NEW YORK STATE | Department of Health | Medicaid Redesign Team

Revised DSRIP Actively Engaged: Project Specific Definitions and Clarifying Information

As of October 28, 2015

General Guidance regarding Domain 1 Active Engagement

- The Independent Assessor (IA) will measure patient engagement via the January Speed and Scale commitments and the clarifying information provided by the IA in collaboration with the NY State Department of Health (DOH).
- Domain 1 Patient Engagement Speed must be submitted for each project every quarter in order to earn the associated AV (this does not apply to Project 2.a.i and Domain 4 projects). In order to receive the AV, PPSs will be expected to meet at least 80% of their actively engaged commitment for patient engagement speed as indicated in the project plan application for each project.
- Each PPS provided detailed information regarding the patient population expected to be engaged through the implementation of each DSRIP project in the Project Plan Applications submitted to the Independent Assessor (IA) in December. In the Speed and Scale commitments, each PPS provided the number of patients expected to be engaged in each project by Demonstration Year (DY) 4.
- In addition to evaluating the total count of patients each PPS would actively engage in the project, the IA also reviewed and scored each PPS Project Application on the clarity and specificity by which each PPS defined the project patient population based on geography, disease type, demographics, social need or other criteria.
- *While the PPS will receive detailed, patient-specific information on those patients attributed by the State via their Member Rosters, it is expected that the PPS will target all patients for each project as identified in the PPS Project Plan Applications in order to fully meet the percent of patients committed to in the Speed and Scale commitments for each project, regardless of those attributed to the PPS. In other words, the PPS should provide project-specific services and programs in line with the population identified in the Project Plan Applications and not focus solely on those patients identified by the State in the forthcoming information release.*

General Q&A regarding D1 Actively Engaged Definitions

Q. Will a service provided to a patient NOT included in a PPS' initial Attribution for Performance count towards that PPS' Active Engagement count?

A. Yes, a PPS may count any patient as actively engaged as long as the specific project active engagement criteria are met, regardless of whether the patient is part of the PPS' Attribution for Performance/Member Roster assignment at any point during the year or ever.

Q. Can more than one PPS claim the same patient who meets the actively engaged definition for a particular project where the provider who rendered the service is included in multiple PPS networks?

A. No. A patient engaged by one provider who is in the network of multiple PPS may not be counted by more than one PPS. PPS are responsible for working together to ensure that there is no double counting of patients for actively engaged reporting. It is incumbent on the PPS to develop a methodology and system for assigning each actively engaged individual to one PPS and to then apply the methodology to the actively engaged counts from shared providers, partners, and contractors. Collaboration across PPS pursuing the same project in overlapping service areas is encouraged to coordinate patient outreach in order to maximize resources and extend the reach of DSRIP projects to all appropriate Medicaid patients.

Q. How are D1 active engagement commitments different from D2 and D3 Pay for Performance measurements?

A. The D1 active engagement commitments are a direct result of the number of patients expected to be engaged in each project the PPS committed to in the January Speed and Scale submission. The IA will review the committed number against the actual engaged number reported quarterly. PPSs are expected to meet 80% of the commitment level for patient engagement speed as indicated in the project plan application for each project. The IA will not cross-check the submitted engaged patient numbers against any PPS-specific patient listing. Slight patient movement in and out of a PPS will occur throughout the DSRIP period, however it is expected the PPS will meet the actual patient engagement numbers for each project as committed in the January Speed and Scale submissions.

Q. Do the definitions for the 'actively engaged' population cover the entire Medicaid population?

A. The actively engaged population for each project is a subset of all Medicaid members (adults and children) based on project-specific definitions provided in previous webinars and guidance.

General Q&A regarding D1 Actively Engaged Definitions

Q. What is the definition of a year for the purposes of calculating active engagement?

A. The measurement year for calculating the actively engaged population will align with the DSRIP Demonstration Years (DY). For example, DY 1 is defined as April 1, 2015 through March 31st, 2016.

