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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.

According to data from the Bureau of Primary Health Care's Uniform Data System, the Ellis PPS' FQHCs, which anchor the safety net, provide quality, patient-centered services to 41,152 low income patients or 18% of the region's 233,382 low income residents. The remaining core safety net providers are made up of a network of hospital-based safety net clinics, most of which are New York State Article 28 clinics. These practice sites serve approximately 39,674 low income Medicaid insured and uninsured patients or 17% of the region's low income population. The remaining 65% of the low income target population either: 1) does not receive regular primary care services; 2) is served by small, independent private practices that typically do not provide comprehensive, timely, patient-centered care; or 3) receives intermittent care, usually by hospital emergency departments. Furthermore, only a limited number of the providers that are available provide patient-centered medical home (PCMH) certified services. Of the 108 Ellis PPS primary care practices, 65 (60%) operate in practice sites that are PCMH certified.

There are high rates of chronic disease as well as high PQI and PPV rates in many areas of the service area. These results show the extent to which those with chronic medical and behavioral health conditions struggle to manage their conditions. In 2012, depression, hypertension, substance abuse, diabetes or asthma were the leading chronic medical conditions and



accounted for approximately 50% of all diagnoses provided to Medicaid beneficiaries. Of these beneficiaries, 55,205 beneficiaries had at least one inpatient admission during the year, and this population accounted for a total of 107,481 inpatient admissions overall. Furthermore, of those diagnosed with these conditions, 71,689 had at least one ED visit, and collectively they accounted for a total of 248,253 ED visits during the year. County PQI rates were substantially higher in 3 of the 6 counties, when compared to overall state rates. Similarly, County PPV rates were higher than the State average in 5 of the PPS' 6 counties.

One of the leading findings from the CNA interviews, focus groups, and community listening sessions with consumers, service providers, and other stakeholders was the overwhelming impact of chronic medical and behavioral health issues, exacerbated by socioeconomic and educational factors, and the fact that those affected have limited access to services and grapple with poorly coordinated care.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 2.a.i. through interventions including: The Ellis PPS will achieve broad based participation of providers within the PPS including medical, behavioral, post-acute, long-term care, and Community Based Organizations. The Ellis PPS will ensure that safety-net-providers are actively engaged – interfacing EHRs – with the RHIO, and that all of PC practices are at NCQA Level 3 by the end of DY3. The Ellis PPS will utilize incentives to overcome cultural challenges to integration and the competing work load pressures on PCPs. The PPS will leverage and supplement existing care management within the PPS continuum of providers (Health Homes, PCMH, Post-Acute and Long-term Care Managers, CBO Care Managers) to create a Virtual Care Management Team to address the needs of the region's patients.

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

The Ellis PPS covers the full continuum of care including three major health care systems and over 1,400 provider partners offering medical, behavioral and psychosocial support services. The PPS will leverage the breadth of experience of these providers to developing an IDS that truly encompasses the full continuum of care.

PPS patients throughout the Ellis PPS 6 county region are served by one of three robust Health Homes. Ellis PPS HHs have experience in identifying, outreaching to, planning for and delivering integrated care to individuals with multi-morbid chronic diseases, including those with behavioral and physical health conditions. HHs employ evidence-based protocols to successfully deliver integrated care to high-risk individuals. The HHs further work closely and collaboratively with 12 separate CBOs to meet population needs. The PPS will leverage HH expertise, methods and relationships with the CBO, BH, physical health and psychosocial providers to support the development of the IDS.

A number of leading partners of the Ellis PPS have current direct experience in the establishment of a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed establishment of a Medicare MSSP ACO through the creation of Innovative Health Alliance of New York, LLC (IHANY). A Clinical Integration Committee will be established as a standing committee of the Ellis PPS governance structure. Through that committee the PPS will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and



possibly contract for IHANY services) to insure standardization of clinical best practices. The IHANY and PPS Clinical Committees will collaborate in the development of operating standards, best-practice clinical guidelines and care pathways that support integrated care through a collaborative, evidence-based process that will include interdisciplinary hospitalists, PCPs, social workers, CBOs, members and others.

The Ellis PPS will leverage prior PCMH experience, designate provider champions and offer financial and other incentives to drive the PPS to 100% NCQA Level 3. The PPS anticipates that broad NCQA recognition will expand access, care management, coordination and cultural and linguistic competence among other system capabilities. To further bolster access to care and decrease ED utilization, the PPS will extend primary care capacity 10-15 hours per week on average, incorporating such best practice models as open-access scheduling within PCP sites. The Ellis PPS will employ best practice recruitment and retention strategies to maximize placement of PC, BH and dental providers in the communities with the greatest gap.

The PPS will leverage relationships with MCOs to develop value-based incentives as a key aspect of the IDS, with data driven payment reform as a central tenet of the PPS' approach to transformation. Existing MCO relationships form the basis of a new, more robust relationship going forward through the institution of PPS and MCO leadership meetings to pursue a collaboratively designed transformation strategy.

- 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.

Existing clinical guidelines do not take into consideration integration of medical, BH and psychosocial needs. The Ellis PPS Clinical Integration Committee will develop IDS best-practice clinical guidelines and care pathways through a collaborative, evidence-based process that will include interdisciplinary hospitalists, PCPs, behavioral health providers, social workers, CBOs, members and others.

Assembling an adequate number of care managers to meet IDS objectives is a challenge. The Ellis PPS will leverage and supplement existing care management within the PPS to create a Virtual Care Management Team to address the needs of patients, reduce preventable admissions, readmissions and ED visits. The PPS will further utilize workforce strategies that include care navigators, patient engagement specialists (community health workers) and peers to support the delivery of culturally competent, community-based care.

Given the goal of creating value-based incentives in partnership with insurers, engaging the MCOs in system transformation will be critical but challenging. The PPS will build upon our effective partnership with MCOs in DSRIP project design to forge a shared vision of integrated, person-centered health care delivery. Specifically, leadership from the PPS Finance Committee and Clinical Integration Committee will establish monthly meetings with MCO leadership to create and implement contractually-driven payment reforms.

Transportation will be a significant barrier to the success of an IDS unless addressed by the Ellis PPS. The PPS will utilize DSRIP funds to contract with existing transportation services for dedicated 24 hour on-call transportation across all service sites within the PPS network, to support the IDS by



ensuring that patients can access the right care, at the right time, at the right level of intensity. It is challenging to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally/linguistically appropriate care by hiring individuals who represent the patient population. The PPS will establish culturally and linguistically appropriate care navigation supports. Additionally, the PPS will establish broad population health strategies with a focus on prevention and social determinates of care and care management, leveraging the full continuum of care in an integrated manner.

- 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.

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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.

Bed Reduction: Staffed hospital beds will not be reduced in the early years, but may be reduced by years 4 and 5 when DSRIP initiatives are in more advanced stages of implementation. At the state level, the number of inpatient hospital beds has been declining since 1980. In 2006 there were 3.3 beds per 1,000 New Yorker compared to 3.0 beds per 1,000 New Yorker in 2014 (see CNA A-8). Narrowing the focus to the 6 county PPS region, Ellis Medicine was ground zero for the 2006 Berger Commission. The 3 Schenectady based hospitals (Ellis Hospital, St. Clare's Hospital and Bellevue Woman's Hospital) merged in 2008 to form Ellis Medicine. Certified beds went from 623 to 425. Current certified Ellis beds stand at 423.



Current certified beds at SPHP stands at 1,145. A CON recently approved by DOH will rationalize services in Troy across the existing two community hospitals (Samaritan and St. Mary's). At the conclusion of construction in October of 2017, Samaritan will be the inpatient campus with 277 beds and St. Mary's will provide ambulatory care services, a reduction from the 408 current certified beds. A strategic study to determine the future configuration of the Albany Memorial Hospital is currently underway which includes consideration of the DSRIP initiatives and associated impact on licensed inpatient bed need.

St. Mary's in Amsterdam has been a hotbed of activity seeking to right size healthcare services in the Fulton/Montgomery region. St. Mary's, together with Amsterdam Memorial Hospital, worked with the NYSDOH to become the first "Berger Like" consolidation of healthcare organizations in NYS. It was a highly successful and voluntary consolidation that utilized HEAL funding to reduce unnecessary capacity and costs in the Fulton/Montgomery region. Current certified beds at St. Mary's Amsterdam stands at 120 acute beds, 160 SNF beds and 10 acute rehab beds.

The Ellis PPS Clinical Integration Committee will have as one of its core charges to make recommendations, via an Action Plan, to the PPS governing body of identified unnecessary inpatient hospital and long-term care beds in years 4 and 5.

Long-term Care beds may also be reduced in during years 3 through 5. Across the 6 county PPS region there are 5,770 nursing home beds (CNA A13). Current occupancy rates across the region equals 95.0% demonstrating no current excess capacity. By 2020, based on current capacity nursing home beds and aging demographics, the per 1,000 new Yorkers to nursing home bed ratio within the six county PPS will decrease to 36.7. Efforts of the PPS will focus on right-sizing future capacity to shift care from institutional care to community based settings and recommendations for decreased nursing home beds will be vetted through the Clinical Integration Committee.

COMMUNITY BASED - Parallel development of community-based healthcare services:

Recruiting specialty providers: The PPS anticipates using a similar process used to recruit Endocrinology providers by Ellis and SPHP collaboratively.

Recruiting additional primary care: The PPS has already partnered with both affiliated and non-affiliated primary care networks. The Clinical Integration Committee will make additional recommendations to the PPS governing body for prioritization of primary care recruitment. PPS Primary Care sites are currently recruiting Care Managers for the 43 Ambulatory Practices at SPHP. Currently 7 of those practices have RN Care Managers who coordinate the care of high risk and/or complex patients. Additionally, as a strategic initiative to coordinate the Care Management activities, SPHP is beginning a quarterly Care Management meeting that will introduce the concepts of appropriate hand off of patients and Care Management responsibilities across the continuum of care from hospital to community based services. Other partners have incorporated similar efforts.

Hiring of care managers: The existing Health Home infrastructure of three established high functioning Health Homes will be leveraged to recruit additional care managers both employed within the Health Homes and Health Home down-stream CBOs. The Health Homes will continue to develop the use of a best practice approach in identification of participants, outreach,



engagement and approach, assessment and ongoing care management, care planning and care plan development, and measurement of outcomes.

IDS MILESTONES: The Ellis PPS will achieve 100% PC practices NCQA Level 3 by the end of DY3. Strategic primary care sites and clinic hours will be extended on average 10 to 15 hours per week by the end of DY2. The Ellis PPS will develop best practice PCP recruitment and retention strategies by the end of the demonstration year. The Ellis PPS Clinical Integration Committee will develop IDS operating standards, best-practice clinical guidelines, and care pathways by the end of the demonstration year. The PPS Finance and Clinical Integration Committees will establish routine meetings (anticipated as monthly) with the MCOs by the end of the demonstration year.

- 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.).

Although this application is being submitted by Ellis as the Ellis PPS, a Newco, LLC is expected to be formed before March 1, 2015, which will be the contracting party in the contract with the State Department of Health as the DSRIP PPS.

The development of an operating agreement will set forth the structure and processes required to effectively govern the articulated Integrated Delivery System vision of the PPS. Agreement on the formation of a collaborative LLC is already a significant milestone in the road to an integrated delivery system. It illustrates the commitment of PPS key partners to creating that system and reveals a common vision of a key feature of the IDS. Four of the key partners of Newco, LLC have current direct experience in the establishment of a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed the establishment of a Medicare MSSP ACO through the creation of the new Innovative Health Alliance of New York, LLC (IHANY). IHANY meets federal requirements for a MSSP ACO, including adoption of clinical standards, a compliance program, and a process distribution of shared savings, all essential components of a high performing IDS. Given the overlap of the geography (the MSSP and DSRIP projects cover the same 6 counties), partner membership, and purpose, it is the intent of the partners to explore ways to leverage the two projects by sharing applicable infrastructure.

