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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.

CNA findings point to a misalignment between the health needs of Orange and Rockland Counties and how individuals access, engage, and receive health care services. Data point to fragmented services leading to suboptimal care management and the need for better integration of services across the spectrum of population-specific needs (CNA 2, 5, 8). The Lead Entity, Refuah Health Center, has taken steps to expand access to services (e.g., opening an urgent care center, reducing ED rates). However, other PQI indicators reveal higher than expected hospital admissions related to avoidable complications of chronic conditions, including COPD, CVD, and diabetes; high rates of hospitalization for children with asthma; and high ED visits for behavioral health. The PPS is home to several large, immigrant and religious communities with unique language, literacy and cultural needs that impact access and utilization of services. An analysis of hot spots by zip code links data regarding the prevalence of chronic conditions with socio-demographic determinants, including poverty, language, race/ethnicity, employment, and reported levels of physical activity. Specific PPS hot spots include Newburgh, Haverstraw, and Middletown in Orange County and Spring Valley in Rockland County. CNA findings signal the need to better manage Ambulatory Care Sensitive Conditions in adult populations (CNA 5, 6). The CNA also revealed high birth rates in the service area and that maternal/child (e.g., vaginal or cesarean deliveries, newborn with other problem) are among the top 20 Medicaid inpatient discharges in the service area.



An Integrated Delivery System (IDS) is an imperative for organizing a system providing timely and streamlined access to the right providers and services for patients with diverse and often complex health care needs and fostering earlier prevention and health promotion among populations.

Aligning partners, providers, and services in an IDS establishes an infrastructure for effective population management and system-wide accountabilities for improving utilization and health outcomes. To support the implementation of the IDS project—and the other 6 projects— the Refuah Community Health Collaborative (RCHC) will develop a Project Management Office, which will provide implementation and improvement support for PPS partners participating in projects as well as connectivity through HIT/HIE solutions. In addition to implementation support, this centralized resource will monitor community needs on an ongoing basis and identify resources to support meeting those needs.

The IDS will establish primary care practices and sites in or near the hot spots as primary care “hubs” offering comprehensive services and expanded care management and coordination. The other 6 projects will link to the hubs, including a navigation project (3.c.i) that will expand access and target appropriate utilization among high-risk populations, such as those experiencing language, transportation, or other barriers to care. The PCMH project (2.a.ii) will set a new bar for primary care practices across the PPS, where currently 2 practices are 2011 NCQA certified and one is 2014 certified. Certification standards call for an advanced level of care delivery, population health, and patient engagement (e.g., risk stratification, team-based care, care management and coordination, and robust relationships with community-based partners). These standards are critical to improve identified deficits in prevention and chronic care management. The behavioral health projects (integration 3.a.i, crisis stabilization 3.a.ii, and medication adherence 3.a.iii), target current utilization such as avoidable ED visits by integrating proven models for behavioral health screening, outreach, and care management for high-risk individuals. Proposed tobacco project 4.b.i targets tobacco use for people who have low SES and/or mental health conditions.

- 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.

RCHC’s new PPS infrastructure will provide support for the IDS project. This includes a Project Management Office (PMO) that will include without limitation a Medical Director, Director of Program Information and Innovation (HIT), and a Compliance Officer. The PMO will oversee project implementation, improvements, and information system enhancements.

RCHC partners bring invaluable assets that will be mobilized as part of the IDS project. Primary care sites from 4 major RCHC partners will be available to serve as major IDS primary care hubs, including 2 Refuah Health Center sites, 1 Ezras Choilim site, and 30 primary care providers from 3 major practices and 10 sites from the Bon Secours Medical Group. The Hudson Valley Community Care Collaborative, a Health Home led by Hudson River HealthCare, will also serve as a primary care hub and contribute expertise, tools, and input based on its experience providing complex Health Homes’ patient care management. Refuah brings PCMH expertise, including an on-staff PCMH expert, and experience providing innovative resources to support access, including a fleet of 5 mobile medical vans providing



care in community-based locations and a free shuttle system that make more than 40 regular stops per hour in Rockland County and bring patients to their sites for care. Other FQHCs in the RCHC network, including Ezras Choilim, Greater Hudson Valley Family Health Center, and Hudson River HealthCare, also bring a similar base of PCMH expertise. The Bon Secours Medical Group has one of its practices 2014 PCMH certified and another in the process of applying. They will have their physician practice management, PCMH/QI, and data analytics staff participate and provide input to the RCHC IDS projects, sharing population health management tools and expertise from their system.

The existing HIT platforms used by RCHC vary in their ability to meet DSRIP requirements and will need to be brought to minimum standards to meet project goals. However, in addition to developing links to SHIN-NY THINC RHIO, the RCHC information management strategy requires a solution for supporting care management and capturing care coordination information and patient interactions among all community-based providers and activities. The specific HIT/HIE solutions will be identified during implementation planning, include exploring collaboration with the other 3 Mid-Hudson PPSs to avoid duplication and ensure prudent use of resources. One vendor for consideration is PeerPlace, which is designed for health and human services agencies to track clients across settings and used by Lower Valley Perinatal Care, a RCHC partner.

RCHC will also leverage current initiatives and assets of community-based partners to build community health worker and care navigator resources. This will include leveraging existing staff and identifying community members who can be trained to become employed in these roles. The RCHC behavioral health crisis intervention program will collaborate with the other 2 Mid-Hudson PPSs to design RCHC mobile crisis unit operations responsive to cultural and hot spot locations and build on current resources: a Rockford paramedic's crisis line development grant, Orange County Department of Health mental health crisis line, and Good Samaritan resources and expertise with crisis-trained social workers in the ED.

Given the high birth rates in the service area and that maternal/child (e.g., vaginal or cesarean deliveries, newborn with other problem) are among the top 20 Medicaid inpatient discharges in the service area, several RCH partners also will develop a birthing center as an alternative to hospital deliveries. The birthing center would be an important part of the Integrated Delivery System by filling a critical gap in the area, reducing hospital costs, and being a resource for navigators (project 2.c.i) to connect with families in need of other care and services.

- 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.

Achieving system integration across the RCHC will be a challenge. New team working relationships must overcome silos across the care spectrum resulting in measurable improvements in outcomes. An effective organizational strategy and resources must support the transformation process and projects, considering the current limited bandwidth of providers and the need for well-orchestrated change management. In response, RCHC's PMO and IDS and PCMH projects will focus and accelerate the



primary care integration and practice reengineering process and apply resources for training, process engineering, coaching, and HIT/HIE to enhance coordination and build capacity for sharing and using patient information among care teams. Clinicians and community-based entities will be linked with direct messaging among EHR platforms and a supplemental care management/coordination platform among priority hub providers by end of DY2.

Engaging all providers in system transformation will be a key challenge. As part of new contractual and payment structures, RCHC governance structure will define accountabilities for outcomes and create financial incentives that reward achieving key milestones and metrics. Across its projects, RCHC's engagement strategy includes cultivating 1) a group of physician/provider champions drawn from across PPS partners and engaged in PCMH certification, behavioral health, and other projects and 2) community health workers and care navigators drawn from the communities they serve and trained to activate patients and providers. These transformation champions will provide peer leadership and culturally competent approaches as changes are implemented as part of DSRIP projects. This collective ground-level leadership group will provide input to the RCHC PMO and Clinical and Data/IT Governance Committees about progress, barriers, and solutions as RCHC pursues transformation.

- 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.

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPSs already collaborated on a single CNA for the Mid-Hudson region. The PPSs will build on this foundation of collaboration into the implementation planning and implementation phases.

RCHC is participating on cross-PPS regional councils to facilitate collaboration and support regional transformation efforts. This will help ease implementation complexity for partners, align community-wide messaging and implementation, leverage economies of scale, and ensure prudent resource utilization.

RCHC leadership will participate on a Regional PPS Council, which will set overall direction for collaboration, including exploring sharing costs for required HIT/HIE standards and other high-cost shared infrastructure needed by providers in multiple PPSs; workforce support, including regional training; capital requests; and implementation requirements (e.g., RHIO consent).

The RCHC CMO will participate in a Regional Clinical Council, composed of clinical leads from the respective PPSs, to promote alignment on evidence-based guidelines, metrics, and options for overlapping projects.

RCHC also will participate in a Regional Public Health Council, composed of public health leads from the respective PPSs, to promote alignment on public health campaigns.