Q. Can the IA provide guidance on the required data sources to report active engagement results such as acceptable data sources, formats and items needed for post-metric submission validation?

A. The PPS must demonstrate that they have engaged the number of patients they committed to in their January Speed and Scale submissions on a quarterly basis. In order to substantiate the number of patients that the PPS has actively engaged, they must provide the IA, via uploads on MAPP:

- A comprehensive patient registry that includes all patients engaged by the PPS during the quarter and lists, at a minimum, the Client ID # (CIN #). The first and last name is preferred, but not required.
- The registry should be project specific in order to substantiate the actively engaged counts for each project the PPS is implementing.

Q. In anticipation of potential actively engaged reviews, will the IA validate the PPS or specific providers?

A. The PPS will be ultimately responsible for reporting Patient Engagement results based on the project-specific active engagement definitions in each DSRIP project through the use of EHRs or other technical platforms. Therefore, it is the PPS who will be required to provide additional information as requested by the IA. The IA will conduct a more extensive review of certain information to ensure the information submitted by the PPS is accurate and verifiable. Furthermore, the IA will review the submitted patient registry data to validate that the PPS has engaged the number of patients indicated in their quarterly report.

Q. Why does Project 2.a.i no longer have an “active engagement” definition?

A. Since the intent of Project 2.a.i is the creation of a high-performing integrated delivery system, it is expected that all patients included in Attribution for Performance (A4P) will be engaged in this project.

Q. What happens if the PPS hits their Active Engagement target (as committed in the January Speed and Scale commitments) but in subsequent quarters falls below the 100% target, due to successful project implementation. For instance, as a result of ED redirection, fewer patients unnecessarily present to the ED.

A. The PPS will not be penalized so long as they provide an appropriate and reasonable explanation for why the patient engagement number decreased after successfully hitting the Speed and Scale commitment. Further, it is expected the P4P measures would demonstrate improvement aligned with project goals.

General Q&A regarding D1 Actively Engaged Definitions

Q. How should a PPS report Actively Engaged counts prior to the completion of the necessary Business Associate Agreement (BAA) or Data Exchange Application & Agreement (DEAA) with network partners?

A. The DOH and the IA have established an alternative option for the purposes of reporting Actively Engaged for the DY1, Q2 report only. If a PPS does not have a completed BAA or DEAA in place with a network partner to allow for the sharing of Protected Health Information (PHI) between the network partner and the PPS, the IA will accept the submission of an aggregated count of Actively Engaged Medicaid members by provider. The PPS Lead must also have a signed attestation form from each network partner for which they are reporting the aggregate count of Actively Engaged Medicaid members in place of the Medicaid Client Identification Numbers (CIN) as required by the IA.

Q. Is the MAPP upload secure enough to accept PHI? Will the IA house this information securely?

A. MAPP, as part of the HCS, is secure for handling PHI. The Independent Assessor also has policies in place for handling PHI and our server is secure for the purposes of saving the data.

Project 2.a.ii

Project Title	Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))
Actively Engaged Definition	*The number of participating patients who receive preventive care screenings from participating providers to identify unmet medical or behavioral health needs from participating PCPs.*
Counting Criteria	*A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.*
Data Source	*EHRs or other IT Platforms (i.e. patient registries) based on billing codes.*

Clarifying Information:

- For these screenings, the preventive medicine service codes are: 99381 - 99387; 99391 - 99397 (note: SBIRT codes are not included here).

Project 2.a.iii

Project Title	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
Actively Engaged Definition	*The number of participating patients who completed a new or updated comprehensive care management plan.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The care management plan should be comprehensive and consistent with those developed for a standard Health Home member.
- The participating patients are the population not currently in Health Homes who would be eligible under the federal definition for Health Home eligibility (i.e. those patients not eligible under the current NYS Health Home rules.)

Project 2.a.iv

Project Title	Create a medical village using existing hospital infrastructure
Actively Engaged Definition	*The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries) based on billing codes.