An LLC operating agreement will facilitate both cooperation and decision-making by specifying, among other matters: the composition of the governing body, their terms, and the appointment and removal process; actions that require majority vote; actions that require supermajority votes; governing body committees, including Finance and Audit, Clinical and Data/IT; a process for adding and removing Participating Partners; a process for deciding upon distributions; a process for securing capital contributions; Compliance (including antitrust compliance) requirements.

NewCo, PPS envisions a management structure, with adequate dedicated and experienced staff, that will provide for central, coordinated oversight of this integrated delivery system, and pursue the stated objectives of DSRIP.



A Clinical Integration Committee will be established as a standing committee of NewCo, LLC. Through that committee NewCo, LLC will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to insure a process for standardization of clinical best practices. The committee will be responsible for establishing operating standards and clinical guidelines, which includes Behavioral Health (BH) and Substance Use Disorders (SUD), to be used in the care of Medicaid members and others served by the PPS, focusing first on the project areas.

The Clinical Integration Committee is also responsible for creating a network annual quality improvement plan, which prioritizes areas where the PPS overall could improve its performance against its own clinical standards and guidelines, which includes Behavioral Health (BH) and Substance Use Disorders (SUD).

To address lower performing members the PPs will: Establish benchmarks for performance expectations; Target benchmarks and performance expectations will be included in the contracts with all participating partners and vendors; Participating partner's compliance with PPS operating standards and clinical guidelines will be monitored and evaluated.

If the Committee finds that a Participating Partner is performing at a level that is significantly below target or expectation then, in conjunction with the Committee and PPS Medical Director, a Corrective Action Plan will be developed. Successful implementation of the Corrective Action Plan is a condition for full distribution of DSRIP funding. The PPS will maintain a compliance program which complies with the Federal and State regulations.

The PPS will conduct an enterprise-wide risk assessment for the PPS as a whole, (updated when needed, or at least annually) to identify any compliance concerns related to PPS operations and performance. In addition, the PPS will have an anonymous hotline that can be used by all employees and the public in order to report any compliance issue(s) that may arise.

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.

(1) Reduce staffed beds at Ellis unit A by 17 beds by converting double rooms into singles to reduce operational costs and provide increasing quality while increasing patient privacy and dignity. (2) IT- There is a significant capital need in order to build the connective IT system across the PPS including, EMR upgrades, purchases and fees, hardware to support EMR changes, hardware for connectivity, interface builds, software upgrades and software for population management. (3) Tele-health needs capital support. Tele-health is vital to IDS, the Home care Collaborative and Palliative care. (4) Baptist Health Care Center (SNF) has space that the PPS plans to convert to observational bed space for substance abuse. The conversion of nursing home will need capital funding. (5) The DSRIP management staff will need a place to work. The PPS has rental space available but the PPS will need to furnish the space. These capital requests would support the entire IDS as well as the implementation of all of the DSRIP projects overall.

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
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	8/2014	3/20/15	Expand and enhance PCMH activities



New York Department of Health
 Delivery System Reform Incentive Payment (DSRIP) Program
 Project Plan Application

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/2014	10/20/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	9/20/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	Pending NOA	(3 yrs)	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/20/15	Health center funding to support uninsured populations



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/20/15	Outreach and enrollment for health insurance marketplace

- 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 St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

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

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

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



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

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



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

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

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

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

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



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.

Based on statewide data provided by the NYS DOH, approximately 36% of the 6,200,740 Medicaid beneficiaries in New York State have at least one serious chronic condition. The largest subset of this population is those with two chronic conditions, who account for 16.2% (1,002,914) of all beneficiaries. The next largest group is those with one chronic condition, who account for 13.8% (854,425) of all beneficiaries. A clear majority of the beneficiaries in both of these groups are further categorized as level 1 or level 2 severity of illness, which means that as relatively low-risk, they are good candidates for ED Triage. Total Level 1 and Level 2 ED/HCPSC codes accounted for 35,036 Medicaid enrollees and 84,049 visits.

In 2012, approximately 95,000 of the service area's Medicaid beneficiaries were categorized in one or more of the following chronic medical and behavioral health conditions: depression, hypertension, substance abuse, diabetes or asthma. Of these beneficiaries, 55,205 beneficiaries had at least one inpatient admission during the year, and in total this group accounted for a total of 107,481 inpatient admissions overall. Furthermore, of these 140,444 beneficiaries 71,689 had at least one ED visit, and accounted for a total of 248,253 ED visits during the year.

This data was further supported by very high PQI rates, which were substantially higher in 3 of the 6 counties when compared to overall state rates. County PPV rates were even more of a pervasive problem as all 6 of the service area's counties had rates that were higher than the state average. The region's PPV rates ranged from being 30% higher than the state rate in Rensselaer County to approximately 20% higher in both Albany and Schenectady, down to only approximately 1% higher in Saratoga.

Quantitative data from the CNA shows that there is limited primary care capacity for the low income target population, high rates of chronic medical and behavioral health issues, and correspondingly very high rates of inappropriate ED and hospital utilization. Many key informant interviews cited that large numbers of consumers simply use the ED as their primary source of health care.

The service gaps and the lack of care management services is exacerbated by socioeconomic and educational factors, including unemployment, lack of affordable housing, lack of health literacy and lack of awareness and understanding health risk factors. Qualitative findings also reinforced the impact that barriers related to transportation, cost, and cultural/language have on the target population's ability to navigate the system. Cost and cultural/linguistic barriers are more intense issues in more urbanized areas and transportation and cost take precedent in rural areas.

Furthermore, care coordination and follow-up are stymied by the inability to share information across participating organizations due to the fragmented adoption of EMRs and HIEs in the



region.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 2.b.iii through interventions including: implement an ED Triage process in each of the PPS EDs to identify and screen all PPS patients and provide coordination with outpatient resources including primary care, urgent care, health homes and CBOs; embed HH Navigators (HHN) in the ED to arrange coordinated care to patients; develop a region-wide transportation solution to facilitate patient access to entire 6 county region; the project partners will develop a referral and outreach process to integrate care management and emergency response services.

- 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 Medicaid members with more than one ED visit in a rolling 12 month period who present to the ED with a non-emergent (ambulatory-sensitive) condition. The PPS will the conduct a separate analysis at each hospital of the population who fits this criteria by age, race/ethnicity, condition, etc. in order to tailor and implement plans that are fully responsive to the needs of the local population and hospital ED context. PPS partners will collaborate to ensure that interventions are offered to all identified to engage in appropriate care and develop an effective transition plan. Hospital partners will collaborate to share ideas on target population and approaches to screening and referral.

- 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.

Within the Ellis PPS there are 3 major health systems which include 6 EDs, 3 home care agencies, 5 urgent care practices, 108 primary care practices, 3 Health Homes, 2 FQHCs, 4 Care Transitions Coach programs, a Home Visiting Physician Program at St. Peter's Medical Associates, and numerous CBOs. These will be utilized to support the distribution of care, mitigating inappropriate utilization of ED services.

PPS patients throughout the Ellis PPS 6 county region are served by one of three robust Health Homes. These HHs have significant experience engaging and contracting with downstream providers, currently working with 12 separate CBOs with unique cultural competency including BH, HIV/Aids, SUD, as well as children and adolescents. The Ellis PPS will leverage this resource by embedding Health Home navigators in the ED.

A number of leading partners of the Ellis PPS have current direct experience in the establishment of a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed establishment of a Medicare MSSP ACO through the creation of Innovative Health Alliance of New York, LLC (IHANY). A Clinical Integration Committee will be established as a standing committee of the Ellis PPS governance structure. Through that committee the PPS will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to insure a process for standardization of clinical best practices. The committee will be responsible for



establishing operating standards to include a “triage out” process to screen Level I & 2 patients to re-direct to appropriate level of care to reduce future ED visits, best-practice clinical guidelines, and care pathways that support ED Triage through a collaborative, evidence-based process that will include ED Physicians, ED nurses, Health Home staff, PCPs, social workers, CBOs, members and others.

ED Triage requires the development of a PPS transportation asset. The Ellis PPS will utilize DSRIP funds to contract with existing transportation services for dedicated 24 hour on-call transportation across all service sites within the PPS network.

- 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.

To further bolster access to care and decrease ED utilization, the PPS will extend primary care capacity 10-15 hours per week on average, incorporating such best practice models as open-access scheduling within PCP sites. The Ellis PPS will employ best practice recruitment and retention strategies to maximize placement of PC, BH and dental providers in the communities with the greatest gap.

Engaging providers to participate and achieve NCQA Level 3 recognition, especially considering the related costs and the existing workload is a challenge. Ellis will leverage prior PCMH experience, designate provider champions, and offer incentives to drive the PPS to 100% NCQA Level 3 by the end of DY3. The PPS anticipates that broad NCQA recognition will expand access, care management, coordination and cultural and linguistic competence among other system capabilities.

For patients presenting with minor illnesses that do not have a PCP, Health Home navigators embedded in the ED will immediately assist the patient in securing an appointment with a PCP, after required medical screening to validate a non-emergency need. Shortages of PCPs present a challenge. In response, the Ellis PPS will employ best practice recruitment and retention strategies to maximize placement of providers in the communities with the greatest gap.

It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals for ED Triage who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly



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scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness



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 additional resources?

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

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

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

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



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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
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/2014	10/20/16	Behavioral Health Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	9/20/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	Pending NOA	(3 yrs)	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case Management in Primary Care



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			reduce readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/20/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/20/15	Outreach and enrollment for health insurance marketplace
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients

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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn form the collaboration.

Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.



5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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



2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regimens. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.

Additional resources for these projects can be found at www.caretransitions.org and <http://innovation.cms.gov/initiatives/CCTP/>.

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

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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



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

There are high rates of chronic disease as well as high PQI and PPV rates in many areas of the service area. These results show the extent to which those with chronic medical and behavioral health conditions struggle to manage their conditions. In 2012, depression, hypertension, substance abuse, diabetes or asthma were the leading chronic medical conditions and accounted for approximately 50% of all diagnoses provided to Medicaid beneficiaries. Of these beneficiaries, 55,205 beneficiaries had at least one inpatient admission during the year, and this population accounted for a total of 107,481 inpatient admissions overall. Furthermore, of those diagnosed with these conditions, 71,689 had at least one ED visit, and collectively they accounted for a total of 248,253 ED visits during the year. County PQI rates were substantially higher in 3 of the 6 counties, when compared to overall state rates. Similarly, County PPV rates were higher than the State average in 5 of the PPS' 6 counties.

There are dramatic gaps in quality, patient-centered outpatient services for those who are in low income brackets, particularly with respect to primary care medical and behavioral health services. The CNA showed that only about 35% of the low income population received care from full service primary care practice sites that provide consistent, well-coordinated services, targeted to low income population. FQHC penetration rates, area health professional shortage Area (HPSA) and medically underserved Area (MUA) designations, and other data from the CNA's survey efforts, show these shortages.

These gaps have broad impacts and hinder the ability of the health care system to engage the target population, provide regular primary care services, and conduct appropriate timely follow-up services after hospital discharge. Patient no-show rates and issues with respect to managing referrals are a particular problem in outpatient settings and these issues were leading themes across the CNA's qualitative interviews, focus groups, and meetings.