## 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.

RCHC's vision for an IDS is to build a new system of care that will shift the focus of care from "downstream" acute care interventions to "upstream" community-based care. This will improve care and outcomes and decrease costs associated with preventable ED and inpatient utilization. Good Samaritan Hospital already reduced certified/in-service beds from 370 to 286 and reconfiguring units to be more efficient through a HEAL NY grant program. Current occupancy levels are at their highest and they continue to see growth in demand. RCHC's goal, therefore, will be to increase the use of community-based resources to better manage the growing demand for inpatient care. Reductions in avoidable hospital use will be offset by projected new hospital use due to population growth.

RCHC will pursue a 4-part strategy for achieving this shift linked to the IDS and other RCHC projects.

1. Creating integrated primary care hubs
2. Strengthening provider capabilities through PCMH certification
3. Expanding comprehensive integrated behavioral health services
4. Establishing an effective infrastructure for ongoing population health management.

**INTEGRATED PRIMARY CARE HUBS.** Primary Care Hubs: RCHC will expand access to evidence-based population health management by enhancing primary care sites to serve as "primary care hubs." The hubs are located in RCHC communities, including hot spot zip codes. The hubs will provide integrated primary care and behavioral health, care management and coordination, navigation services, and links to health prevention and behavioral health programs. They will lead comprehensive care planning and the coordination of patient services provided by a full range of community-based providers, specialists, and hospitals. The hubs will tailor patient care teams and service coordination to meet the needs of their patient panels. Engagement and planning among these primary care practices will be part of developing a PPS implementation plan, including actions and timelines for recruitment, hiring, and training. In conjunction with PCMH project plans, RCHC has selected priority sites for implementation: 2 Refuah Health Center sites, 1 Ezras Choilim Health Center site, the Hudson Valley Community Care Collaborative (a Health Home), and some percentage of the 30 PCPs and 10 Bon Secours Medical Group primary care sites.

**Additional Navigation Services:** CNA findings point to hot spots where cultural, language, and transportation barriers to access lead to missed primary care/prenatal/behavioral health visits, avoidable ED visits, hospital readmissions within 30 days, and medication adherence challenges. Project 2.c.i will address these issues by implementing a community-based navigation service that will provide culturally appropriate outreach and peer supports for patients. Navigators will be affiliated with primary care hubs but deployed across multiple provider practices to serve specific communities and





populations.

Implementation will begin in Q1 DY1 by developing of role descriptions and navigation processes, identifying potential resources, and developing business/hiring agreements. Representatives from primary care practice hubs and others who serve targeted populations will be involved in this development.

**PROVIDER CAPABILITIES. PCMH Implementation and Certification:** The PCMH project will create the building blocks for the new primary care hubs and ensure that all RCHC primary care providers have advanced care delivery capabilities (e.g., patient engagement, risk stratification, care management and coordination, integrated care). Through this project, RCHC will build provider-level capacity for robust population health management.

Implementation planning will include workforce recruitment and hiring especially for RN care managers, behavioral health clinicians/staff, and care coordinators. Practices will work with RCHC behavioral health and other community partners to identify potential resources who can serve as part of expanded PCMH teams. Respecting the challenges of shifting practice cultures and achieving full readiness for PCMH certification, RCHC is targeting a 3-year timeframe to achieve full implementation of capabilities and PCMH certification for all providers by the end of DY3. However, RCHC expects to build on the readiness of certain practices that have already adopted PCMH elements, are certified under 2011 standards, or are already working toward certification on 2014 standards. These practices will be the initial cohort of providers that will be ready for certification earlier than DY3.

**COMPREHENSIVE INTEGRATED BEHAVIORAL HEALTH SERVICES. Integrated Physical and Behavioral Primary Health Care:** PCMH certification involves integrating behavioral health screening, referrals, care coordination, and care management as part of primary care processes. The RCHC primary care workforce will be expanded to include care managers and coordinators in primary care sites, including nurse practitioners and other clinicians and professionals to support physical and behavioral health integration. During implementation planning, primary care practices will work with behavioral health partners to identify specific recruitment and hiring plans for behavioral health personnel (e.g. RN/NP, social workers, psychologists or other clinical and non-clinical personnel with appropriate experience and qualifications). As part of the initial phase of PCMH preparation in DY1, practices will develop blueprints for how behavioral health will be integrated into their practice work flow and processes of care.

**Targeted Behavioral Health Services:** CNA findings show a concerning rate of suicide and a high prevalence of avoidable ED visits by individuals with behavioral health conditions. Rockland County ambulance service reports 51 behavioral health related ambulance runs a month for 2 years. In addition to integrating behavioral health screenings and care management as part of organized PCMH practices, three additional services will be implemented through projects 2.c.i navigation, 3.a.ii crisis stabilization, and 3.a.iii medication adherence targeting individuals with higher mental health risks and co-morbid physical and behavioral health conditions such as those identified in the CNA (e.g., depression, bipolar disorders and schizophrenia).

**INFRASTRUCTURE FOR POPULATION HEALTH MANAGEMENT. HIT, HIE, and Advanced Analytics:**  
Enhancing the information management infrastructure will be a key priority,



including augmenting provider competency in using EHRs, implementing clinical decision supports and care coordination applications, and implementing technical strategies to support real-time data sharing for care management and coordination. All partners will have to comply with the PPS' data sharing plan. This plan requires that providers be actively capturing and sharing patient information via interoperable EHR platforms. RCHC also will implement centralized analytic support in its Project Management Office that will assist partners using data to target interventions and to monitor population health, including in existing hot spot zip codes.

Strategic IDS milestones are to immediately implement PMO functions during the first quarter of DY1, engage and develop the initial set of hubs by the end of DY1, demonstrate enhanced hub operations and branding with patients by the end of DY2, and demonstrate application of care management protocols and new services for high priority patients (e.g., respiratory, diabetes, depression, bipolar disorder, schizophrenia) necessary for PCMH level 3 certification by the end of DY3.

- 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 IDS governance structure is the PPS governance structure. The governance structure creates an overarching population health management infrastructure by including each of the major PPS partner provider categories, the RCHC Executive Governing Body, Operations Committee, and the Clinical and Data/IT Governance Committees. Part of the Executive Governing Body's role is to define partner accountabilities, align efforts across the PPS related to achieve specific performance goals and objectives, manage performance across the PPS, and develop and apply payment incentives that incentivize performance among providers.

The Executive Governing Body will be accountable to ensure that participating partners actively participate in the integrated delivery system. The proxy measure for this will be the number of providers connected and sharing information via the RHIO.

Developing primary care hubs across the PPS requires systems capacity to capture and share information beyond traditional clinical patient visits. A full range of patient information related to physical and behavioral health, medications, and social supports must be incorporated into comprehensive care plans and registries and be available to care teams for managing individual patients and panels of patients. The Executive Governing Body and Operations Committee will need information in the aggregate to analyze, monitor, and intervene based on observed patterns of care, trends, and progress against goals for IDS development and performance. The Clinical Governance Committee will be responsible for analyzing and reporting these data to the Executive Governing Body and Operations Committee. The Data /IT Governance Committee will be responsible for executing a data sharing plan with components of an effective population health management platform that includes appropriate software applications and supports and provide reports to the Executive Governing Body and Operations Committee. Priorities will be to ensure that a data sharing solution is implemented across the PPS by all participating providers during DY1-2, and that a plan is in place to ensure that adequate use of a PPS-wide solution(s) is achieved by the end of DY3, which will support achievement of PCMH



certification and Meaningful Use requirements. Incremental targets include 100% of providers to be using at least a portal and/or direct secure messaging facilitated by THINC RHIO as a data sharing solution by the end of DY2; 100% of participating primary care providers with full EHR and interoperability capacity meeting meaningful use standards by the end of DY3; and 100% of major primary care hubs using an additional care coordination platform for capturing information about care coordination, navigation, and other community services.

In line with overseeing successful implementation of Project 2.a.ii, the Executive Governing Body will be responsible for ensuring that all participating primary care providers achieve PCMH Level 3 certification by the end of DY3. PCMH certification is itself a proxy indicating that providers have instituted the advanced primary care practices that are required for optimal patient-centered, population-focused care management. Moving providers to Level 3 PCMH certification will involve a sequence of steps to assess, train, coach, and continually improve policies and processes. These efforts will be overseen by the Executive Governing Body, Operations Committee, and Clinical Governance Committee. Currently, 1 of the PCMHs in the PPS network is Level 3 certified and 2 providers are certified on 2011 standards. Targets will be to increase certification to 100% of primary care practices by the end of DY3.