Clarifying Information:

- Only Medicaid billable services will count as qualifying services.
- Medicaid billable services only include those services that can be billed to Medicaid through a traditional FFS rate or as part of a Managed Care rate. For example, services provided by CBOs would be excluded as they are not billable to Medicaid.

Project 2.a.v

Project Title	Create a medical village/alternative housing using existing nursing home infrastructure
Actively Engaged Definition	*The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village within a year.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries) based on billing codes.

Clarifying Information:

- Only Medicaid billable services will count as qualifying services.
- Medicaid billable services only include those services that can be billed to Medicaid through a traditional FFS rate or as part of a Managed Care rate. For example, services provided by CBOs would be excluded as they are not billable to Medicaid.

Project 2.b.i

Project Title	Ambulatory ICUs
Actively Engaged Definition	*The number of participating patients who had two or more distinct services at an Ambulatory ICU ~~in a year.~~*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries) based on billing codes.

Clarifying Information:

- Only Medicaid billable services will count as qualifying services.
- In order to count as an engaged patient, at least one of the "two or more distinct services" must be provided onsite at the Ambulatory ICU. While it is expected that the additional services should be performed on the same day, the IA will accept a second distinct service if the PPS can demonstrate the second service appointment was scheduled (as demonstrated in the patient's medical record).
- All services should be included in one APG claim when provided by the same health system provider on the same day. In the case where ambulatory ICU services would be provided at a site on the same day by different practitioners, the PPS could use one or more E&M modifiers (in accordance with AMA coding guidelines) to indicate that separate and distinct services are being rendered by different practitioners. Additionally, the multiple professional doctor/practitioner services would be billed to the practitioner fee schedule(s) by each rendering practitioner and paid fully. Regardless of how these services get billed, the PPS must utilize EHRs or other IT platforms to capture distinct services provided via an Ambulatory ICU.
- Patients included in this project are those patients the PPS submitted in their January Speed and Scale commitment who would benefit from medical, behavioral health, nutritional, rehabilitation and other necessary specialty services provided within a newly created Ambulatory ICU.

Project 2.b.ii

Project Title	Development of Co-Located Primary Care Services in the Emergency Department
Actively Engaged Definition	*The number of participating patients who presented at the ED but were successfully and appropriately redirected to a PCP, after medical screening.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The standard of "successfully and appropriately redirected" will be met by the PPS when one of the following two conditions is met:
  - A) the patient who received a medical screening at the ED and was found not to require emergency services was instead referred to and kept an appointment at a collocated primary care site (meeting PCMH and/or APCM standards) for treatment within 24 hours OR
  - B) the patient who received a medical screening at the ED and was found not to require emergency services had a follow-up medical or preventive health care appointment scheduled and kept with the plan PCP or a Collocated PCP Site (meeting PCMH and/or APCM standards) within 30 days of the initial medical screening at the ED.
- The term "collocated" is defined as being within walking distance of the ED.
- For relocated PCMH practice sites which must meet NCQA 2014 Level 3 within the first two Demonstration Years, the PPS may count participating patients who presented at the ED but were successfully and appropriately redirected to a PCMH/APCM site for providers with pre-2014 PCMH Level 3 certification and/or pre-APCM certification.
- After the beginning of DY3, active engagement can only count as those patients who are referred to providers who meet NCQA 2014 PCMH Level 3 and/or APCM.

Project 2.b.iii

Project Title	ED care triage for at-risk populations
Actively Engaged Definition	*The number of participating patients presenting to the ED, who after medical screening examination were successfully redirected to a PCP as demonstrated by a scheduled appointment, or successfully redirected to a PCP en route to the ED.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The term “successfully redirected” means that the patient had and was made aware of an appointment with a PCP within 30 days after ED presentation and medical screening.
- A redirection could occur within or en route to the ED.