Issues related to poor coordination and fragmentation of services are exacerbated by underlying demographic, socioeconomic and educational factors that create barriers to access and engagement, which were also highlighted in the CNA's qualitative findings. The CNA's qualitative findings also identified lack of cultural/linguistic barriers and health literacy, as well as lack of awareness and understanding of health risk factors as major issues that affect care transitions. Finally, qualitative findings reinforced the impacts related to transportation and cost. All segments are impacted by primary care and behavioral health shortages, fragmentation of services, cultural and language barriers, poor coordination and inability for providers to share health information across settings.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 2.b.iv through interventions including: The Ellis PPS will develop standardized protocols and job descriptions for a Care Transitions Intervention Model. The Ellis PPS will ensure that 100% of all PC practices are recognized as NCQA Level 3 by the end of Year DY3 which includes embedding care coordination resources in the primary care practices and in-patient setting and expanding the length of time the coordinator follows the patient. Care coordinators will be embedded in behavioral health settings. Currently there are limited transition services available for these patients. The Ellis PPS will develop service agreements with MCOs to standardize payment reimbursement for transition of care services. The Ellis PPS will link Health Home eligible patients to care transition resources including home care.



- 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 population for this project will be hospitalized patients discharged to home and community based care. Particularly emphasis will be placed on diagnoses of congestive heart failure, other cardiac issues, diabetes, behavioral health diagnoses, respiratory and renal, which are responsible for the majority of all inappropriate hospital readmissions. Further emphasis will place on identifying those with mild, moderate and severe levels of mental illness, regardless of whether this issue is the cause of the initial or readmission due to the high proportion of the target population with underlying, identified or unidentified, co-morbid mental health issues. All severity levels will be addressed by program but prioritization will be made, as necessary on those in low to moderate severity-levels as those in higher severity levels are more likely be readmitted regardless of any intervention.

- 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.

Within the Ellis PPS, there are 3 major health systems with 2 operated and owned home care agencies that have received training from Dr. Eric Colman CT Model and a proven successful Care Transition program. The PPS will leverage these experienced resources to expand Care Transition programs into the hospital setting. Specifically, by embedding care transition resources and working with the discharge planners, using chronic illness/advance illness management tools. Interventions for the management of CHF, COPD, Diabetes, and pneumonia are currently in place. Providing coaching services to targeted high-risk patients will help increase coordination of care, communication to providers, understanding and using medication correctly, knowledge regarding red flags or signs and symptoms of the chronic illness, and help achieve the patient-centered care model of disease management.

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

Given the burden of chronic medical and behavioral health conditions in the service area and the impacts that these conditions have on overall morbidity, mortality, and inappropriate hospital utilization, it will be critical that the Ellis PPS focus on facilitating appropriate care transitions, particularly from the hospital setting. Proper follow-up, care coordination, and care planning, combined with HIT/HIE systems will be critical to the success of this effort. It will also be critical to ensure that these efforts respond to the substantial cultural, linguistic, health literacy, transportation, and cost barriers that hinder the target population's ability to understand, follow, and engage in the care plans that are provided.

Engaging providers to participate and achieve NCQA Level 3 recognition, especially considering the related costs and the existing workload is a challenge. According to data from NYS DOH, only



5% of the service area's PCPs operated in practices that are PCMH certified. The PPS will leverage prior PCMH experience, designate provider champions, and offer incentives to drive the PPS to 100% NCQA Level 3 by the end of DY3.

Coordination of care strategies focused on Care Transition are not uniform, and were developed through a narrow focus. In response, the Ellis PPS Clinical Integration Committee will establish Care Transitions operating standards and best-practice clinical guidelines through a collaborative, evidence-based process that will include home care agency staff, interdisciplinary hospitalists, PCPs, Health Homes, MCOs, social workers, CBOs, members and others.

Lack of transportation services is a barrier especially in rural counties where there is a little or no public transportation. In some programs, care transition coordinators are allowed to transport patients to appointments; however, there are liability issues for providers that would have to be resolved. To supplement transport by Care Transition coaches, the Ellis PPS will contract with existing transportation services for dedicated 24 hour on-call transportation across all service sites within the PPS network.

It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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

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

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

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.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	8/2014	3/20/15	Expand and enhance PCMH activities
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/2014	10/20/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	9/20/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	Pending NOA	(3 yrs)	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO



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 Project Plan Application

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case Management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce Readmissions
FQHC Whitney Young	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

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.



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

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

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



2.b.viii Hospital-Home Care Collaboration Solutions

Project Objective Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high risk patients.

Project Description: Many patients who previously were transferred to skilled nursing facilities (SNFs) are now being discharged to less restrictive alternative locations, primarily home-based. Aside from the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance to discharge regimens, missed provider appointments, and less frequent observation of an at-risk person by medical staff. This project will put services in place to address these risks by matching services with transition care management. Services are expected to last more than 30 days.

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. Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.
2. Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.
3. Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT-like principles.
5. Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.
9. Utilize telehealth/telemedicine to enhance hospital-home care collaborations.
10. Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.
11. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
12. Use EHRs and other technical platforms to track all patients engaged in the project.



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

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

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

There are high rates of chronic disease as well as high PQI and PPV rates in many parts of the service area. These results show the extent to which those with chronic medical and behavioral health conditions struggle to manage their conditions. In 2012, depression, hypertension, substance abuse, diabetes or asthma were the leading chronic medical conditions and accounted for approximately 50% of all diagnoses provided to Medicaid beneficiaries. Of these beneficiaries, 55,205 beneficiaries had at least one inpatient admission during the year, and this population accounted for a total of 107,481 inpatient admissions overall. Furthermore, of those diagnosed with these conditions, 71,689 had at least one ED visit, and collectively they accounted for a total of 248,253 ED visits during the year. County PQI rates were substantially higher in 3 of the 6 counties, when compared to overall state rates. Similarly, County PPV rates were higher than the State average in 5 of the PPS' 6 counties.

As discussed above, many of the service area's counties have high rates of PQIs and/or PPRs. PQIs indicate when an adult's hospital admission is considered, at least typically, to be preventable or avoidable with more timely, effective, higher quality primary care services. Across the counties in the service area, PQI rates were substantially higher in 3 of the 6 counties, for the overall composite PQI, which includes a broad selection of chronic disease and acute conditions. Four of the 6 counties had higher PQI rates for the acute diagnosis composite, when compared to overall state rates. County PPV rates were even more of a pervasive problem as all 6 of the service area's counties had rates that were higher than the state average. The region's PPV rates ranged from being 30% higher than the state rate in Rensselaer County to approximately 20% higher in both Albany and Schenectady, down to only approximately 1% higher in Saratoga.

The 2013 NYS PPR rate per 100 at risk admissions was 6.31 for the Medicaid population. All hospitals in the Ellis PPS had lower Medicaid PPR rates lower than the State average. However, the rates are high and represent an unacceptable level of readmission. Ellis Hospital (n=314) and St. Peters Hospital (n=266) had the largest number of potentially preventable Medicaid readmissions in 2013.

The CNA's qualitative findings, particularly with consumers, indicate that issues related to poor coordination and fragmentation of services, exacerbated by underlying demographic, socioeconomic, and educational factors, create barriers to access and engagement. The CNA showed that only about 35% of the low income population received care from full service PCP sites.

Given the burden of chronic medical and behavioral health conditions in the service area and the impacts that these conditions have on overall morbidity, mortality, and inappropriate hospital utilization, it will be critical that the Ellis PPS focus on facilitating appropriate care



transitions, particularly from the hospital setting.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 2.b.viii through the interventions including: The Ellis PPS will develop hospital/home care rapid response teams focused on maximizing the number of hospital discharges to the home and community based settings while assuring needed home care services are in place to meet acute care needs, as well as services to meet non-acute/coordination needs. The PPS will form a task force to build an Interact-like assessment and management program and will educate staff on the principles of that program. The Ellis PPS will target identified areas for improvement with rapid cycle improvement methodologies, develop plans and evaluate results of initiatives demonstrated by plans, root cause analysis Implementation reports and results.

- 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 population for this project will be a subset of the target population articulated in project 2.a.i. Specifically, this project will target those that were identified in 2.a.i that are being transitioned to the home-setting. Given this, the target population will be drawn from all hospitalized patients or those at risk of hospitalization, currently receiving home care. An emphasis on those with diagnoses of congestive heart failure, other cardiac issues, diabetes, behavioral health diagnoses, respiratory, and renal, which are responsible for the majority of all inappropriate hospital readmissions. Once again, further emphasis will be placed on identifying those with mild, moderate, and severe levels of mental illness, regardless of whether this issue is the cause of the initial admission or the readmission due to the high proportion of the target population with underlying, identified or unidentified, co-morbid mental health issues. All severity levels will be addressed by program but prioritization will be made, as necessary on those in low to moderate severity-levels as those in higher severity levels are more likely be readmitted regardless of any intervention.

- 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 Ellis PPS includes three major health systems: Ellis, St. Peter's Health Partners, and St. Mary's Healthcare Amsterdam, within which exist 6 acute care hospitals. These hospitals have a total of 1698 certified beds. In 2013 they totaled 68,859 inpatient admissions and 261,556 ED visits.

The Ellis PPS has 5 home care agency partners, including a home care partner affiliated with each of the 3 major health systems. The two other home care partners bring significant home care experience to the Ellis PPS; Albany VNA, and Living Resources which brings particular expertise with the Developmentally Disabled population.

The three health system's homecare agencies have a well-documented history of innovation. They have piloted a number of programs that will be leveraged in expanding hospital-home care collaboration across the Ellis PPS. These pilot programs include: Resident Service Advisors embedded at 22 apartment complexes; DME "loan closets" at 22 facilities for



immediate DME access; Health Home based out of one homecare agency with staff embedded at YMCA, City Mission and Bethesda House. In addition Care Managers and Community Health Workers (CHW) embedded at 2 EDs. In addition navigators embedded at 3 PCPs; Home infusion on-site pre-discharge education; Physician home visit program; Mid-level home visit transition program; Home based palliative care programs with interdisciplinary teams.

Each Home Health Agency in the Ellis PPS has a robust tele-health program in use.

The Ellis PPS has established RN liaisons cross-trained on palliative care, and care transition coaches at each of the 6 hospitals within the PPS as well as in their affiliated licensed home care corporations. These will be leveraged to drive connectivity to the discharge planning process.

Two of the five home care corporations are already in the process of establishing connections with HIXNY (RHIO) that are bi-directional, multiple of these corporations have portal access to the HIE.

The Ellis PPS has 12 Coleman trained coaches, experienced in an evidence based model who will be leveraged in the PPS commitment to educate staff on Interact-like principles.

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

There are multiple assessment tools in place for evaluating post discharge needs. Implementing an Interact-like system over the large network of programs and providers in our PPS is a challenge. A strong Interact-like process involves full staff involvement. To address this, the PPS will form a task force including 13 Coleman trained coaches to educate staff on Interact-like principles. The task force will examine best practices to create a comprehensive training program including grand rounds, on-site trainings, webinars, and on-line training standardized across the PPS. Advanced care planning in cooperation with 3.g.i (palliative care), will be incorporated into our training and care protocols as well as public outreach, including a palliative care risk assessment completed on all new admissions.

Hospitals are challenged by the lack of a reliable discharge planning process that begins upon admission. To address this, the Ellis PPS will develop hospital/home care rapid response teams focused on maximizing the number of hospital discharges to the home while assuring needed home care services are in place to meet acute care needs, as well as services to meet non-acute/coordination needs.