The Executive Governing Body, with assistance from the Operations Committee and Clinical Governance Committee, will oversee all IDS integration projects. In conjunction with the Operations Committee, the Executive Governing Body will develop and institute strategic and management plans, including provisions for shared resources, policy development, and other dimensions of IDS operations. A plan and schedule for system-wide training will be part of the PPS implementation plan. As part of PCMH project rollout, iterative phases of engagement, assessment, training, and intensive process reengineering will take place in DY1-2 to support achieving certification of practices by the end of DY3.

One critical area of responsibility will be to facilitate payment reform and the transition to value-based payment for participating providers. This effort will involve developing agreements with managed care organizations (MCOs). The Executive Governing Body, with assistance from the Operations Committee and Financial Governance Committee, will be responsible to formulate effective financial strategies for the PPS and translate its DSRIP commitments into a defined set of performance expectations linked to payment. Staff with responsibilities for managed care relationships and contract management will be part of the Project Management Office, reporting to the Operations Committee.

As part of the proposed governance structure, the transparency and accountabilities of the PPS Executive Governing Body will be detailed in the participating provider agreements with PPS partners.

### **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.

RCHC will need to enhance IT Infrastructure to allow interoperability and improve care management, care coordination, and population health management capabilities. Partners will need to update their systems to support expanded care management and coordination, health education/promotion activities, and the roles of navigators.

New software solutions will be required to meet the goals of improved care management and coordination, data sharing, and data analysis. Capital funding will be requested for HIT in the following categories:

- A new standardized EHR solution for providers who do not have a solution that meets PCMH/Meaningful Use requirements and for locations where primary care and behavioral health records are not currently integrated;
- A care management and coordination platform for documentation and sharing of data among providers and community partners;
- Centralized data analytics solution for reporting and analyzing PPS financial, clinical, and population metrics.
- New IT hardware to meet the minimum IT/computing requirements associated with new solutions, including networking equipment, high-speed internet lines, servers, and computers.

Partners with existing EHR solutions may need to upgrade to newer versions in order to receive the features required to achieve RCHC's goals. Upgrade costs would include charges from their existing vendor, new servers, and workstations to support the increased requirements for the upgraded



solution, and time from the partner IT staff to install/configure new hardware.

To assist with creating an environment with strong data security, RCHC will need to ensure that any PHI data at rest and in transit is properly secured. Capital funding for technologies that support these security requirements across the PPS will be requested and includes email encryption, mobile device management, computer hard drive encryption, and physical security hardware.

Training and collaboration among partners is also an important aspect of all PPS projects. Both remote and in-person training is likely to be used. To assist with this, the PPS will need webinar/webcast technology to facilitate remote training scenarios. In addition, group training space will be needed for any in-person training, with computer hardware to allow for partners to receive in-person training.

Any new hires to facilitate the IDS project will also have HIT needs, including new computers, phones, mobile devices, and all subsequent software and technology required to work in a modern health care environment.

- 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
Hudson Valley Collaborative Care	New York Medicaid Health Home Program	SPA approved Feb 2012	N/A	The Health Home Program was a recommendation of the Medicaid Redesign Team (MRT) in 2011 to reduce costs and improve the quality and efficiency of care. Under the ACA 2703 provisions, NY Medicaid transitioned existing case management programs into the health home program.



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

The Health Home model of care differs from a Patient-Centered Medical Home (PCMH). Health Homes target NYS DOH-defined high-cost populations rather than all attributed Medicaid patients in a geography. Health Homes encompass PCMH concepts but allow for more comprehensive and diverse teams and services. PCMHs are responsible for coordinating all of the individual's health care needs and arranging for appropriate care with other qualified providers and support services. Health Homes focus on the provision of a defined set of care management services.

RCHC's network includes an already established Health Home lead entity as a primary care provider and PPS partner. In conjunction with the IDS project, RCHC proposes to lead all participating primary care practices to achieve PCMH 2014 level 3 certification while also expanding certain primary care practices to become primary care hubs, which will lead care management, coordination, navigation, and integration efforts in that area. The lead Health Home entity will be one of those hubs, thereby incorporating Health Homes within the primary care network.

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

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

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

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

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

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



7. Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.
8. Implement preventive care screening protocols including behavioral health screenings (PHQ-9, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.
9. Implement open access scheduling in all participating primary care practices.

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

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

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

CNA findings show high rates of avoidable complications from chronic diseases (CNA 1, 2, 5) pointing to problems with access to care and effective primary care management. The zip code hot spots in the service area (Newburgh, Middletown, and Spring Valley) contain large clusters of the region's health resources but also show the largest concentrations of Medicaid beneficiaries with chronic conditions (such as diabetes, congestive heart failure, and hypertension) and behavioral health issues (such as bi-polar disorder, depression, and schizophrenia). Of concern are high avoidable hospitalization rates; Orange County's hospitalization rate for adult short-term diabetes complications (5.9 per 10,000) exceeds the PA target (4.86 per 10,000), and hospitalization rates for heart attack (18.1 per 10,000) exceed both the PA target (14.0) and statewide rate (15.2). Of the patients surveyed in the service area, 27% reported receiving care in the ED in the past year for reasons including perceptions about the seriousness of problems, no open doctor's office, and the ED is the closest provider. Mental health was rated in the top 5 out of 17 health issues in the community; however, 20% surveyed claimed that they did not know where to go in the counties to access mental health services and 9% of Medicaid beneficiaries had 1+ behavioral health ED and/or hospital claims. Focus groups revealed language and cultural barriers to access and patient frustration due to the lack of a single point of contact for providing information on health issues and support services.

Overall, these data speak to the importance of strengthening primary care to be more coordinated and responsive to patient needs and to be integrated with behavioral health care, providing a strong rationale for orienting the Refuah Community Health Collaborative (RCHC) primary care around the PCMH model. PCMH 2014 Level 3 certification standards include important dimensions of advanced primary care that will address patient needs for more comprehensive, highly coordinated care management services that are driven by patient health and healthcare goals. Requiring providers to achieve 2014 level 3 PCMH certification raises the bar for providers' level of practice. Greater team-based processes of care will leverage the capacity of primary care sites and expand access. Greater use of evidence based protocols for chronic care management, including screening for behavioral health as well as physical health issues will address the prevalence of mental health issues and



comorbid physical and behavioral health conditions among RCHC populations.

This PCMH project closely aligns with the IDS project goals, providing a structure, pathway, and resources to support providers to design and implement enhanced integrated primary care services; re-engineer work flows; learn to function as a team; coordinate with community resources; enhance cultural competency; use HIT and data analytics to plan, monitor, and communicate patient needs and progress; and improve performance. To meet DSRIP timelines and respond to the urgency of CNA findings, RCHC will deploy the PCMH certification project for all providers beginning with broad training about the goals of the projects. Targeted implementation efforts will accelerate certification preparation among a cohort of practices demonstrating readiness and among those practices serving as primary care hubs for patient populations in hot spots. Considering the limited bandwidth of busy practices, the PCMH project will supplement provider efforts with PCMH project resources, including project management, PCMH expertise, coaching, and other technical assistance to help practices design PCMH processes that will work best for them and their patients. As outcomes of the project, practices will eliminate gaps and fragmentation of care, leading to increased patient satisfaction and reductions in preventable healthcare utilization.

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

The patient populations to be engaged include those panels of Medicaid patients being served by all primary care providers participating in the PCMH certification project. Providers serving hot spot communities (e.g., areas with clusters of high PQIs) and transitioning to be enhanced primary care hubs will prioritize engagement of Medicaid patients identified as having one or more chronic conditions and demonstrating the poorest levels of control in areas of concern identified by CNA data; this includes adults with diabetes, children with asthma, adults with asthma and COPD, adults with cardiovascular disease and hypertension, and adults with co-occurring physical and behavioral health conditions. As part of implementation planning and the first phase of PCMH project implementation, data will be compiled from Medicaid, health plan, and provider registries to profile high-priority patients for engagement. Efforts to re-engineer policies, protocols, and processes of care to meet PCMH 2014 standards will use these patient profiles as templates to enable providers to quickly begin to identify patients, conduct outreach and engagement, and target care management strategies for these patient populations.

- 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.