Project 2.b.iv

Project Title	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
Actively Engaged Definition	*The number of participating patients with a care transition plan developed prior to discharge.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- There is no specific definition of a "care transition plan." However, a care transition plan should be consistent with the best practices of CMS' Community-Based Care Transitions Program and should include core components such as: patient self-education, follow-up appointments, and medication reconciliation.
- "Participating patients" refers to those patients who are at a high risk of readmission, particularly those patients with cardiac, renal, diabetic, respiratory and/or behavioral health disorders. These are the same patients who would fit the 3M definitions for successfully prevented readmissions. While the project is specifically focused on certain conditions, any hospitalized patients who receive a care transition plan prior to discharge will count.
- The discharge needs to be accompanied by a care transition plan in order for that patient to count as actively engaged, i.e. if a patient is discharged with the intent to develop a treatment plan within a predetermined number of hours/days/etc., that patient would not count as actively engaged.

Project 2.b.v

Project Title	Care transitions intervention for skilled nursing facility (SNF) residents
Actively Engaged Definition	*The number of participating patients with a care transition plan developed prior to discharge.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- There is no specific definition of a “care transition plan.” However, a care transition plan should be consistent with the best practices of CMS’ Community-Based Care Transitions Program and should include core components such as: patient self-education, follow-up appointments, and medication reconciliation.
- “Participating patients” refers to those patients who are at a high risk of readmission, particularly those patients with cardiac, renal, diabetic, respiratory and/or behavioral health disorders. These are the same patients who would fit the 3M definitions for successfully prevented readmissions. While the project is specifically focused on certain conditions, any hospitalized patients who receive a care transition plan prior to discharge will count.
- The definition of actively engaged for this project would include Medicaid nursing home patients with recent hospital discharges who are at-risk for re-hospitalization with a care transition plan developed prior to discharge.

Project 2.b.vi

Project Title	Transitional supportive housing services
Actively Engaged Definition	*The number of participating patients who utilized transitional supportive housing post-hospital discharge and were appropriately monitored via telephonic and face-to-face contact throughout a 90-day transition period to address a specific housing-related need.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Transitional housing must be monitored by staff but there is no specified minimum number of contacts for the 90-day period. To be counted as actively engaged, the patient must have utilized the service. Contact should be commensurate with need, likely frequent at first and then tapering off. It is not a measure of the quality of the service.
- The only “participating patients” counted in the metric are those who use transitional housing post-hospital discharge (any diagnosis).
- Appropriate monitoring will include face-to-face contact and may include telephonic monitoring as appropriate throughout the 90-day transition period.

Project 2.b.vii

Project Title	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
Actively Engaged Definition	*The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The count refers to the number of patients participating in the INTERACT program.
- Any patient who was transferred to an acute facility (including an ED visit, even if they were not admitted to the hospital) from the nursing home would not count in the actively engaged population.

Project 2.b.viii

Project Title	Hospital-Home Care Collaboration Solutions
Actively Engaged Definition	*The number of participating patients who avoided home care to hospital transfer, attributable to INTERACT-like principles, as established within the project requirements.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The count refers to the number of patients participating in the INTERACT program.
- Any patient who was transferred to an acute facility (including an ED visit even if they were not admitted to the hospital) from home care would not count in the actively engaged group.

Project 2.b.ix

Project Title	Implementation of observational programs in hospitals
Actively Engaged Definition	*The number of participating patients who are utilizing the OBS services that meet project requirements.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- One utilization unit of the observation services consists of:
  - One episode of care = APG rate code 1402 billed with CPT/HCPCS code G0378 (without regard to units [hours] attached to the G0378).

Project 2.c.i

Project Title	To develop a community based health navigation service to assist patients to access healthcare services efficiently
Actively Engaged Definition	*The number of participating patients assisted by community navigators (in-person, telephonic, or web-based).*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- To warrant being “assisted,” there is no minimum number of connections per patient.