Existing clinical guidelines are hospital focused and developed through a narrow physician led process. The Ellis PPS Clinical Integration Committee will develop critical pathways and best-practice clinical guidelines for hospital-home care collaboration through an evidence-based process that will include a much broader cadre of hospitalists, Home Care RNs, PCPs, social workers, CBOs, patients and others.

There is a lack of necessary resources/capacity in outpatient and community-based settings. This limits the ability to schedule timely follow-up appointments which could result in readmission. In response, the Ellis PPS will enhance current recruitment efforts including offering financial and other incentives to attract a greater number of PCPs to the area and increase the retention rate of graduating residents from local programs.



It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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

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

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system 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
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/2014	10/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	09/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative



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FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 years	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ client
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case Management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce Readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not overlap with this grant target.

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.



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- 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.

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2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

In order to be eligible for this project, a PPS must already be pursuing 10 projects, demonstrate its network capacity to handle an 11th project, and evaluate that the network is in a position to serve uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations. Any public hospital in a specified region has first right of refusal for implementing this 11th project. Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project. Finally, in order to participate in pay-for-reporting outcome metrics in Demonstration Years (DY) 4 and 5, the PPS will submit data as specified.

Project Objective: The objective of this 11th project is to address Patient Activation Measures® (PAM®) so that UI, NU, and LU populations are impacted by DSRIP PPS' projects. Feedback from the public comment period resulted in the state to include UI members in DSRIP, so that this population benefits from a transformed healthcare delivery system. Please refer to the body of literature found below on patient activation and engagement, health literacy, and practices to reduce health care disparities:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/>
<http://content.healthaffairs.org/content/32/2/223.full>
<http://www.hrsa.gov/publichealth/healthliteracy/>
<http://www.health.gov/communication/literacy/>
<http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page>
<http://www.hrsa.gov/culturalcompetence/index.html>
<http://www.nih.gov/clearcommunication/culturalcompetency.htm>

Project Description: This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The PPS will be required to formally train on PAM®, along with base lining and regularly updating assessments of communities and individual patients. This project encapsulates three primary concepts, which drive the requirements for this project:

- Patient activation
- Financially accessible health care resources
- Partnerships with primary and preventive care services

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

1. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.



2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.
3. Identify UI, NU, and LU “hot spot” areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified “hot spot” areas.
4. Survey the targeted population about healthcare needs in the PPS’ region.
5. Train providers located within “hot spots” on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).
 - This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
 - Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.
7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.
8. Include beneficiaries in development team to promote preventive care.
9. Measure PAM® components, including:
 - Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or “hot spot” area for health service.
 - If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM® survey and designate a PAM® score.
 - Individual member score must be averaged to calculate a baseline measure for that year’s cohort.
 - The cohort must be followed for the entirety of the DSRIP program.
 - On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving beneficiaries to a higher level of activation.
 - If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
 - The PPS will NOT be responsible for assessing the patient via PAM® survey.
 - PPS will be responsible for providing the most current contact information to the beneficiary’s MCO for outreach purposes.
 - Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.
10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.
11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community health care resources (including for primary and



- preventive services) and patient education.
12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.
 13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.
 14. Ensure direct hand-offs to navigators who are prominently placed at “hot spots,” partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive health care services and resources.
 15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.
 16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.
 17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.

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

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

Qualitative and quantitative information from the CNA highlights the fact that a large portion of the unmet need that exists among the low-income population is more related to a lack of engagement in regular primary care, chronic disease management, and preventive services than it is about a lack of raw primary care capacity or expertise.

Research and CNA findings shows that foreign born and non-English speaking segments of the population often have limited health literacy, lack acculturation, and struggle with cultural/linguistic barriers. While quantitative data is not readily available, key informants from the CNA highlighted the impact of undocumented immigrants who often have very limited access for a range of factors including cost, culture, language, health literacy and fear of being identified as “illegal.”

There are high rates of chronic disease as well as high PQI and PPV rates in many areas of the service area. These results show the extent to which those with chronic medical and behavioral health conditions struggle to manage their conditions. In 2012, depression, hypertension, substance abuse, diabetes or asthma were the leading chronic medical conditions and accounted for approximately 50% of all diagnoses provided to Medicaid beneficiaries. Of these beneficiaries, 55,205 beneficiaries had at least one inpatient admission during the year, and this population accounted for a total of 107,481 inpatient admissions overall. Furthermore, of those diagnosed with these conditions, 71,689 had at least one ED visit, and collectively they accounted for a total of 248,253 ED visits during the year. County PQI rates were substantially higher in 3 of the 6 counties, when compared to overall state rates. Similarly, County PPV rates



were higher than the State average in 5 of the PPS' 6 counties.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 2.d.i. through the following interventions: The Ellis PPS will partner with Community Based Organizations (CBOs) that work with the uninsured (UI), low utilizing (LU) and non-utilizing (NU) Medicaid populations. The PPS has identified UI, LU and NU hot spots through communication with CBOs already strongly engaged in DSRIP including places of worship, municipal housing sites, food pantries, shelters, community action programs, libraries, county jails and Department of Social Services (DSS). The Ellis PPS will build a team to be trained in PAM and patient activation techniques. CBOs will assist with the identification of individuals to be trained. The Ellis PPS will place patient engagement specialists in hot spots identified in conjunction with CBOs. These specialists will reflect the diversity of the population served by the Ellis PPS and will receive training on PAM and community resources such as insurance enrollers. The Ellis PPS will explore interventions that target barriers experienced by the UI, LU and NU Medicaid populations when trying to access health care. Possible interventions include expansion of mobile health care, increasing use of community shuttles, improving translation services, expanding the prescription assistance counselor model and offering extended hours in primary care offices. A Community Advisory Group will be developed that has beneficiaries from each of the racial/ethnic populations, as well as other marginalized groups typically found in the Medicaid population such as low-income, LGBTQ, people with disabilities, Veterans, formerly incarcerated individuals, etc. This group will provide guidance to the PPS on healthcare needs and feedback on proposed interventions.

- 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. Note: Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project.

The target population for this project are the uninsured (UI), low utilizing (LU) Medicaid members, specifically defined as those identified with less than 3 visits in the last 24 months and non-utilizing (NU) Medicaid members. Those targeted will be identified by public health, community, and health service partners throughout the PPS network but particularly through the PPS primary care safety net, hospital emergency rooms, and other outpatient safety net behavioral health and specialty care clinics. In addition, the target population will be identified by community organizations that work with or somehow have contact with the low income UI, LU, and NU residents that are targeted by this initiative, including community service, social service, faith-based, correctional institutions, and other community organizations. EDs will be a key setting for identifying the target population due to the fact that they often serve patients who have delayed needed care and have very acute needs and/or use the ED as their usual source of care.

The PPS will reach out to the managed care organizations and request a report identifying MCO enrollees who are LU, NU, and recently lapsed UI. Other members of the target population will be captured through targeted outreach and enrollment activities, intake processes, and educational sessions/outreach sessions. A great many primary care practices, EDs and CBOs in



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the PPS focus on breaking down barriers when it comes to language and culture. Translation services are often available on site and several partners have implemented a program called "Bridges out of Poverty," which helps staff better understand the cultural and lifestyle challenges encountered in a poor community.

- c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

The Ellis PPS includes two Federally Qualified Community Health Centers (FQHC), both with a mission to care for underserved individuals and offer greater access to primary care, Behavioral Health and Dental services. The FQHC's will expand hours to cover nights and weekends to ensure access to urgent and primary care in an effort to reduce avoidable ED usage. The PPS also has Health Homes through Ellis Medicine, St. Peter's Health Partners, and St. Mary's Hospital. The staff is experienced in working with the UI, LU and NU Medicaid populations and will be engaged as part of the PAM training team. There is also a peer program through Ellis' Health Home that has been successful in reducing readmissions among its behavioral health population.

The Schenectady Coalition for a Healthy Community is an active, broad-based, community coalition with over 70 partners. This group, along with similar coalitions in the Ellis PPS, will be mobilized to provide guidance on hot spotting and assist with the identification of individuals who will serve as community navigators.

Two grants have been recently awarded within the region served by the Ellis PPS that will provide training opportunities for Community Health Workers (CHWs). One of the grants was received by Schenectady County Community College and will train 12 CHWs using a comprehensive curriculum that includes topics such as community navigation, cultural competency and health literacy. The second is a LIGHT grant that was awarded to St. Peter's Health Partners that will train CHWs in asthma education. The Ellis PPS will have an opportunity to hire graduates of these programs and can use the programs as a platform for increasing capacity of training opportunities for project staff.

St. Peter's Health Partners employs two full-time prescription assistance counselors who advocate for lower cost prescriptions for patients with their healthcare providers. Expanding this model will be an intervention that will target financially accessible resources.

Whitney Young, in partnership with the Healthy Capital District Initiative, provides mobile dental services to youth at Albany City schools through the Seal-A-Smile program. The Ellis PPS will be exploring the pros and cons of expanding the mobile health model across its service area to increase access to care.

Recently Ellis Medicine began using a Video Remote Interpreting service in both inpatient and outpatient settings that provides face-to-face translation in multiple languages through an iPad. There has been improved patient satisfaction and a substantial reduction in cost for translation services. The Ellis PPS will explore expansion of this program as a component of improving health literacy and cultural competency.

The Schenectady Bridges Out of Poverty program has influenced a number of interventions at Ellis Medicine over the past few years such as the creation of a free community shuttle and open access scheduling for the dental health and primary care practices. The Ellis PPS will look to expand



such successful models across its service area and engage certified Bridges trainers in its planning and implementation.

The Ellis PPS has already engaged Managed Medicaid plans in its DSRIP PAC. Their partnership will be crucial to identify the LU and NU Medicaid patients, as well as those whose coverage is expired or due to expire and will need assistance with re-enrollment/recertification. Outreach and Enrollment workers currently offering insurance assistance and education at Hometown Health and Whitney Young will be a valuable resource.

- 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.

Improving cultural competency across the PPS will be a challenge due to the diversity of the populations in our service area. For example, the City of Schenectady has a large population of Guyanese, comprising close to 10% of the total city population and the City of Albany is home to diverse refugee populations. Therefore, a key component is to employ and engage Community Health Workers (CHW) who live, work and have family and friends in underserved communities. Many of the CHWs will understand the culture and community need, but training and recruitment is required. In response, the Ellis PPS will provide cultural competency training, tailored to the racial and ethnic populations prevalent in their service area, to PPS providers. Community navigators will be staffed to reflect the diversity of the populations being served. The Ellis PPS will form a Community Advisory Group which will include representatives from each of the racial/ethnic populations, as well as other groups typically found in the UI, LU and NU Medicaid populations such as low-income, LGBTQ, people with disabilities, Veterans, formerly incarcerated individuals, etc. This group will provide guidance to the PPS on proposed interventions. Finally, additional questions will be added to intake forms across the PPS to capture data on race and ethnicity, sexual orientation and gender identity due to the unique medical needs and health disparities experienced by these populations. This data will be stratified in order to pinpoint population needs for culturally and linguistically diverse minority populations.

Improving health literacy across the PPS and awareness of social determinants of health among providers will be crucial to achieving success. To address this challenge, organizational assessments of health literacy will be conducted to determine gaps and standardize policies such as reading level and language availability of all educational materials. The Schenectady Bridges Out of Poverty trainings will be expanded across the PPS.

The length and perceived invasiveness of survey questions can result in reluctance or refusal of the target population to complete the survey. In response, the Ellis PPS will offer financial and other incentives to patients for participating in PAM activities.



