EMR systems, to complete the "5 A's". Third, RPCI holds three contracts under the DOH Advancing Tobacco Free Communities (ATFC) initiative. ATFC is a grassroots program to advance



chronic disease prevention with a community-based strategy including community education, mobilization, and public education to develop/reinforce tobacco-free norms via youth action and community engagement. One AFTC initiative is to reduce secondhand smoke exposure in shared multiunit housing environments. This program currently has staff working with landlords, public housing authorities and others to promote smokefree policies, including advocating for tobacco-free outdoor policies. One in 12 WNY smokers live in multiunit housing and persons with low SES disproportionately reside there, making it a rich location to educate about tobacco use and smoking cessation. Because of the significant community partnership built, we propose to expand this current asset by adding a staffer who would focus on smoking cessation within multiunit housing. We will work directly and through our partners with the companies managing the largest number of multiunit rentals and with municipal housing authorities to promote smoking cessation among these residents.

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

The largest gains will come from the rapid adoption of the OTQ program by many providers. We face four barriers: First, providers don't know about or understand the OTQ program. Second, technology barriers make it challenging to exchange patient information across systems. The additional staff request will help address these barriers. A third challenge is that the focal clinics for the HSC initiative serve a complicated patient profile that is difficult to reach; however, these are the populations that stand to gain the most from smoking cessation and there are successful models to follow. Additional staff will allow for a stronger field team to work with these clinics to push for systems change. Lastly, gaining access to multiunit housing tenants can pose challenges; however, we will work with and through community-based partners such as the Urban League to facilitate our program.

- 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.

Community Partners WNY is the only PPS in the region undertaking project 4.a.i. Our PPS expects to collaborate broadly across the 8 counties of WNY to meet the goals of this project.

- 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.

For OTQ, we project 25% increase in patient participation in Year 1 via recruitment of at least 4 providers. We project subsequent annual 33% increases in participation or a 4-fold increase from current levels (800 patients monthly from 17 providers). For HSC, we project that by the end of Y1, negotiations will be advanced with at least 2 FQHCs, and in years 2-5 health systems policy changes will be adopted in at least 2 clinics per year for a total of at least 8 clinics. For AFTC, in each year we aim to have agreements in place with at least 4 property mgt. firms holding at least 5% of the multiunit housing market share, to allow our team to work directly with their residents



to promote smoking cessation, for a total 20 firms covering at least 25% of multiunit housing residents.

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

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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?

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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.

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



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

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

- a. Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.
  
- b. Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.