Project 2.c.ii

Project Title	Expand Usage of Telemedicine in Underserved Areas to Provide Access to otherwise Scarce Services
Actively Engaged Definition	*The number of participating patients who receive telemedicine consultations.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The consultation can be done by health care professionals as per the NYS telehealth reimbursement law.
- There is no minimum required number of telemedicine consultations per patient. One is sufficient to warrant the count.

Project 2.d.i

Project Title	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care
Actively Engaged Definition	*The number of individuals who completed PAM® or other patient engagement techniques.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Currently PAM® is the only activation measure being considered for implementation in this project.
- If additional patient engagement techniques are utilized they must be evidence-based and/or peer reviewed, demonstrating that they are patient activation techniques that are equal to or better than PAM®.
- PAM® surveys completed by parents/guardians on behalf of younger patients would count for active engagement.

Project 3.a.i (Model 1)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	*The total number of patients receiving appropriate preventive care screenings that include mental health/substance abuse.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The PPS is expected to utilize the preventive care screening based on nationally-accepted best practices determined to be age-appropriate.
- Any staffer working at a PCMH/APCM Service Site who is qualified to perform a preventive care screening can do so. However, preventive care screenings conducted with a patient via telepsychiatry alone will not count within this active engagement definition.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The expectation of a co-located primary care-behavioral health site is that there is a licensed behavioral health provider on site engaged in the practice.

Project 3.a.i (Model 2)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	*The total number of patients receiving primary care services at a participating mental health or substance abuse site.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Primary Care Services are defined as preventive care screenings billed through Current Procedural Terminology (CPT) codes.
- The mental health and substance abuse sites have to be partners in the Network Tool in order to count.
- Any staffer working at a Behavioral Health Site who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.
- The only types of “primary care providers” that may be utilized to provide primary care services within the BH site are participating PCPs, NPs, and physician assistants working closely with a PCP.

Project 3.a.i (Model 3)

Project Title	Integration of primary care and behavioral health services
Actively Engaged Definition	*The total number of patients screened using the PHQ-2 or 9 / SBIRT.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Patients for this project will only count as actively engaged if they receive either the PHQ-2 or 9 or SBIRT screenings.
- All five principles of the IMPACT model must be in place for a site to count.
- Any staffer working within the IMPACT model who is qualified to perform a preventive care screening as required within the project can do so.
- Appropriate screenings would only count if the PCP or the clinical staff is provided the results of the screen and they are incorporated into the medical record.

Project 3.a.ii

Project Title	Behavioral health community crisis stabilization services
Actively Engaged Definition	*Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- "Participating patients" are people experiencing an acutely psychotic episode or who are otherwise behaviorally unstable, who may potentially be referred to the ED, but who are instead diverted to more appropriate crisis stabilization services.
- Crisis stabilization services include all activities required to help stabilize one individual patient after an episode, including their immediate treatment and follow-up services. A readmission/relapse could count as another instance for that same patient who has achieved baseline after the previous event.
- While crisis stabilization services cannot include telepsychiatry on a long-term basis, telepsychiatry encounters with patients would be acceptable in an urgent situation for a patient in a rural or underserved area.
- As defined in Project Requirement 1, a crisis intervention program must include "at a minimum, outreach, mobile crisis, and intensive crisis services" To that end, a hotline on its own would not qualify as a "crisis intervention program."

Project 3.a.iii

Project Title	Implementation of Evidence-Based Medication Adherence Program (MAP) in Community Based Sites for Behavioral Health Medication Compliance
Actively Engaged Definition	*The number of participating patients receiving services from participating providers with documented self-management goals in the medical record. One of these goals must be medication-related, others can include diet, exercise, nutrition, tobacco cessation, etc.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries or medical records).

Clarifying Information:

- To be included, a patient must have a behavioral health diagnosis documented in the medical record **and** must either currently be receiving or under consideration for a behavioral health medication prescription.
- Core components require documentation of patient-driven, self-management/wellness goals in the medical record, which are addressed with interventions as outlined in the collaborative treatment plan.
- Information must be updated in the medical record on an ongoing basis as clinically indicated, but no less frequently than in quarterly treatment plan updates.