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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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

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

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

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
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/14	10/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	09/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplementa	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 years	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospita	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/1
Ellis Hospita	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospita	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospita	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in primary care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce Readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities

- 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.



The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

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

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

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

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



Domain 3 Projects

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

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

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

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

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

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

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

A. *PCMH Service Site:*

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



B. Behavioral Health Service Site:

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

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

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

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

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.

Based on NYS Expanded BRFSS and Medicaid utilization data, the prevalence of BH and the subsequent hospital utilization related to those with behavioral health conditions is extreme. Overall, in 5 of the 6 counties in the service area, the percentage of adults reporting with poor mental health status is substantially higher than the NY State average overall. Of the approximately 170,000 Medicaid beneficiaries in the service area in 2012, 79,790 of these were categorized with mental health disorders using 3M's Clinical Risk Group Classification Matrix. Of these 79,790 beneficiaries, 24,062 (30.1%) had at least one inpatient admission during the year, and a total of 46,451 inpatient admissions overall. Furthermore, of these 79,790, 42,576 (53%) recipients had at least one ED visit and a total of 153,642 ED visits during the year. With respect to substance abuse, 20,452 Medicaid beneficiaries in the service area had a substance abuse condition and of these beneficiaries, 11,023 (53%) had at least one inpatient admission during the year. In total these beneficiaries had 60,300 ED visits during the year overall.

Research conducted nationally by the RWJ Foundation indicates that 69% of those with a MH disorder also have a chronic medical condition. The research also shows that 29% of those with



a medical condition also have a chronic mental health disorder. Applying these percentages to the large number of Medicaid beneficiaries in the PPS' service area means that there are approximately 55,055 beneficiaries that have a co-morbid behavioral health - chronic medical condition. Furthermore, statewide data from NYS DOH shows that of all Medicaid beneficiaries with 1 or more chronic conditions, 59% of them are in mild to moderate severity categories, which would make them strong candidates for integrated primary care medical behavioral health approach.

The PPS Provider survey conducted as part of the CNA found that less than 30% of PCPs that responded indicated a high level of confidence in treating patients with a mental health diagnosis and less than 15% indicated a high level of confidence in treating SUD patients. Slightly less than 50% indicated they used a BH screening tool in their practice and over 75% said if they have a positive screen for a patient with a BH disorder their first step would be to refer the patient out of their practice rather than treating the patient in the practice. This is a clear indication of the current lack of ownership of BH screening and treatment in many primary care settings.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 3.a.i. through interventions including: Identification and targeting of safety-net PCPs to establish either co-located BH services or integrated models in their practice. The Ellis PPS will establish an Article 31 clinic with co-located PC services in the each of the 4 major urban areas of the region identified as hotspots based on ED utilization in combination with a primary BH diagnosis and at least one chronic underlying somatic disease is what led the Ellis PPS to identify Part B of this project as a priority.

- 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.

For integrated behavioral health into primary care, the targeted population is all primary care patients seen in participating primary care sites for behavioral health screening (such as the PHQ-9 and/or SBIRT). For integrated medical care into behavioral health, the targeted population is all behavioral health patients seen in participating practices for medical screening and patients with medical conditions or preventive health care needs treated or referred on to treatment. Part A of the project will target those patients associated with primary care practices that have a history of caring for low-income chronic disease populations. These practices are disproportionately located in the more highly populated areas within the PPS region.

- 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 Ellis PPS has a broad range of assets and resources to draw upon for this project. These



include 2 FQHCS, Whitney M. Young Jr Health Center and Hometown Health Center, Health Homes associated with each of the three major health system partners, as well as the hospital-associated practices of St. Peter's Health Partners, Ellis, and St. Mary's Healthcare Amsterdam (SMHA), which constitute the majority of providers who serve Medicaid patients in the area. Many of the primary care practices operated by the PPS partners are NCQA PCMH Level 3 recognized and as such bring a rich history of comprehensive chronic disease management to this project. The expertise from these practices will not only directly contribute to the further integration of BH screening in the primary care setting but the clinical leadership from those practices will assist in mentoring other practices in the region on engaging in this project.

The Ellis PPS includes the vast majority of licensed mental health programs and all of the SUD agencies in the 6 county region which can serve as a resource to the primary care sites that are integrating behavioral health. These providers could be leveraged to provide behavioral health staff to primary care, offer training and/or technical assistance related to behavioral health, and serve as referral partners in cases where patients may require referral out of primary care for optimal health outcomes. Additionally, these programs are ideal locations to co-locate primary care for the PMI and SUD population as the staff in these programs are familiar to their current patients and they are very knowledgeable of the nuances required to gain confidence in that population if you want them to engage in a primary care relationship.

These resources identified above will collaborate with the PPS Clinical Integration Committee will develop integrated delivery system operating standards, best-practice clinical guidelines, and care pathways through a collaborative, evidence-based process that will include interdisciplinary hospitalists, PCPs, behavioral health providers, social workers, CBOs, members and others.

The University of Albany School of Social Welfare faculty is training behavioral medicine graduate level social workers to work in primary care settings managing chronic diseases. Albany College of Pharmacy is placing residents under faculty members for training in primary care settings to maximize patient engagement and medication adherence. HMAHEC is currently offering care coordinator training in PCMH practices in collaboration with Empire State College. The Ellis PPS will provide practice locations for these programs to increase the number of providers and offer incentives for retaining these providers after training. The Ellis PPS also includes three Health Home entities that cover the six county region and they bring a successful history of collaborative care and patient engagement that will be critical to the success of this project.

- 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 existing threshold billing regulations prohibit billing for PC and BH on the same day, counter to the objectives of PC/BH integration. The Ellis PPS will advocate for regulatory relief and explore alternative payment methodologies to overcome this challenge.

Implementing an Integrated PC/BH model across the entire region will be challenging, largely driven by cultural differences in practice among PCPs and BHPs. To address this, the PPS will deploy provider champions in both primary and behavioral health care and form a PC/BH integration task force to promote integration among provider practices and strengthen training (including cultural sensitivity training), and provide technical assistance to PCPs, BHPs. The PPS-wide provider survey indicated that over 75% of providers would participate in such a co-location or integration approach if assistance with required infrastructure development was available.

Given that team meetings are not billable, the PPS anticipates challenges associated with holding training sessions, and interdisciplinary team meetings. The Ellis PPS will address this challenge the PPS will provide incentives to help offset costs associated with “Lunch and Learn” sessions where PCP and BHPs will gather to identify common patient needs and better understand how to bridge differences in the approach to care delivery within the different disciplines.

Achieving 100% NCQA Level 3 throughout the Ellis PPS will be a challenge. The PPS will leverage prior PCMH experience, designate provider champions, and offer financial and other incentives to achieve 100%.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.



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

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

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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.

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FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/14	10/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	09/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 years	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Doctors across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in primary care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce Readmissions



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not overlap with this grant target.



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.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs

Project Objective: To develop withdrawal management services for substance use disorders (SUD) (ambulatory detoxification) within community-based addiction treatment programs that provide medical supervision and allow simultaneous or rapid transfer of stabilized patients into the associated SUD services, and to provide/link with care management services that will assist the stabilizing patient to address the life disruption related to the prior substance use.

Project Description: The majority of patients seeking inpatient detoxification services do not require the intensive monitoring and medication management available in the inpatient setting. These patients can be monitored in an outpatient program until stability is assured and, then, rapidly integrated into a co-located outpatient SUD program with PCP integrated team. Additionally, patients will be provided with care management services that will assist the stabilizing patient to organize medical, educational, legal, financial, social, family and childcare services in support of abstinence and improved function within the community. Care management can be provided as part of the SUD program or through a Health Home strongly linked to the SUD program if qualified for Health Home services. Such programs can address alcohol, sedative and opioid dependency as well as provide access to ongoing medication management treatment.

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 community-based addiction treatment programs focusing on withdrawal management that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.
2. Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.
3. Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.
4. Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.
5. Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.
6. Develop care management services within the SUD treatment program.
7. Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.



8. Use EHRs or other technical platforms to track all patients engaged in this project.

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

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

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

Overall, in 4 of the 6 counties, 61% of Medicaid and uninsured ED visits are by members presenting with behavioral health issues including substance abuse. A review of 2012 Medicaid data related to chronic illness is even more powerful. Behavioral health (BH) conditions (i.e. critical risk groups [CRGs] labeled as depression, drug abuse, chronic stress/anxiety, chronic alcohol abuse, schizophrenia, bi-polar, and other chronic mental health diagnoses) were a more significant driver of inpatient and ED utilization for Medicaid-insured populations than were chronic medical (CM) critical risk groups. With respect to substance abuse, a review of 2012 data for the Medicaid beneficiaries in the Ellis PPS service area shows that 14,000 of the approximately 170,000 beneficiaries were classified in the drug abuse CRG, and 6,452 were categorized in the chronic alcohol abuse CRG. This comes to a total of 20,452 beneficiaries for substance abuse overall, which translates to approximately 12% of the all Medicaid beneficiaries. Of these beneficiaries 11,023 were admitted to the hospital at least once and all combined accounted for a total of 24,342 inpatient admissions in total. More strikingly, when it came ED utilization, 13,899 of these beneficiaries had at least one ED visit and all together they accounted for 60,300 ED visits overall. A recent survey of detox units in the PPS reflects a 15% increase in the number of members presenting in EDs for opiate and other drug withdrawal issues since 2012. One inpatient detox provider surveyed experienced an almost 5 fold increase in heroin admissions since 2012 and a percentage of these patients could be treated in an available ambulatory detox setting.

Over utilization of hospital and inpatient services is further supported by the high rates of PQI and PPV rates in many areas of the service area. County PQI rates were substantially higher in 3 of the 6 counties, when compared to overall state rates. County PPV rates were higher than the State average in 5 of the service areas 6 counties. Opioid users in the targeted super-utilizer population have ED use rates 17 times higher than the general population and admit/readmit rates 5-7 times higher.

A key theme from the CNA's qualitative interviews, focus groups and community meeting was the overwhelming impact of substance abuse and the shortages of behavioral health providers, particularly DEA X-licensed physicians available to prescribe buprenorphine.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for



project 3.a.iv. through interventions including: Development of community based addiction treatment programs focused on withdrawal management by leveraging existing hospital and community based service providers to build out ambulatory detox services. The PPS Clinical Integration Committee will develop operating standards and best-practice community based ambulatory detox clinical guidelines through a collaborative, evidence-based process that will include, a board certified addiction medicine physician, hospitalists, inpatient addiction and outpatient SUD providers, PCPs, social workers, CBOs, patients and others.

- 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 all low income Medicaid and uninsured residents of the service area identified with severe substance issues who are in need of intensive care management and detox services. Those targeted will be identified by public health, community, and health service partners throughout the PPS network but particularly through PPS hospital emergency rooms, outpatient behavioral health clinics, and other community venues that tend to attract those who are substance abusers, such as homeless shelters. In addition, the target population will be identified by law enforcement and first responders and systems need to be established that will facilitate referrals and appropriate transfers for those picked-up by these agencies. EDs will be a key setting for identifying the target population due to the fact that they often serve patients with substance abuse issues who are in need of detox and other substance abuse services. Consistent with established treatment protocols users of opiate and benzodiazepines will be particularly targeted for this service.

- 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 Ellis PPS includes three major health systems: Ellis, St. Peter's Health Partners, and St. Mary's Healthcare Amsterdam. The PPS has identified inpatient and outpatient SUD partners committed to building community based ambulatory detox services. If a waiver is granted existing inpatient programs will utilize existing infrastructure, staffing, and expertise to rapidly ramp up licensed ambulatory withdrawal services at traditional points of access for members such as the ED.