Primary care practices from 3 major RCHC partners will be serve as major IDS primary care hubs, including 2 Refuah Health Center sites, 1 Ezras Choilim site, and 30 primary care providers from 3 major practices and 10 sites from the Bon Secours Medical Group. Refuah brings PCMH expertise, including an on-staff PCMH expert, and experience providing innovative resources to support



access, including a fleet of 5 mobile medical vans providing care in community-based locations and a free shuttle system that makes more than 40 regular stops per hour in Rockland County and bring patients to their sites for care. Other FQHCs in the RCHC network, including Ezras Choilim, Greater Hudson Valley Family Health Center, and Hudson River HealthCare, also bring a similar base of PCMH expertise. The Bon Secours Medical Group has one of its practices 2014 PCMH certified and another in the process of applying. They will have their physician practice management, PCMH/QI, and data analytics staff participate and provide input to the RCHC IDS projects, sharing population health management tools and expertise from their system. In addition, the Hudson Valley Community Care Collaborative, a Health Home, will also serve as a primary care hub and contribute expertise, tools, and input from its experience with population health management and providing Health Homes' patients with care management.

The Mental Health Association of Rockland County, the Mental Health Association in Orange County, and St. Christopher Inn, all of which have extensive expertise with community-based mental health services, will assist in designing behavioral health integration, including the use of screening instruments and care coordination staffing and protocols. Other community-based organizations currently providing case management and care coordination services will be engaged to help develop blueprints for navigation services and effective protocols and communication links for primary care hubs.

The existing HIT platforms used by RCHC vary in their ability to meet DSRIP requirements and will need to be brought to minimum standards to meet project goals. However, in addition to developing links to SHIN-NY THINC RHIO, the RCHC information management strategy requires a solution for supporting care management and capturing care coordination information and patient interactions among all community-based providers and activities. The specific HIT/HIE solutions will be identified during implementation planning, include exploring collaboration with the other 3 Mid-Hudson PPSs to avoid duplication and ensure prudent use of resources. One vendor for consideration is PeerPlace, which is designed for health and human services agencies to track clients across settings and used by Lower Valley Perinatal Care, a RCHC partner.

- 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.

Given the enhanced requirements of NCQA's 2014 level 3 PCMH standards, achieving certification of 100% of providers by the end of DY3 will be a challenge. New 2014 standards require effective team-based care; compliance with the most recent Meaningful Use standards; the adoption detailed policies, procedures, and capabilities. Certification is the end point of several intensive phases of activity by practice teams including provider training; individualized practice assessment and gap analysis; redesigning workflows, policies, and protocols; implementation, testing, and revision of new processes; and ongoing coaching to reference new skills and practices among provider teams. Lack of provider bandwidth given daily practice demands will be a major challenge to overcome. Currently, only 3 RCHC practices are PCMH certified and only 1 at 2014 standards. RCHC will demonstrate to providers that PCMH certification is achievable and valuable from a patient outcome and financial perspective, and provide technical assistance/coaching to individual practices



to engage and support them to make changes and achieve certification. RCHC will provide dedicated resources through its PMO and contracted resources, including PCMH expertise, project management, and analytic and process supports. PCMHs that achieve 2014 Level 3 certification, including sites outside RCHC, will be engaged as peer coaches working with provider champions from each practice site. As providers design major changes in traditional workflows and patient access points, RCHC will leverage the experience of network FQHCs already offering those access supports (e.g., same-day appointments, extended hours, coverage outside of business hours, and alternative types of encounters) with assistance in developing those elements. Input will also come from RCHC navigator and crisis stabilization projects and resources such as Refuah's urgent care center in Rockland County. Community partners and navigators will inform culturally relevant workflows and processes. During implementation planning, RCHC will consider potential financial support for loss revenue due to reduced productivity associated with PCMH efforts. RCHC also will communicate to all of its partners the shift in the State's PCMH Medicaid incentive program to pay for 2014 certification in 2015.

- 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.

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPS already collaborated on a single CNA for the Mid-Hudson region. The PPSs are planning for a collaborative structure of regional councils that will be especially important for this project as well as overall workforce development. A Regional Clinical Council will be a forum for leveraging shared expertise and resources for all the phases of the PCMH certification project, including practice redesign, workforce development, and HIT/HIE development. This will avoid the duplication of efforts and ensure prudent use of resources. It also will reduce the burden among partners that are in more than one PPS, which was a request PAC members made at multiple meetings

**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.

RCHC’s partners may require construction or renovation to achieve compliance with PCMH 2014 requirements. Providers may need to enhance healthcare delivery under the PCMH model by modernizing their facilities and improving clinical areas, establishing separate consultation rooms, and re-designing patient waiting areas to offer access to patient portals and health education kiosks.

RCHC does expect new hires among partners and, at the PPS level, to assist partners with PCMH certification. Therefore, we expect capital funding for the associated costs (e.g., network wiring and hardware, computers, phones, mobile devices, software and licenses) for these new hires.

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.

N/A

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

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

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

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

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



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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.

There are several indicators from the CNA that show a need for a community-based navigator program to promote more efficient and effective use of the healthcare system and avoid preventable inpatient use. Orange County Medicaid preventable ED visits have been at or above expectations for the past several years. Similarly, Orange County inpatient admissions for multiple PQIs (e.g., diabetes short-term complications, COPD, hypertension) are above expected. Some communities within RCHC's service area have high rates of late entry into pre-natal care and adverse birth outcomes (Western Orange). Focus group findings point to the need to support patients in better accessing care and available resources. Participants reported that many patients do not know who to call, email, or visit for support. They also described the challenges that low-income mothers face when they or their children get sick and they do not have the support system in place to manage lost work time and get childcare. Transportation was also cited as a challenge for older adults and mothers. Provider and peer focus groups identified the need for more care managers and peer supports, suggesting the need for additional care coordination support, particularly by peers.

In addition, the service area is home to several large immigrant communities, including Hispanic and Haitian communities living in some of the high-density disease hot spots identified in the CNA (Middletown, Spring Valley, Newburgh). The hot spots are marked by high poverty and low employment (~30%), and have low levels of education (~50% high school or less). There is also a very large Hasidic Jewish community. Residents of these communities have unique language, literacy and cultural needs that impact the way they utilize health care services.

The Refuah Community Health Collaborative (RCHC) will deploy community-based navigators to help its patients overcome barriers to accessing health care services. Navigators will be recruited from the communities of the patients they serve and will have a strong knowledge of cultural barriers and community resources. Their roles will include creating stronger linkages between patients and the health care system; assisting with care coordination and managing care transitions; offering interpretation and translation services; supporting care teams in providing culturally competent care; providing health literacy education; advocating for patients to receive appropriate health and community-based services; providing informal counseling; and conducting outreach in the community about the navigator program and community health.

Navigators will be assigned to practices that will identify patients who need navigator support and will also have an assigned geographic "territory," based on an implementation planning process that considers navigator proximity to target populations and community resources. Navigators will spend a portion of their time in communities, where they will conduct outreach in areas of



the community that are easily accessible and will meet with patients in their homes and other community-based settings.

A centralized toll-free number will be provided to users of the navigator program in outreach materials and will be promoted among RCHC's partners as well as among community members who may need support. A care team member will be available to triage calls and direct callers to the appropriate navigator. Navigators will also have access to technology that will allow them to document their activities and update care plans and provide secure online support that patients will be able to access via a web-based portal. Navigators will also have access to an online resource database that will be updated and enhanced regularly as changes and new services are identified.

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

The target population for this project includes patients with 1) two or more missed appointments for primary care or behavioral health visits, 2) avoidable ED visits, 3) readmissions within 30 days of discharge, 4) behavioral health medication adherence challenges (based on target population specifications for project 3.a.iii), and 5) first-time pregnant mothers.

This target population reflects patients whose utilization is suboptimal and could potentially benefit from navigators to help them more effectively use the healthcare system. Given the low rates of early prenatal care in western Orange as well as low rates of well-child visits and child immunization in both Orange and Rockland counties, first-time pregnant mothers will also receive targeted support. Navigators will receive reports of patients who meet the criteria and then will discuss with the patients' care team whether outreach is appropriate. They will also engage new patients when they are conducting outreach in their communities.

Navigators will be assigned geographically, with a strong focus on the hot spot zip codes identified in the CNA. They will be on the ground in the communities to engage and assist patients. Reports about patients will be sortable by geography, allowing navigators to readily identify areas of particular need.