Project 3.a.iv

Project Title	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
Actively Engaged Definition	*The number of patients who have received outpatient withdrawal management services at participating sites.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Outpatient withdrawal services can include transition to withdrawal management or stabilization services. Ongoing medication management, including methadone or buprenorphine maintenance for substance use disorders, will not count as actively engaged.

Project 3.a.v

Project Title	Behavioral Interventions Paradigm (BIP) in Nursing Homes
Actively Engaged Definition	*The number of participating patients impacted by program initiatives (bed census).*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Bed census is the number of patients under the care of skilled nurse practitioners, psychiatric social workers, and other appropriate staff who have undergone BIP model training to identify at-risk patients.

Project 3.b.i

Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Actively Engaged Definition	*The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries or medical records).

Clarifying Information:

- Core components require documentation of patient-driven, self-management goals in the medical record, which are reviewed at every appointment.
- Information must be updated in the medical record on an ongoing basis and goals should be reviewed at every appointment.
- Key patient information needs to be available through the HIE throughout the PPS. This is needed so that, for example, a cardiologist and PCP seeing the same patient can access the same information through the RHIO.
- Participating provider systems undertaking this project will be required to engage a majority (at least 80%) of their primary care practices in this activity (as stated in the Domain 1 DSRIP Project Requirements Milestones and Metrics document).

Project 3.c.i

Project Title	Evidence-based strategies for disease management in high risk/affected populations. (adult only)
Actively Engaged Definition	*The number of participating patients with at least one hemoglobin A1c test within the previous 12 months.*
Counting Criteria	For reporting period DY1Q2 only: The PPS will report number of participating patients with at least one hemoglobin A1c test within the last 6 Reporting Quarters (DY0 +DY1Q1 + DY1Q2) through September 30, 2015. For DY1Q3 and future quarters: The PPS will report the number of participating patients with at least one hemoglobin A1c test within the last 4 Reporting Quarters, inclusive of the current reporting quarter.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The target population should include either individuals who have diabetes or are "at-risk" for diabetes. It should be noted that to be considered a patient "at-risk" the individual would have to demonstrate sufficient risk factors or clear cut symptoms prior to official diagnosis as outlined in Table 2.2 of the ADA's Diabetes Care website indicating the criteria for testing for diabetes or prediabetes in asymptomatic adults (http://care.diabetesjournals.org/content/38/Supplement_1/S8/T2.expansion.html) or the most updated guidance.
- Please reference the following PowerPoint presentation for additional clarification - Project 3.c.i and 3.e.i Revised DSRIP Actively Engaged: Patient Engagement Definitions and Counting Criteria.

Project 3.c.ii

Project Title	Implementation of evidence-based strategies in the community to address chronic disease-primary and secondary prevention strategies (adult only).
Actively Engaged Definition	*The number of participating patients participating in programs developed at the project sites.*
Counting Criteria	A count of patients at-risk for or with diabetes who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The target population should include either individuals who have diabetes or are "at-risk" for diabetes. It should be noted that to be considered a patient "at-risk" the individual would have to demonstrate sufficient risk factors or clear cut symptoms prior to official diagnosis as outlined in Table 2.2 of the ADA's Diabetes Care website indicating the criteria for testing for diabetes or prediabetes in asymptomatic adults (http://care.diabetesjournals.org/content/38/Supplement_1/S8/T2.expansion.html) or the most updated guidance.
- Implement Centers for Disease Control and Prevention (CDC)-recognized National Diabetes Prevention Programs (NDPP) and/or create partnerships with community sites to refer patients to CDC-recognized programs.
- To be considered “participating” in a program, a patient is expected to have attended at least one session provided by that program.