Robust referral relationships exists between PPS partners, St. Peters, Catholic Charities, Belvedere Outpatient, Conifer Park, St Mary's Amsterdam, St. Mary's Troy, Hospitality House, Hudson Mohawk Recover Center, and Equinox Outpatient. These will be leveraged and expanded through written agreements that will require regularly scheduled and documented meetings, and the creation of a PPS virtual care coordination resource (PCMH, HH, CBOs, etc.) that will ensure the provision of wrap around services and activities across partners and develop member care transition plans.



There are established Health Homes at each of the 3 healthcare systems. The Ellis PPS will utilize this resource by utilizing Health Home care management staff deployed in the ED (see 2.b.iii) to triage patients to ambulatory detox settings.

The Ellis PPS has an existing harm reduction program for those patients who are actively using or in danger of relapse. This Catholic Charities program (Project Safe Point) will expand PPS harm reduction services including syringe access, overdose prevention, HIV/Hepatitis C screening/referral and treatment readiness.

- 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.

Transportation is a significant barrier to project success. Listening sessions confirmed that physicians are not willing to admit patients into outpatient ambulatory detox unless they are confident patients have reliable transportation to deliver them to their initial and follow up appointments. The Ellis PPS will contract with existing transportation services for dedicated 24 hour on-call transportation across all service sites within the PPS network.

There are no licensed operating ambulatory detox programs in the PPS. The project design fills this gap in the treatment continuum by designing a treatment delivery system to address member's needs when and where they access care.

There are insufficient physician resources to meet the needs of PPS patients with SUD diagnoses. The Ellis PPS recruit physicians needed for the newly created ambulatory detox services. Additionally, the Ellis PPS will identify a physician champion charged with increasing the number of PCPs willing to accept stabilized buprenorphine maintenance patients in their practices. DRSIP funds will also be used to incent PCPs to treat these patients by increasing the fee for service rates to provide buprenorphine induction and maintenance.

Regulatory waivers will need to be granted to allow existing Part 816 providers to develop ancillary withdrawal services.

Providing for consistent use of protocols and the development of skilled staff in support of these protocols is a challenge. Accordingly, the Ellis PPS will provide regular training for ambulatory detox staff to reinforce established care protocols.

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

The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative



opportunities: 2ai and 2di (Ellis, AMC and AHI), 2biii, 3ai, 3diii, and 4bi (Ellis and AMC), 2bviii, 3ai, 3aiv, 3gi, 4aiii (Ellis and AHI).

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS is not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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

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

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

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.

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FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 yrs	Re-engage clients, expand HIV services



New York Department of Health
 Delivery System Reform Incentive Payment (DSRIP) Program
 Project Plan Application

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
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FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
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FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
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VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining



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Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in Primary Care
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FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities



- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose. Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above. In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

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

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

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

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

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

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.



Asthma and other related respiratory and pulmonary diseases is a major contributor to overall morbidity and mortality and inappropriate hospital utilization in the service area. In 2012, 15,383 (7.9%) beneficiaries were categorized with asthma, which was the fourth most prominent condition across the service area, behind depression, hypertension and diabetes. Additionally, 6,229 were categorized with COPD (11th most common) and 4,117 with chronic bronchitis (16th most common). All together these three conditions account for 99% of all respiratory diseases and together make up the Diseases and Disorders of the Respiratory System diagnostic category, which is the third most prevalent major diagnostic category, and only conditions related to mental illness and cardiovascular account for more morbidity and mortality in the Medicaid population. Of the 25,729 beneficiaries categorized with these respiratory conditions, 9,470 had at least one inpatient admission during the year, and in total accounted for a total of 17,845 inpatient admissions overall. Furthermore, of the 25,729 beneficiaries with respiratory disease, 14,474 had at least one ED visit, who all together accounted for a total of 48,790 ED visits during the year. Asthma was the largest contributor to these totals, accounting for approximately 60% of all utilization.

Looking specifically at prevalence data for asthma across the Ellis PPS service area is equally startling. According to NYS Expanded BRFSS data, all 6 of the counties in the service area have higher percentages of adults who currently have asthma or have ever been told by their doctors that they have asthma than state averages.

Five of the 6 service area counties have higher percentages of adults who categorize themselves as currently smokers than adults statewide and all of these counties have seen their smoking rates stay roughly the same or increase from 2008-09 to 2013-14.

The counties that have higher proportions of foreign born residents who are linguistically isolated, and other at-risk populations who typically struggle with access and engagement in care are those that have the highest rates of inappropriate hospital utilization. As such it will be critical that this project target those in Albany, Rensselaer and Schenectady.

In response to gaps identified in the CNA, the Ellis PPS will meet DSRIP requirements for project 4.a.iii through interventions including the following: The Ellis PPS will form an asthma taskforce to develop training and home-based asthma self-management education services. The Ellis PPS will collaborate with medical and social service partners to assess patient homes and provide self-management services that are consistent with tools used in the clinical setting, including trigger reduction, self-monitoring, and medication use. The Ellis PPS will assist partners in developing an asthma protocol that incorporates self-management tools such as Asthma Action Plans (AAP), trigger reduction plan, and referrals to appropriate community resources. The Ellis PPS will collaborate with the RHIO to create a system-wide patient registry to enroll and track patients with persistent asthma.



- 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 are those with persistent asthma who have either been admitted to the hospital inpatient setting at least once or seen in the ED setting at least once and have been identified as having difficulties engaging in and successfully completing their medication regimens. Additionally, patients can be identified and involved in the program through other community-based settings such as primary care and behavioral health outpatient clinics. The hospital ED and inpatient settings and primary care safety net settings are the most likely venues for outreach and engagement. In addition, the target population will be identified by community organizations that work with or somehow have contact with those who have persistent asthma and are not engaged in regular primary care or chronic disease management services, including community service, social service, faith-based, correctional institutions and other community organizations.

- 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.

Ellis PPS partners are active members of the Asthma Coalition of the Capital Region (ACCR), which is funded by New York State Department of Health (NYSDOH). ACCR's mission is to coordinate sustainable initiatives that will reduce the burden of asthma in Albany, Fulton, Montgomery, Rensselaer and Schenectady Counties. ACCR is a coalition of medical and public health professionals; universities; foundations; schools; and other member organizations and has developed an excellent system of asthma patient identification and engagement. The PPS will build upon ACCR expertise and experience to create a robust home-care program.

The Ellis PPS Clinical Integration Committee will develop operating standards and best-practice home-based self-management asthma clinical guidelines through a collaborative, evidence-based process that will include hospitalists, PCPs, nurses, MCOs, dietitians, social workers, CBOs, patients and others.

Ellis has successfully implemented a Lean Six Sigma approach to moving asthma patients through the ED. Developed by the Schenectady Asthma Support Collaborative (SASC), this redesign of the ED pathway for asthma patients has streamlined 26 process steps to 7. The result is that patients move more rapidly through the ED and are connected through care management to PCPs and community resources. This streamlined approach will be expanded to all EDs throughout the Ellis PPS.

The Schenectady School-Based Asthma Management Program has trained school nurses and provided unit-dose albuterol to the schools so that students can access their medications in the school health office in the event of a flare-up. The Ellis PPS will leverage this program, expanding it to school districts in CNA identified hotspots throughout the PPS region.



- 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.

Existing evidence based asthma guidelines are hospital focused which presents a challenge to the expansion of home-based self-management programs. In response, the Ellis PPS Clinical Integration Committee will develop operating standards and best-practice home-based self-management asthma clinical guidelines through a collaborative, evidence-based process that will include hospitalists, PCPs, nurses, MCOs, dietitians, social workers, CBOs, patients and others.

While the largest MCO in the Ellis PPS region provides reimbursed for home visits for asthma patients, the remaining MCOs have not adopted the policy. Additionally, the project is challenged by MCO policies that do not cover multiple scripts for the same inhaler so that inhalers can be simultaneously available at home, school, and other family member locations. Building on PPS partnership agreements with the regional MCO's, the Ellis PPS Clinical Integration Committee will advocate for enhanced coverage shown to reduce overall costs through home-based self-management.

There is a lack of understanding of coordinated care for asthma patients which includes social services and supports for asthma home-based self-management. To respond to this challenge the Ellis PPS will form an asthma taskforce to develop and coordinate in-services to educate providers and care managers about community based resources and referrals.

It is a challenge to engage patients. The Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who represent the patient population.



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

The Ellis PPS will hold regularly scheduled meetings with overlapping PPSs to review implementation on common projects and identify specific collaborative opportunities: 2ai and 2di (Ellis, AMC and AHI), 2biii, 3ai, 3diii, and 4bi (Ellis and AMC), 2bviii, 3ai, 3aiv, 3gi, 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

Specific elements of collaboration between Elis and AMC PPS's include the development of a regional asthma registry using a HIXNY interface with participation asthma treatment partners. Additionally, providers in the AMC PPS Evidence Based Guidelines project will be encouraged to develop asthma action plans with members that include ambulatory follow-up and interventions with the Ellis PPS asthma self-management team.

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

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

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

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
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/2014	10/20/16	Behavioral Health Expansion
QHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	9/20/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Qualitative Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	Pending NOA	(3 yrs)	Re-engage clients, expand HIV services



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young	HRSA/Ryan White Part	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part	08/14	07/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Homes services to designated Medicaid patients - will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarship grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	3/20/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/20/15	Outreach and enrollment for health insurance marketplace
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose. Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in



identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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



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

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

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

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

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

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

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

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

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

A review of hospitalization data from State DOH’s Medicaid Beneficiary Chronic Health Conditions, Inpatient and ED Utilization data set strongly corroborates findings from the analysis of Expanded BRFSS data, reinforcing the dramatic impact that chronic medical



conditions have on resource utilization. In the Ellis PPS service area overall the underlying chronic medical conditions that were at the root of most hospital admissions were hypertension, cardiovascular disease, respiratory disease and asthma. In 2012, 96,321 (49%) beneficiaries were categorized in at least one of these 4 critical risk groups (CRG). Of these beneficiaries, 38,575 beneficiaries had at least one inpatient admission during the year, and a total of 73,395 inpatient admissions overall. Furthermore, of these 96,321, 46,101 had at least one ED visit, and a total of 148,972 ED visits during the year.

A review of the region's Prevention Quality Indicator (PQI) data from the NYS DOH, representing avoidable hospital inpatient use, shows that 3 of the 6 counties in the PPS' service area have higher rates of PQI conditions than the New York State average. PQI data are a series of indicators that collectively assess the extent to which people are admitted to the hospital for conditions that in most cases can be controlled with appropriate Primary Care and evidenced-based disease management protocols. Similarly, a review of the Potentially Preventable Visit (PPV) data from the NYS DOH, representing potentially preventable hospital ED visits, shows that 5 of the 6 counties in the PPS' service area have higher rates of PPVs. Much like the PQI data, PPV data gauges the extent to which patients are seen in the ED for services that could have been treated in the PC setting. These data further reinforce the importance and potential impact that proper palliative care in the PC setting could have on improving health status and decreasing inappropriate utilization.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 3.g.i. through interventions including: The Ellis PPS will ensure that 100% of all PCP practices are recognized as NCQA Level 3 by the end of Year DY3. The PPS will educate providers on the benefits of palliative care and deploy palliative care coaches in PC practices to increase provider comfort and willingness to offer palliative care interventions. The Ellis PPS will partner with community based organizations including hospice providers to incorporate CBO services and supports that offer and strengthen the delivery of culturally and linguistically appropriate coordinated care that includes palliative care.