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

Several RCHC partners have experience working with lay community members helping patients navigate the health care system. RCHC plans to leverage the best practices among these partners in designing the roles and protocols for the navigator program and identifying potential candidates for positions.

Refuah Health Center has 5 mobile medical vans to deliver services to its patients. As navigators identify needs in the community for mobile medical services, they will be able to coordinate the use of these medical vans.



Partners within RCHC's network bring many years of providing culturally competent care to its patients. They also recognize the importance of enhancing health literacy skills among patients, providers, and staff. Navigators will be trained in cultural competency and become cultural competency and health literacy "ambassadors" across the RCHC networks. They will be responsible for assessing cultural health literacy needs and gaps that need to be addressed and identifying resources that can support cultural competency and health literacy. Training will be provided through the Cultural Equity Taskforce in Orange County and the Rockland County Health Department in Rockland County.

Several of RCHC's community partners have developed their own community resource guides specific to the populations they serve. An array of community resources has been documented as part of the CNA process. RCHC will pull together the community resources that have been collected across partners as a base for its community resource guide and make the comprehensive guide accessible to all PPS partners. Navigators also will be integral to identifying new community resources that are needed and/or resources that could be repurposed.

- 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 Haitian and Hispanic communities, both of which have large and quickly growing populations in Orange and Rockland Counties, have cultural beliefs about health that can present particular challenges. For example, the Haitian perception of the need to seek care is based on whether they have to miss work; therefore, accessing preventive care is not always a high priority. Similarly, Hispanics generally view pregnancies as healthy, non-medical processes, which may lead to late or limited prenatal care access. The navigators RCHC recruits to serve these communities will be from the communities they serve and will therefore be best suited to provide education and promote awareness that respects cultural beliefs.

Navigators will likely identify barriers to care that may not be easily addressed because a resource is not available or cannot be quickly developed. When these types of barriers are found, RCHC's Project Management Office (PMO) will work with its partners and the other 2 Mid-Hudson PPSs, managed care organizations, or the State, as appropriate, to identify solutions. The PMO will also develop short-term strategies to address the issues, whenever possible.

Given that the navigator role is specifically designed to help provide support to vulnerable populations and the people who will fill the roles will, by design, be lay community members who may not previously have experience as navigators, RCHC anticipates that some navigators will need training and support to learn how to promote self-management. There will be specific training on self-management as part of the navigator curriculum.

Using laypersons from the community is a key element of the navigator program, but some navigators and practices may have challenges integrating navigators onto the care team. Navigators may need support adjusting to a professional environment and care teams will need to be open to hearing feedback from the navigators about culturally competent care. Navigators will be included in trainings



related to developing patient care teams and the trainings will focus on establishing care teams that include navigators. RCHC also will support navigators through supervision and provider champions. The Clinical Governance Committee will monitor implementation and address any issues with integrating navigators with care teams.

- 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.

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPS already collaborated on a single CNA for the Mid-Hudson region. The PPSs will build on this foundation of collaboration into the implementation planning and implementation phases. This will avoid duplication of effort and ensure prudent use of resources.

The RCHC CMO will participate in a Regional Clinical Council, composed of clinical leads from the respective PPSs, to promote alignment on evidence-based guidelines, metrics, and options for overlapping projects. RCHC also will participate in a Regional Public Health Council, composed of public health leads from the respective PPSs, to promote alignment on public health campaigns.

**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.

Navigators will be given access to care coordination information via mobile technology, such as iPads or tablets. These platforms will provide the opportunity to access information specific to the patients' needs in a language and reading level appropriate to the patient and at a time and place more suitable for education. The platforms will offer a comprehensive and up-to-date (real-time) data bank of community resources specific to the patient's needs. Educational material relevant to the patient's medical conditions can be available for the navigator to review at home or in the office with the patient. This can include information about specific medical conditions as well as accurate and up-to-date information about local resources, such as support groups, food banks, social services, companion care, and faith-based services.

RCHC also anticipates the need for support for renovation or construction of office space for navigators, navigator supervisors, and support staff as well as furniture, fixtures and equipment for the offices.

Other capital funding will be needed for website design, hosting, and one-time implementation of the community resources used to be used by navigators and the public. If mobile vans are utilized in areas prior to construction of permanent office space, then the associate costs for this would include the vehicle and IT hardware, including computers, printers, switches, and mobile connectivity to internet resources.

In addition, some patients may be best served at their home location. Navigators may therefore need a PPS-provided vehicle and mobile device to reach RCHC patients who require assistance from home.

- 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.

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

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

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

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





## Domain 3 Projects

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

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

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

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

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

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

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

A. *PCMH Service Site:*

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



*B. Behavioral Health Service Site:*

1. Co-locate primary care services at behavioral health sites.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

*C. IMPACT:* This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:

1. Implement IMPACT Model at Primary Care Sites.
2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
5. Measure outcomes as required in the IMPACT Model.
6. Provide "stepped care" as required by the IMPACT Model.
7. Use EHRs or other technical platforms to track all patients engaged in this project.

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

**2. 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 Refuah Community Health Collaborative (RCHC) serves patients in Rockland and Orange Counties. The prevalence of mental health disorders and substance abuse disorders among Medicaid beneficiaries within these counties is 7%. That is as prevalent as diabetes and is often times a comorbid condition that complicates their care and increases the need for better primary care and BH integration. Of that 7%, depression is the most common diagnosis and affects over 10,000 patients in Rockland and Orange counties alone. National numbers show us that depression is most commonly presented and treated within primary care. Following closely is bipolar disorder and schizophrenia, with over 7,000 patients with these conditions in these counties. This also warrants better access and care management within BH settings and the need for primary care. National numbers show patients with serious mental illness die up to 25 years earlier due to untreated chronic medical conditions and potentially preventable conditions if appropriately screened. In 2013, mental health/substance abuse was the third most frequent diagnosis type for ED visits at Good Samaritan. In addition, alcohol abuse and depression were among the top 5 inpatient DRGs at Good Samaritan and Bon Secours Community Hospital. Best practices show that coordinated and integrated primary care models will promote better self-management for patients and result in fewer ED visits, admissions, and readmissions. More coordinated BH care with



primary care within their offices will also help to promote better whole-person care for those suffering from more complex conditions and who tend to not seek out primary care separately.

The focus for this project will be to implement both models: integration of BH into a primary care setting and integrating primary care into some BH sites. Co-location of BH will be implemented throughout all the provider partner sites over the DSRIP years, and collocating primary care into the BH sites will be implemented in 1 site. RCHC will build systems and routines for frequent screenings in primary care and BH settings and coordinated hand-offs to a BH care manager for those screening positive and implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in both primary care and BH for substance abuse. In both models, there will be a care manager that is the center of the care team and integrates either the needed preventive care with BH or the needed BH needs in primary care. This dual co-location will also serve for better communication among the provider partners within the RCHC.

- 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 behavioral health integration project is two-fold. Within the co-location model into the primary care sites, the target population will be those most often presenting and being managed within primary care settings, which are patients with major depression and generalized anxiety disorders and positive substance abuse screening. The model will be primarily focused on adult patients due to the fact that many of the screening tools and evidence-based models are only validated within the adult population. The target population within the behavioral health sites integrating with primary care will be those with more serious mental illness, including bipolar disorder and schizophrenia. This is consistent with the national data on Serious Mental Illness and the need for focus on their primary care needs. In both settings, one of the first systems that will be implemented across all populations is standard screening tools (such as the PHQ-9, GAD 7, and SBIRT) for identification of these needs and then "warm transfers" to the respective programs.

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

There is currently some co-location with behavioral health and primary care currently in behavioral health sites. It is a base model of true co-location and needs to be expanded to systematic screening, warm transfers, follow up, tracking, and team-based care communication back and forth between behavioral health and primary care.

8 primary care sites within the provider network will integrate behavioral health by DY5. 1 behavioral health site will implement the primary care integration aspect. With both of these models, there will be new care coordinators and managers hired, some with behavioral health background and others with physical health. There will be retraining for both primary care staff as well as behavioral health staff in cultural competency, health literacy, motivational interviewing, and self-management.



RCHC will use teleconferencing, which has been shown to improve access to specialists that may otherwise be unavailable to patients in need of these services. HIPAA compliant, secure teleconferencing can significantly widen the reach to patients in a way that is cost effective and scalable. Video conferencing may also be used to provide professional consultations among providers and for peer-to-peer support. Primary care providers may feel more comfortable managing mental health issues when this support is available to them.