Project 3.d.ii

Project Title	Expansion of asthma home-based self-management program
Actively Engaged Definition	*The number of participating patients based on home assessment log, patient registry, or other IT platform.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- Any IT platform will count for determining the number of participating patients as long as it is able to meet the requirements of accurately documenting persons participating in the program.
- Any program that meets the project requirements and is based on evidence-based guidelines will count as an “asthma home-based self-management program.”

Project 3.d.iii

Project Title	Implementation of evidence-based medicine guidelines for asthma management
Actively Engaged Definition	*The number of participating patients with asthma action plan.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The asthma action plan must be developed based on nationally recognized, up-to-date, evidence-based medicine guidelines.

Project 3.e.i

Project Title	Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS
Actively Engaged Definition	*The number of participating patients who received two, sequential anti-retroviral medication scripts and/or attended two office visits within the previous 12 months.*
Counting Criteria	For reporting period DY1Q2 only: PPS may report patients who received two, sequential anti-retroviral medication scripts and/or attended two office visits within the last 6 Reporting Quarters (DY0 +DY1Q1 + DY1Q2) through September 30, 2015. For DY1Q3 and future quarters: The PPS will report patients who received two, sequential anti-retroviral medication scripts and/or attended two office visits within the last 4 Reporting Quarters, inclusive of the current reporting quarter.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- The active engagement definition does not require evidence that the patient has taken his/her medication, only that he/she has received and filled the required prescriptions.
- Please reference the following PowerPoint presentation for additional clarification - Project 3.c.i and 3.e.i Revised DSRIP Actively Engaged: Patient Engagement Definitions and Counting Criteria.

Project 3.f.i

Project Title	Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)
Actively Engaged Definition	*The number of expecting mothers and mothers participating in this program.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- An individual patient could count as actively engaged more than once in a year, but only if she is included in the program again under a new pregnancy in the same year.

Project 3.g.i

Project Title	Integration of Palliative Care into the PCMH model
Actively Engaged Definition	*The number of participating patients receiving palliative care services at participating PCMH sites, in accordance with the adopted clinical guidelines.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- In order to be considered receiving "palliative care services," the participating patients must be receiving palliative care from providers at the PCMH site who have appropriately integrated palliative care into practice models. Thus, the intent of this project is not to limit services to be provided only by palliative care specialists, but also to include members of the clinical team who have been trained to bring integrated palliative care into practice models.
- Palliative care services can include both services billed to Medicaid, as well as services not billable to Medicaid that are clearly documented in the member's medical record.
- Palliative care services provided through this project must meet the principles established by the Center to Advance Palliative Care (https://www.capc.org/providers/palliative-care-resources/joint-commission-certification/), be consistent with the NQF's A Crosswalk of National Quality Forum Preferred Practices (https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf), or the most updated guidance.

Project 3.g.ii

Project Title	Integration of Palliative Care into Nursing Homes
Actively Engaged Definition	*The number of participating patients receiving palliative care services at participating nursing home sites, in accordance with the adopted clinical guidelines.*
Counting Criteria	A count of patients who meet the criteria over a 1-year measurement period. Duplicate counts of patients are not allowed. The count is not additive across DSRIP years.
Data Source	EHRs or other IT Platforms (i.e. patient registries).

Clarifying Information:

- In order to be considered receiving "palliative care services," the participating patients must be receiving palliative care from nursing home personnel at the nursing home site who have appropriately integrated palliative care into practice models. Thus, the intent of this project is not to limit services to be provided only by palliative care specialists, but also to include members of the clinical team who have been trained to bring integrated palliative care into the nursing home.
- Palliative care services can include both services billed to Medicaid, as well as services not billable to Medicaid that are clearly documented in the member's medical record.
- Palliative care services provided through this project must meet the principles established by the Center to Advance Palliative Care (https://www.capc.org/providers/palliative-care-resources/joint-commission-certification/), be consistent with the NQF's A Crosswalk of National Quality Forum Preferred Practices (https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf), or the most updated guidance.

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