- 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 primary target population will be all individuals with a chronic health condition, not including a mental health condition. While palliative care services have conventionally been associated with end of life care, this project targets individuals upstream in primary care settings in order to improve disease symptom management and reduce the use of emergency department and inpatient services. The population which will benefit most will include those individuals which are more advanced in their disease severity, and whose health status has devolved, or for whom there are co-occurring issues (such as cardiovascular disease in individuals with diabetes).



Health severity assessment (screening) will also be used to assist in targeting all patients with a chronic condition. Patient targeting promotes early intervention with palliative care services and focuses on closing the gap to reduce avoidable hospital care among those individuals with highest need and disease severity.

- 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 Ellis PPS includes three major health systems: Ellis, St. Peter's Health Partners, and St. Mary's Healthcare Amsterdam, within which exist 6 acute care hospitals. These hospitals have a total of 1,698 certified beds. In 2013 they totaled 68,859 inpatient admissions and 261,556 ED visits. Each of the three systems has a Health Home and a home care agency. The PPS hospitals each offer inpatient palliative care consultation services. The expertise gained in PPS hospital settings is a meaningful input into development of clinical guidelines for palliative care that will be implemented across the care continuum. Health Homes will effectively inform the strategy for enlisting PCPs in a more holistic population based approach to care delivery including palliative care. PCPs will be engaged by a signed agreement for integrating Palliative Care into this practice model. Agreements will be established with non-PCMH certified practices insuring they will achieve at least level 1 of 2014 NCQA PCMH model by the end of DY3.

The Ellis PPS has a certified hospice program that provides end-of-life care throughout the region. The PPS will strengthen palliative care competencies through peer to peer consultation, sharing their experiences in the development of protocols and approaches to integrating community resources into the PCMH and integration of palliative care assessment and services into clinical workflow across the care continuum to drive earlier application of palliative interventions. One important intervention will be the MOLST form and demonstrated use. This will be incorporated in our agreement with the PCMHs and non PCMH's. Ellis PPS EMR will track and collect data to meet NCQA standards.

A number of leading partners of the Ellis PPS have current direct experience in the establishment of a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed establishment of a Medicare MSSP ACO through the creation of Innovative Health Alliance of New York, LLC (IHANY). A Clinical Integration Committee will be established as a standing committee of the Ellis PPS governance structure. Through that committee the PPS will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to insure standardization of clinical best practices. The IHANY and PPS Clinical Committees will collaborate in the development of operating standards, best-practice clinical guidelines, and care pathways that support palliative care through a collaborative, evidence-based process that will include interdisciplinary hospitalists, hospice staff, PCPs, social workers, CBOs, members and others.

A project committee will be developed to oversee the full implementation of this project under the PPS governance structure.



- 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 majority of PPS PCPs do not presently provide palliative care interventions. The Ellis PPS will provide palliative care training to PCPs and deploy palliative care coaches to support these providers in offering palliative interventions that are culturally and linguistically appropriate. Additionally, the PPS will utilize DSRIP funding to provide incentives for provider adoption of palliative care interventions.

Of the 108 Ellis PPS primary care practices, 65 (60%) operate in practice sites that are PCMH certified. The Ellis will leverage prior PCMH experience, designate provider champions and offer financial and other incentives to drive the PPS to 100% NCQA Level 3. The PPS anticipates that broad NCQA recognition will expand access, care management, coordination and cultural and linguistic competence among other system capabilities. Establishing protocols for NCQA and agreement with providers will help provide consistent care and positive clinical outcomes.

Given that palliative care is not presently a covered benefit, and the broader role that the PPS will fulfill in population health incentives, engaging MCOs in system transformation is challenging. The PPS will build upon our effective partnership with MCOs in DSRIP project design to forge a shared vision of health care delivery.

It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals for palliative care who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community



based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

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:

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

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

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

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



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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.

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FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	9/20/14	08/16	Medical Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	Pending NOA	(3 yrs)	Re-engage clients, expand HIV services
FQHC Whitney Young Home Town Health	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention



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FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	8/14	7/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarship grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining



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ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce readmissions
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FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn form the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose. Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the



PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.
In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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



Domain 4 Projects

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

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

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

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

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

Partnering with Entities Outside of the PPS for this Project

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



Entity Name
Catholic Charities of Albany, Troy, Schenectady, Amsterdam and Saratoga Housing Authorities of 6 counties in PPS Capital Region Coalition to End Homelessness City Missions of Albany and Schenectady Capital District YMCA/YWCA Centro Civico United Way The Salvation Army Department of Social Services

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.

Based on NYS Expanded BRFSS and Medicaid utilization data, the prevalence of BH and the subsequent hospital utilization related to those with behavioral health conditions is extreme. Overall, in 5 of the 6 counties in the service area, the percentage of adults reporting with poor mental health status is substantially higher than the NY State average overall. Similarly, in 4 of the 6 counties, the percentage of adults who binge drink is higher than the NY State average. Of the approximately 170,000 Medicaid beneficiaries in the service area in 2012, 79,790 of these were categorized with mental health disorders using 3M's Clinical Risk Group Classification Matrix. Of these 79,790 beneficiaries, 24,062 (30.1%) had at least one inpatient admission during the year, and a total of 46,451 inpatient admissions overall. Furthermore, of these 79,790, 42,576 (53%) recipients had at least one ED visit and a total of 153,642 ED visits during the year. With respect to substance abuse, 20,452 Medicaid beneficiaries in the service area had a substance abuse condition and of these beneficiaries, 11,023 (53%) had at least one inpatient admission during the year. In total these beneficiaries had 60,300 ED visits during the year overall. The behavioral health conditions that were the most significant drivers of hospital inpatient and ED utilization for this population were depression, illicit drug abuse, anxiety, schizophrenia, ADHD, Bi-polar, other unspecified chronic mental health diagnoses, and alcohol abuse, in order of magnitude.

While data specific to the Ellis PPS is limited, there are extremely high percentages of those with BH conditions that also have co-morbid chronic medical condition. Research conducted nationally by the RWJ Foundation indicates that 69% of those with a MH disorder also have a chronic medical condition. The research also shows that 29% of those with a medical condition also have a chronic mental health disorder. Applying these percentages to Ellis PPS' service area, means that there are approximately 55,055 beneficiaries that have a co-morbid behavioral health - chronic medical condition.

One of the leading findings from the CNA's key informant interviews, focus groups, and community meetings with consumers, service providers, and other stakeholders was the overwhelming impact of behavioral health issues on the service area overall and especially those who are low income.

Finally, there is a great deal of quantitative and qualitative evidence from the CNA that there are: 1) major shortages of behavioral health providers, and 2) large proportions of the population, particularly the low income population are not engaged in appropriate care, either due to the stigma associated with mental illness or because the beneficiaries have limited to no access to behavioral health services.



In response to gaps identified in the CNA, the Ellis PPS will meet DSRIP requirements for project

4.a.iii through the following interventions: The Ellis PPS will deploy a MEB taskforce to train PCPs and other professionals in MEB health promotion and MEB disorder prevention based on the development of a trauma informed culture using NYS Prevention Agenda strategies. The PPS will implement the Collaborative Prevention Model for individuals at moderate or high-risk of poor health outcomes. This model will fill gaps identified above through an integrated team approach to integrate standardized, evidence based screening tools into care delivery. The PPS will increase access to screening for MEB conditions into physical health settings with primary care settings as a priority. In addition, physical health screenings will be integrated into behavioral health settings. To address any cultural and linguistic gaps that the Ellis PPS population experiences, the Ellis PPS will develop staff training programs to increase cultural and linguistic competence as well as increase health literacy.

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

The target population for this project will fall into three segments. First, the project will target those in community-settings (e.g., community centers, WIC/Head Start Programs, health department programs, YMCAs, PC clinics, local DSS, homeless shelter network, and other community venues where low income populations interface.) These entities will be recruited on a regional basis focusing on the low income hotspots and on areas that have the highest rates of behavioral health morbidity (e.g., Albany, Rensselaer, and Schenectady) and exposure to trauma.

The project will coordinate with 4bi (tobacco cessation) to reach out to low income tobacco users in mental health settings. This segment of the population is known to have extremely high rates of inappropriate hospital utilization due to their co-morbidities and risk factors. Efforts will be tailored to facilities and those identified will be addressed through a multi-pronged effort that includes tobacco free policies, enhanced screening and education, and cessation interventions.

The project will reach out to community leaders including representatives from State agencies, municipalities, services providers, and community organization to form an interdisciplinary implementation team whose responsibilities are to prioritize needs related to data, training, technical assistance, and evidence-based practices that are necessary to promote MEB health and prevent MEB disorders.



- 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 PPS contains an existing Integrated Care Model, initially funded by OMH in 2012, and presently self-sustaining at a pediatric practice in Troy. Behavioral Health screening tools are used in this site to identify children/youth in need of behavioral health services. Ellis will leverage this asset by having providers already involved in this model serve as champions for the overall PPS. Ellis will further replicate this model, which includes community based and other organizations, within additional sites across the PPS. The newly created collaborative care network will provide the environment for screening and prevention education to improve coping and protective factors to improve physical and emotional health and wellbeing.

Provider ability to meet Meaningful Use (MU) standards supports increased collection, stratification, and collection of MEB health promotion and disorder prevention data. To further develop this IT resource the Ellis PPS will utilize DSRIP funding to establish a centralized IT resource team to support and drive the balance of PPS PCPs to NCQA Level 3, and offer incentives for early adoption.

HIXNY has been an active participant on the Ellis PPS IT committee. Plans call for developing a common IT platform which includes an EHR clinic information prompt, so as soon as a targeted diagnoses is issued the PCP and Behavioral Health providers would be prompted to administer the appropriate MH/SA or medical screening. This will be used as a base for the collection of data regarding the impact of mental health and substance abuse throughout the PPS region as well as provide early identification and intervention for those most vulnerable to developing co-morbid behavioral and physical health disorders. Data collected and batched by zip code in the PPS will be used to inform state and local planning for targeted prevention strategies and service development.

25% of the Ellis PPS PCPs routinely screen for MH disorders, and 35% of PPS PCPs routinely screen for SA disorders. The PPS will form a centralized PPS MEB taskforce who will train PCPs and other professionals in MEB health promotion and MEB disorder prevention, including access to screening. Prevention education is lacking throughout the PPS re: the increasing of protective factors and improving a person's ability to cope. Such efforts are presently funded by NYS OASAS and are limited to school settings and some community coalitions focused on decreasing substance use. Existing programs will be leveraged to provide training and advisement in the implementation of MEB health promotion in collaborative care settings and other community based MEB promotion partnerships.

Education and training will be provided to recipients and providers via a trauma informed care approach to integrate prevention and treatment efforts through community based partnerships. Recognized prevention curriculum will be used with recipients to improve protective factors and reduce risk.

The existing and the newly created collaborative care network of the health care delivery system have strengths and challenges in delivering prevention services and care. The impact of policies and programs will be identified to build upon success and challenges in strengthening the health of recipients through longitudinal tracking of claims data for those who have participated in prevention/education services.



- 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.

Provider understanding of the impact that trauma (i.e. exposure to poverty, violence and abuse in childhood) has on subsequent development of physical and BH disorders is insufficient. To overcome this, the Ellis PPS will form a MEB task force utilizing consultants from the Institute on Trauma and Trauma-Informed care at SUNY-Buffalo.

The Ellis PPS lacks uniform screening tools. The MEB taskforce will be charged with implementing a standardized Adverse Childhood Experience (ACE) screening tool in the physical/ behavioral healthcare settings to identify at-risk patients who can benefit from MEB prevention education to improve coping and protective factors.