The EHR will be modified to have a shared care plan for both primary care and behavioral health viewing and documenting as well as a registry for patient tracking for follow-up and progress towards goals in all the models.

This project complements and directly links to the two other projects focused in behavioral health that the RCHC has chosen: the medication adherence program and BH crisis stabilization. The models will be designed to interface and will provide a comprehensive continuum of care for the BH populations.

- 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.

Gaining buy-in and participation from BH and primary care team members to practice in a new way will be a challenge. RCHC will deploy primary care and behavioral health “peer champions” to lead the commitment of the providers and staff in all the areas. RCHC will need to reduce barriers associated with health literacy, language barriers, and cultural competency, which will be addressed through training programs for all care team members. Overcoming the social stigma related to behavioral health illness and the acceptance of services will be a challenge. RCHC will implement public campaigns and use “wisdom figures” from within the community to reduce the stigma. Tracking patients among providers and sharing care plans will be a challenge. RCHC will implement HIT/HIE upgrades for shared documentation, care plans, and tracking of patients with warm transfer and follow-up care.

- 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.

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPS already collaborated on a single CNA for the Mid-Hudson region. The PPSs will build on this foundation of collaboration into the implementation planning and implementation phases. This will avoid duplication of efforts and ensure prudent use of resources.

The RCHC CMO will participate in a Regional Clinical Council, composed of clinical leads from the respective PPSs, to promote alignment on evidence-based guidelines, metrics, and options for overlapping projects, including this project that all three PPSs have selected. RCHC also will participate in



a Regional Public Health Council, composed of public health leads from the respective PPSs, to promote alignment on public health campaigns.

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

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

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

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

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

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

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

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

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

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

This project's HIT capital funding needs mostly overlap with project 2.a.i. However, we expect new hires among partners for this project in order to provide these expanded services. Therefore, we expect capital funding for the associated costs (e.g., renovation/expansion to provide space for new services, network wiring and hardware, computers, phones, mobile devices, software and licenses) for these new hires. Partners may need to upgrade their EHR systems to properly integrate primary care and behavioral health records. In regards to renovation and construction activities, some partners may need to establish additional counseling rooms, provider meeting rooms, a space for the behavioral health care coordinator, and new workstations to transmit data between the partner and the PPS.



- 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.

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

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

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

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



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

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





### 3.a.ii Behavioral Health Community Crisis Stabilization Services

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

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

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

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



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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.

This project is a critical component that interplays with the other the Refuah Community Health Collaborative (RCHC) projects on behavioral health integration, medication adherence, and patient navigation services to offer a full range of whole-person-centered care throughout Rockland and Orange Counties. There are more than 20,000 people living in these counties with behavioral health needs. Approximately 9% of Medicaid patients have had at least one behavioral health ED visit or inpatient admission within the past year. Mental health-related conditions are in the top 5 reasons for admissions and top 3 reasons for ED visits in the Bon Secours Health System Hospitals in Orange and Rockland. They are the cause of more than 50 ambulance calls per month in Rockland county alone. Suicide rates in the region are significantly higher than statewide, suggesting a need for crisis services and a broader awareness about crisis assistance in the community. Focus groups of persons with behavioral health disorders specifically reported the need for more intensive crisis services and crisis beds and the value of using peer crisis workers. Participants also noted that ambulance rides to the ED can increase patient agitation and discourage them from seeking future help. They also expressed concerns about adequate follow up after ED discharges for behavioral health crises.

In collaboration with the 2 other Mid-Hudson PPSs, there is a plan to develop a comprehensive crisis management system in the region, directing access to the appropriate level of service and specially trained providers. This system will include implementation of mobile crisis units serving Orange and Rockland counties that will provide evidence-based, protocol-driven crisis stabilization services in home, school, and other community settings. The mobile crisis teams will comprise mental health professionals, including peer counselors who will offer services such as assessment, crisis intervention, supportive counseling, information and referrals, linkages with appropriate community-based mental health services for ongoing treatment, and follow up. When necessary, the team will safely and sensitively move patients to RCHC's outpatient observation unit, where mental health professionals will continue to assess, stabilize, and monitor patients for up to 48 hours.

A centralized crisis line will provide direct telephonic consultation and triage to the closest crisis team, with the ultimate goal of helping the patient return to pre-crisis functioning, using focused and recovery-oriented interventions. RCHC will develop a public outreach campaign to promote understanding and awareness of these services. In addition, collaborative agreements will be forged among participating providers, including hospitals, the Health Home, behavioral health and primary care sites, and organizations administering the crisis teams, to develop and implement diversion protocols to avoid ED



and inpatient services when clinically warranted. In addition, there will be discussions held with the MCOs to negotiate payment methodologies for the services developed for this project.

- 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.

This project is designed to increase awareness about available community-based crisis services and establish specially trained teams to meet the needs of individuals in crisis. The target population for this project will be unique patients who have one or more ED visits or inpatient discharges with behavioral health or serious mental illness/substance use as the primary diagnosis. RCHC will also target patients who call the crisis line. For this target population, the crisis line will provide a just-in-time opportunity to deliver various crisis intervention services in order to prevent future ED visits or inpatient admissions.

- 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 need for this program has been clearly noted in RCHC's service area. This project is also critical across multiple counties and overlapping PPSs. To that end, the three overlapping PPSs will be forming councils to focus on each domain of work. The council specifically charged the behavioral health (BH) crisis stabilization project with conducting a deeper needs assessment and gap analysis across all the counties. Then, bringing together the county commissioners and other key community stakeholders to review and discuss these needs, the council will co-create a full implementation plan covering the four critical elements for BH crisis stabilization: mobility, diversion, intense outpatient treatment, and a universal hotline that will triage and support all areas and patients appropriately.

Recognizing this need, Rockland Paramedics recently applied for a license as a mobile crisis unit. The Orange County Department of Health has also been offering a mental health crisis line for residents of Orange. RCHC plans to collaborate with both organizations to design the new RCHC mobile crisis units.

Good Samaritan Regional Medical Center's ED is already staffed with crisis-trained social workers who help to assess, stabilize and observe individuals who come in to the ED in crisis and consult with psychiatrists and other mental health professionals, as needed. RCHC will build on these resources and will expand the services and observation beds to maintain sufficient access.

A local RCHC team will be established to oversee development and coordination of the various activities and parts of the crisis intervention program within Rockland and Orange counties and to coordinate and connect with the overall council of all PPSs. This oversight group will manage the collaboration agreements, engage all the community partners, including certified Health Homes in the service area (Open Door and Hudson River HealthCare) and other FQHCs, to create and gain consensus on standardized treatment protocols for all partners to use and oversee the implementation and ongoing surveillance of compliance to the protocols and program.



EHR connectivity for PPS providers with interface capabilities and platforms for tracking patients engaged in this program will also need to be developed and discussed across the PPSs in the region for both program effectiveness and economies of scale.

- 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 Haitian and Hispanic communities, both of which have large and quickly increasing populations in Orange and Rockland counties have cultural beliefs about health that may present particular challenges for accessing mental health services. The outreach campaigns that will be developed will need to consider how best to promote awareness within these communities. RCHC will work closely with individuals and organizations from these communities to design relevant campaigns. In addition, RCHC plans to deploy community navigators as part of project 2.c.i who will be uniquely positioned to provide education and promote awareness respectful of the cultural beliefs of patients.

Developing evidence-based diversion protocols will be complicated given the range of providers that need to be involved to develop a comprehensive system to divert patients from the ED and inpatient settings. RCHC will address this challenge by engaging strong clinical leadership to lead the effort and to establish financial incentives for participating partners that promotes robust and innovative collaboration. Protocols will all be the same across all 3 PPSs in the region, which will help promote adherence among partners in multiple PPSs.

Across the country, there is a shortage of psychiatrists. As the clinical protocols and crisis teams are developed, RCHC will need to work creatively to develop clinical models that only use psychiatrists when necessary and use of telecommunication options in order to efficiently use limited psychiatric resources.

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

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPS already collaborated on a single CNA for the Mid-Hudson region. The PPSs will build on this foundation of collaboration into the implementation planning and implementation phases. This will avoid duplication of efforts and ensure prudent use of resources. The RCHC CMO will participate in a Regional Clinical Council, composed of clinical leads from the respective PPSs, to promote alignment on evidence-based guidelines, metrics, and options for overlapping projects, including this project that all three PPSs have selected.



**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.

Capital funds will be needed for additional observational beds within Good Samaritan as well as HIT/HIE and tele-communication.

This project will be performed in collaboration with the other PPSs in the region. Our intent is to build a centralized crisis telephone hotline. The associated costs with this service will include:

- An incident tracking and entry solution for calls received and triaged. Integration with care coordination platforms will also be utilized if we determine proper patient consent requirements for this crisis stabilization service.
- Building, renovating or expanding facilities at a PPS partner site to provide space for this new service to operate from.
- Equipment for new hires, including network wiring and hardware, computers, phones, mobile devices, and one-time software and licenses for these new hires.



- 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.

N/A
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**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.a.iii Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance

**Project Objective:** To assist patients who have difficulty with medication adherence to improve compliance with medical regimens.

**Project Description:** Medication adherence is particularly important for persons with psychiatric conditions to maintain health and function. This program is based upon shared decision-making and behavior modification to effect sustained change. Tools in the New York City Department of Health and Mental Hygiene's and the Fund for Public Health NY's Medication Adherence Project (MAP), while not originally focused on behavioral health, would be useful to form the basis of this intervention. Other evidence based tools and educational materials may be used. Various factors influence "non-compliance" including health literacy, cultural values, language, and side effects of treatment. The goal of this program is to assist patients identify these issues and resolve them with motivational interviewing and structured conversations around medication compliance.

**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. Develop a medication adherence program to improve behavioral health medication compliance through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).
2. Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.
3. Use EHRs or other technical platforms to track all patients engaged in this project.
4. Coordinate with Medicaid Managed Care Plans to improve medication adherence.

#### **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.

Nationally, almost 1 in 5 patients released from a hospital is readmitted within 30 days. For Rockland County, readmission rates for potentially preventable readmissions (PPR) are 8% and 7% for Orange County. Literature shows that 30-40% of these readmissions are due to their medication regimen,



unclear instructions, lack of understanding and engagement, and adherence issues related side effects. National data also show that patients with chronic illness have less than 60% adherence to their medications and those on complex medication regimens have around 10% adherence.

Within the Refuah Community Health Collaborative (RCHC) service area, the prevalence of both bipolar disorders and schizophrenia is over 8,000 and many with severe cases. This reveals many patients in need of behavioral health support and, for many, complex behavioral health medications. Rockland and Orange County patients' adherence to anti-psychotics averages at 60% and their adherence to anti-depressants averages at around 40%. This shows the need for support related to medication regimens and education and a focus on understanding why, how, and when to take medications.

In addition, ED visits for behavioral health reasons are in the top 3 reasons for ED visits in the Bon Secours Health System Hospitals in Orange and Rockland and ambulance rates for mental health calls are on average over 50 per month in Rockland county alone. Suicide rates in both Rockland and Orange Counties are higher than state rates. These data speak to the need to focus on the engagement of patients in education on their medications, medication adherence, and shared decision making.

This multi-layered approach will happen at the time of discharge with a hand-off back to the primary care team, through coordination when transitioning from behavioral health to primary care, and through support in patients' homes. This will require an organized approach from outpatient, inpatient, community services, and mobile units as well as for standard training, tools, and electronic solutions to share patient information and coordinate care. Community health workers will be hired as new resources for this project. The community health workers will be laypersons from the communities they serve and will be trained to provide support in both clinical and community-based settings, including in patients' homes.

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

The target population for this project is adult patients on a medication regimen for schizophrenia and/or those on 3 or more medications with 1 or more being a behavioral health medication. RCHC's goal is to concentrate on those with schizophrenia first and then those that are on polypharmacy or those taking complex medications along with a chronic condition, which creates more of a challenge for accurate medication adherence. In addition, reviewing and focusing on those that have had an admission within the last 30 days, creates a just-in-time opportunity to catch those most likely to have a readmission or that are at a higher risk for it due to medication changes or poor medication reconciliation, education, or engagement in their medication regimen.

- 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 approach to this work will be multi-faceted and will use the PCMH teams within the primary care provider sites. This model also will be implemented within 1 behavioral health site for those patients with serious mental illness and on complex psychiatric medications. The care teams within the sites will be trained on specific skills and tools on medication adherence and have an ad hoc pharmacist as a team member for those patients with polypharmacy or complex medication regimens, health literacy problems, or other social needs inhibiting good medication adherence.

In addition, RCHC will partners with community-based groups, such as Rehabilitation Support Services Inc. in Orange County, to offer home visits to those Medicaid patients needing more intensive education and tracking of their medical adherence. The JMHCA currently provides this service for people within the communities they serve and this will expand the services for high-need patient populations. Community health workers will be hired and trained to support this program.

The project will include care team members using evidenced-based interventions in a variety of settings. Because critical information regarding medication indications, dosage, and side effects can be overwhelming for patients to understand and retain, care team members can review this information again with a patient in a comfortable and familiar setting such as a patient's home. Family members can more easily join in the discussion and participate in the patient's care plan. RCHC will use mobile device such as an iPad or tablet to provide patient specific information. The use of mobile devices will enable other care team members such as a clinical pharmacist to respond to real-time messaging or join the conversation by audio-visual communications. Medication adherence will also be addressed by using automated reminders such as text messaging. The messages will be specific reminders but also give contact information should the patient have questions, concerns, or need to request refills. Designated family members and/or caregivers will be engaged through the use of medication (pill box) reminders via messages when the patient is late in taking a dose or fails to respond to reminders. These remote monitoring mobile solutions keep the patient and family members involved in medication adherence.

The heart of this medication adherence model is comprehensive training for care team members on such skills as motivational interviewing, "teach back" techniques, self-management support, and goal setting. Training will be organized as a community-wide effort for the provider teams, the community resources, and other PPS staff. The other key component will be the implementation of universal tools such as AskMe3 questions for medication understanding and adherence, and self-management goal setting worksheets. Implementation will include training care teams, community health workers and navigators, and other community service workers; embedding tools in EHRs, where possible; and using the electronic tools during home visits.

- 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 integration of non-traditional care team members, particularly lay community health workers, will pose a challenge. Community health workers may need support adjusting to a professional environment and care teams will need to be open to hearing feedback from the community



health workers. Community health workers will be included in trainings related to developing patient care teams and the trainings will focus on establishing care teams that include community health workers. RCHC also will support community health workers through supervision and provider champions. The Clinical Governance Committee will monitor implementation and address any issues with integrating community health workers with care teams.

The use of new technologies, including mobile devices such as iPads and tablets, may also present a challenge for some patients and care team members who do not regularly use such devices. Patients will be trained by community health workers who, due to their connection with the communities they serve, will be best suited to help patients adopt the new technologies. All care team members will be trained on the devices and provider champions will promote their use among peers. Use of the devices will also be monitored and reported to the Clinical Governance Committee.

- 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.

RCHC's PPS overlaps with the service area of the Westchester Medical Center PPS and Montefiore PPS. The three emerging PPSs already have been collaborating on a single CNA for the Mid-Hudson region. This collaboration will build the foundation of collaboration into the implementation planning and implementation phases. This will avoid duplication of effort and ensure prudent use of resources. The PPSs are discussing opportunities for shared HIT and HIE systems, which will support this project, as well as collaboration on projects that they are all implementing. Although this project is unique to RCHC, other PPSs will be invited to attend the training sessions specifically on motivational interviewing, "teach back," and other skill building that will benefit any PCMH team member and/or care management program.

**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.

Community health workers will require the ability to engage patients in multiple settings. Therefore, use of mobile devices (iPads/iPhones/laptops/tablets) will be required for documentation and collaboration. Workers who are engaged with the community may also need to be provided with transportation/vehicles in order to reach remote locations. These costs will be incurred by the PPS and all equipment will be distributed to partners and to the identified staff.

RCHC will also need solutions to help with planning, tracking and measuring medication adherence. This will likely include new software, in combination with remote monitoring devices like smart pill boxes in patient homes. In addition, video conference tools may be used to help facilitate the interaction between the care provider, pharmacist, and patient.

New hires for this project will require the standard desk space, computers, phones, and software licensing needed with any modern health care setting. If partners do not have sufficient space, then renovation/expansion may also be required to create sufficient facility space to complete the activities related to this project.

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

N/A

**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



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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.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
1. New York State Smoker's Quitline
2. New England American Lung Association
3. POW'R Against Tobacco Community Partnership

**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.

Findings from the CNA suggest that the communities in the Refuah Community Health Collaborative's (RCHC) service area are not immune to morbidity and mortality attributable to smoking. Although Rockland County meets the 2017 Prevention Agenda (PA) goal for 15% of adult smokers and Orange County has rates slightly above, there remain populations within these counties with high rates of smoking or smoking-related illnesses.

There are concentrations of Medicaid beneficiaries by volume with COPD/bronchiectasis in central and eastern Rockland County (Spring Valley, Haverstraw) and in eastern Orange County (Newburgh). Among adults with behavioral health conditions served by Office of Mental Health facilities in both counties, 30% reported being smokers. There is room for improvement for providers to more routinely screen and counsel smokers. Fidelis and Hudson Health plans, the largest Medicaid plans in the region, experienced similar suboptimal 2012 results, with approximately 75% of smokers being advised to quit and around 50% having discussed tobacco use cessation medications or strategies. In addition, there are elevated PQIs for COPD (123 – 362%) in several areas across both counties, suggesting an opportunity to improve primary care management.

RCHC will leverage the array of state and community-based resources available to increase rates of delivering tobacco dependence treatments, quit attempts, and successful tobacco control (TC), and will



coordinate with and supplement these resources, as needed. RCHC will support a PPS Tobacco Cessation Coordinator, who will be responsible for overseeing the components of this project. By Q2 DY1, RCHC will kick-off tobacco control efforts by having the Clinical Governance Committee review and adopt US Public Health Service Tobacco Cessation guidelines. RCHC will have all provider partners identify practice champions, who will provide leadership for the organization's TC efforts and promote TC benefits across the practice. The champions will recommend and help implement necessary system changes and promote collaborative participation for all staff. RCHC will also encourage each champion to form a committee to plan together and measure practice improvement. The coordinator will assess whether a workgroup comprising practice champions might be formed to share strategies and lessons learned across RCHC providers.

Recognizing that there is no safe level of exposure to second-hand smoke and that it is critical for providers to embrace a tobacco-free culture to help their staff and patients lead a healthier life, RCHC commits to having all PPS providers adopt tobacco-free outdoor policies. For all providers who do not already have policies, RCHC will coordinate for the expert guidance of POW'R Against Tobacco Community Partnership (POW'R). RCHC will support its partners to configure EHRs for the 5As (Ask, Advise, Assess, Assist, and Arrange), either by reconfiguring existing EHRs or ensuring functionality of new EHRs. RCHC will train provider organization staff on how to consistently and efficiently implement the 5As. Trainings will improve primary care provider confidence in their clinical knowledge and awareness about the benefits of TC. RCHC will coordinate and collaborate with the New England American Lung Association for system redesign and training support. RCHC will survey providers about the impact of inconsistent TC insurance coverage and will use the survey results to inform decisions about recommended advocacy with health plans.

RCHC's implementation approach will prioritize organizations serving populations most in need for improved TC strategies, including hospitals, primary care sites, and behavioral health providers serving patients in "smoking hot spots." RCHC will work collaboratively with the other 2 Mid-Hudson PPSs to plan and coordinate a regional public health campaign.

- 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 patient population for this project will be adults ages 18 and over who have a primary care, dental, or behavioral health visit. Patients will be asked about their smoking status at each visit, and users will be advised to quit. Those ready to quit will be referred to the NYS Quitline, who will further assess the patients and assist with quitting. Recent quitters will also be supported so that they successfully stop smoking. NYS Quitline will feed information back to the referring EMR to arrange for follow up.

RCHC will geographically target the initiative to zip codes where there are clusters of community members with high rates of smoking and smoking-related illnesses (Spring Valley, Haverstraw, Newburgh).



- 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.

RCHC has access to an array of experts and resources that can be leveraged for this project. RCHC will collaborate with our local state-funded Health Systems for a Tobacco-Free New York contractor, Center for a Tobacco-Free Hudson Valley - American Lung Association of the Northeast, to support providers to consistently and effectively assess and treat patients who smoke, including support with addressing systems barriers and increasing staff knowledge about available treatments and how they can be delivered. RCHC will work with the Center to identify specific practices that could most benefit from their resources and build upon the shared goal of targeting organizations serving low-income populations and persons with mental health conditions.

RCHC will also collaborate with POW'R Against Tobacco Community Partnership, the local Advancing Tobacco-Free Communities contractor, which has a wealth of experience implementing tobacco-free spaces. RCHC will work with them to provide support to PPS partners that have not yet implemented tobacco-free outdoor policies, including providing sample policies, signage, staff education, and strategies to roll-out the policy.

Many of RCHC partners have some level of experience screening, advising, and referring patients to the NYS Quitline, including use of EHRs to prompt for and track TC interventions. RCHC will be able to build on this experience in implementing additional strategies to increase the TC rates of the population we serve and support RCHC partners without such experience.

RCHC also plans to deploy community-based navigation services (2.c.i), where we will engage navigators to support community awareness around the benefits of quitting tobacco as well as connect patients to TC resources.

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

For those PPS partners who do not have tobacco-free outdoor policies, implementation may pose some challenges based on the need to educate them about the benefits of such policies, manage staff resistance, and work around constraints with surrounding spaces. RCHC will work closely with POW'R Against Tobacco Community Partnership, which has experience implementing these policies to provide expert advice to RCHC partners as they implement this project. RCHC also will develop a workgroup with interested PPS providers to provide them with technical assistance and group support.

As part of RCHC's efforts to analyze the impact of different insurer coverage on our population, RCHC could potentially face challenges getting provider cooperation to respond to our survey. RCHC will work with partners to develop a survey tool and survey collection process that minimizes the burden on providers.



Special populations, such as patients with disabilities, mental health conditions, and substance abuse, may present unique challenges to providers working with them to quit smoking. Guided by research summarized in the USPHS Guidelines for Treating Tobacco Use, RCHC will help train providers about the evidence supporting the effectiveness of counseling and treatment for special populations. For example, RCHC would train the providers on special considerations, such as the fact that patients with psychiatric disorders may have an increased risk for relapse, necessitating ongoing support for maintain their abstinence. We will also share the evidence about the potential benefits of certain medications. The training curriculum will include an important focus on the unique counseling and treatment considerations that may apply to the targeted patients.

RCHC could experience challenges advocating for increased coverage of tobacco dependence treatment counseling and medications and consistent prescription and over-the-counter TC medications. RCHC has long-standing relationships with health plan partners that will be used to address their concerns and advocate coverage expansion. RCHC will also share the information from our provider survey as a way to more concretely demonstrate the impact of health plan policies.

- 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.

RCHC's service area overlaps with the service area of the Westchester Medical Center and Montefiore PPSs. The three emerging PPS already collaborated on a single CNA for the Mid-Hudson region. The PPSs will build on this foundation of collaboration into the implementation planning and implementation phases. This will avoid duplication of efforts and ensure prudent use of resources. The RCHC will participate in a Regional Clinical Council, composed of clinical leads from the respective PPSs, to promote alignment on evidence-based guidelines, metrics, and options for overlapping projects, including this project that all three PPSs have selected. RCHC also will participate in a Regional Public Health Council, composed of public health leads from the respective PPSs, to promote alignment on public health campaigns, including on tobacco use.

- 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.

- Partners will adopt tobacco-free outdoor policies by end of Q2 of DY1.
- Providers will designate a practice champion by end of Q1 of DY1.
- RCHC's Quality Committee will adopt USPHS guidelines by end of Q2 of DY1.
- Providers with existing EMRs will reconfigure EMRs to prompt for 5As by end of DY1.
- Providers without EMRs or EMRS not meeting minimum requirements will prompt for 5As by end of DY3.
- Conduct provider survey of tobacco cessation coverage impact on patients by end of DY1.
- Determine recommended universal, consistent medication benefits by end of Q2 of DY2.
- Advocate for increased coverage of treatment and counseling and consistent medication benefits by end of DY2.
- Coordinate and commence roll-out of provider training programs by end of Q3 of DY1.



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

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

This project will be performed in collaboration with the other PPSs in the region. We expect that capital funding will be required for the following categories:

- Shared facility from which new hires will work
- Desks, computers, phones, and software licenses for new hires.
- Marketing will require website design and start-up activities to launch the new website.

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.

N/A

**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.