Implementing a Collaborative Care Model across the entire region will be challenging, largely driven by cultural differences in practice among PCPs and BHPs. To address this, the PPS will deploy provider champions in both primary and behavioral health care to promote the Collaborative Care Model among provider practices and strengthen training and technical assistance to PCPs, MEB health workforce, and community leaders in evidence-based, (including cultural sensitivity training), approaches to MEB disorder prevention and mental health promotion.

The PPS is challenged as a result of team meetings that are not billable, screening and MEB health promotion that are not reimbursable and demanding practice schedules. The PPS will provide technical and financial incentives the MEB taskforce to purchase evidence based screening tools, and to cover staff hours for “Lunch and Learn” sessions where PCP and BHPs will gather to identify common patient needs and better understand how to bridge differences in the approach to care delivery within the different disciplines.

There currently exists no data base across the PPS for data collection specific to demographics, screening results, and prevention education services provided by zip code in the PPS. The PPS will collaborate with HIXNY, utilizing DSRIP funding, to develop this data base. This will provide a mechanism for cost benefit analysis related to claim costs for persons participating in prevention/education and those who do not.

It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic



discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO, and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

- 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.

MEB taskforce formed and deployed by end of DY1.

Collaborative Care Model provider champions named by end of DY1.

The MEB taskforce with the Ellis PPS Clinical Integration Committee will develop operating standards and best-practice MEB health disorders and prevention clinical guidelines through a collaborative, evidence-based process that will include interdisciplinary hospitalists, PCPs, social workers, CBOs, members and others by the end of DY1.

Outreach teams to the homeless will be developed in each of the PPS regions by end of DY 3.

Uniform screening tools utilized in all PCP practices by end of DY3.

The Collaborative Care Model will be deployed in all PC and BH practices by the end of DY 3.

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

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



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

Yes	No
<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
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	09/14	08/16	Behavioral Health Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 yrs	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	Various	Various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce readmissions
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplementa	9/20/14	08/16	Medical Expansion

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn form the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.



3. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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



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

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

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

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

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health. This project 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
Catholic Charities of Albany, Troy, Schenectady, Amsterdam and Saratoga
Housing Authorities of 6 counties in PPS
Capital Region Coalition to End Homelessness
City Missions of Albany and Schenectady
Capital District YMCA/YWCA
Centro Civico
Department of Social Services
Gloversville Free Methodist Food Pantry
Fulmont Northville Outreach Center
Joseph House and Shelter
Mechanicville Area Community Service Agency

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.

Each year, approximately 443,000 Americans die from tobacco-related illnesses. In New York State, there are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. A simple extrapolation of this data to the Ellis PPS service means that approximately 9,000 low-income Medicaid insured or uninsured residents of the service area have serious diseases that can be directly attributable to tobacco use.

In the Ellis PPS region in 2012, 15,383 (7.9%) beneficiaries were categorized with asthma, which was the fourth most prominent condition across the PPS region, behind depression, hypertension and diabetes. Additionally, 6,229 were categorized with COPD (11th most common) and 4,117 with chronic bronchitis (16th most common). All together these three conditions account for 99% of all respiratory diseases. Of the 25,729 beneficiaries categorized with these respiratory conditions, 9,470 had at least one inpatient admission during the year, and in total accounted for a total of 17,845 inpatient admissions overall. Furthermore, of the 25,729 beneficiaries with respiratory disease, 14,474 had at least one ED visit, and all together



accounted for a total of 48,790 ED visits during the year. Asthma was the largest contributor to these totals, accounting for approximately 60% of all utilization.

Looking specifically at New York State and the Ellis PPS service area, 5 of the 6 service area counties have higher percentages of adults who categorize themselves as currently smokers than adults statewide and all of these counties have seen their smoking rates stay roughly the same or increase from 2008-09 to 2013-14.

Cardiovascular disease (heart disease), cancer, cerebrovascular disease (stroke) and respiratory diseases are absolutely among the leading causes of illness and death in the United States, New York State, and the Ellis PPS service area, and tobacco use is one of a small handful of leading health risk factors for all these conditions. The health data cited coupled with the higher than average smoking rates that have not declined over the past 6 years suggest a need for a population based approach to smoking cessation.

In response to gaps identified in the Ellis PPS CNA, the PPS will meet DSRIP requirements for project 4.b.i through interventions including: The Ellis PPS will collaborate with CBOs and MH/SUD treatment providers to advance the adoption of tobacco-free outdoor policies, coordinating evidence based strategies to build public, political and organizational support for tobacco free environments that promote smoking cessation. To move the needle on smoking cessation among the low SES populations and those with poor mental health, the Ellis PPS will implement the 10 clinical guidelines of the US Public Health Service in BH, SUD treatment, and social service settings, focusing on universal screening, provision of cessation materials, pathways to tobacco dependence treatment, counseling and increasing the availability of medication assisted interventions. The Ellis PPS will collaborate with MCO partners on coverage for the required treatment interventions across care environments. The Ellis PPS will embed clinical assessment and motivational interviewing tools in electronic medical records throughout the continuum to prompt providers to complete the 5 A's and the 5 R's. To promote smoking cessation benefits among providers and counseling among all smokers the Ellis PPS will implement an every visit every time saturation model across the care continuum ensuring that each smoker receives assessment and education at each visit throughout the provider and social service community.

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

The target population for this project is the low income, Medicaid insured and uninsured residents of the service area who have a mental health diagnosis, have been seen in the hospital ER or inpatient setting at least once in the past year, and who use tobacco. Those targeted will be identified by public health, community, and health service partners throughout the PPS network but particularly through the hospital emergency rooms and inpatient settings as well as outpatient primary care and behavioral health care settings. In addition, the target population will be identified by community organizations that work with or somehow have contact with Medicaid insured and low income uninsured 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.

St. Peter's Health Partners (SPHP), one of the three health system partners of the Ellis PPS, boasts the Center for Smoking Cessation at Seton Health. The center has long been committed to reducing the burden of tobacco related illness in the Greater Capital Region. Since 2001, the Center has provided training and technical assistance on the Public Health Service Guideline for treating tobacco dependence to health care organizations and behavioral health care providers. The Center has assisted thousands of smokers in quitting via the Butt Stops Here Program, an intensive group cessation counseling program with impressive abstinence rates. The Ellis PPS will leverage this expertise in adoption of Public Health Services guidelines in BH, SUD, and social service settings throughout the PPS region. Additionally, the Center will drive an increase in referrals to the NYS Smokers' Quit Line from all PPS partners. The center will be used to provide subject matter expertise, education and train the trainer approaches across the provider community.

The Tobacco-Free Coalition, a PPS partner, has extensive resources and knowledge to advance tobacco-free outdoors. Since 1993 the Coalition has worked to reduce adolescent and adult use of tobacco through cooperative programs in prevention, cessation, advocacy, and community education. The Coalition has a successful track record with more than 500 organizations and businesses, landlords and property owners and municipalities going tobacco-free. Recent examples include a tobacco ordinance in the City of Albany, a resolution in the City of Watervliet, and tobacco-free grounds at Crossgates Mall and Siena College. The Coalition has partnered with SPHP's Center for Smoking Cessation at Seton Health on a collaborative Tri-County Behavioral Health for Tobacco Free Living Initiative. Ellis PPS will leverage the Coalition and its history of close partnership with Seton Health to expand tobacco-free grounds policies with PPS partners and mental health and substance abuse providers throughout the 6 county region. The PPS will leverage relationships with the Local Government Units to gain support, identify agency champions, and spread the successful work already done.

Advancing Tobacco-Free Communities of Hamilton, Fulton & Montgomery Counties, formed by Ellis PPS partner Catholic Charities, engages local stakeholders, educates community leaders and the public, and mobilizes community members and organizations to strengthen tobacco-related policies that prevent and reduce tobacco use. This resource will be leveraged to establish tobacco-free community norms through tobacco-free outdoor air policies, among other tobacco cessation initiatives.

The Ellis PPS includes the vast majority of licensed mental health programs and all of the SUD agencies in the 6 county region. These established PPS partnerships provide access to low SES populations as well as those with poor mental health. This will be leverage to drive results with those targeted populations. "Train the trainer" approaches will be employed to train and subsequently embed smoking cessation efforts in these care environments as well as social service agencies. This approach focuses on natural pathways for individuals with Behavioral Health, SUD and low SES.



- 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 project is challenged by a culture of social acceptability of tobacco use within mental health settings, including a higher than average smoking rate for behavioral health staff. This is exacerbated by the misconception that tobacco use helps to alleviate anxiety, sadness and agitation, and that smoking cessation is not a realistic objective for the mentally ill. In response, the Ellis PPS will offer training and technical assistance to all BH, SUD treatment, and CBOs, as well as incentives to adopt tobacco free facilities and grounds.

Fully engaging local government units in aggressive tobacco free grounds policies is a challenge. The Ellis PPS has strong LGU representation. A LGU advocacy champion and taskforce will be formed by the Ellis PPS to educate LGUs on best-practice approaches to developing and implementing tobacco free policies.

Given that smoking cessation groups in BH settings is not presently a covered benefit, and the broader role that the PPS will fulfil in population health incentives, engaging MCOs in system transformation is challenging. The PPS will build upon our effective partnership with MCOs in DSRIP project design to forge a shared vision of health care delivery that encompasses expanded coverage for smoking cessation treatment.

Existing clinical guidelines are hospital focused and developed through a narrow physician led process. The Ellis PPS Clinical Integration Committee will develop best-practice clinical guidelines for community based smoking cessation through a collaborative, evidence-based process that will include hospitalists, PCPs, Behavioral Health providers, SUD treatment providers, social workers, CBOs, members and others.

It is a challenge to engage patients in the delivery system. Therefore, the Ellis PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who represent the patient population.

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

The Ellis PPS made overtures to the AMC PPS prior to submitting the DSRIP LOI. These discussions resulted in agreement to retain the same firm to conduct a CNA for the entire region, including of course, overlapping counties. Subsequently, there have been periodic discussions with both of the overlapping PPS's; AHI (Saratoga County) and Albany Med PPS's (Albany and Saratoga counties) on DSRIP projects and initiatives. The Ellis PPS will hold regularly scheduled meetings with overlapping PPS's to review implementation on common projects and identify specific collaborative opportunities: 2ai, 2di, 3ai (Ellis, AMC and AHI), 2biii and 4bi (Ellis and AMC), 2bviii, 3aiv, 3gi and 4aiii (Ellis and AHI).

The Ellis PPS recognizes that collaborative efforts could generally be beneficial in a number of areas including, staff training and education, patient education, working with the local RHIO,



and standardization of protocols. In particular, it is the PPS' intent to ensure that community based providers participating in more than one PPS are not faced with differing protocols, staff or interventions. The PPS also hopes to share best practices and explore ways to improve efficiency and effectiveness.

- 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.

Training developed and incentive program designed for BH, SUD treatment and CBOs to become tobacco free facilities and grounds by the end of DY1.

LGU advocacy champion and smoking cessation taskforce developed by the end of DY1.

Operating standards and best-practice clinical guidelines for community based smoking cessation will be developed by the end of DY1.

Begin conversations with MCOs regarding metrics and payment issues associated with expanded coverage for smoking cessation treatments by the end of DY2.

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

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

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

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.



New York Department of Health
 Delivery System Reform Incentive Payment (DSRIP) Program
 Project Plan Application

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	08/14	03/15	Expand and enhance PCMH activities
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	11/14	12/16	Behavioral Health Expansion
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	09/14	08/16	Medical Expansion
FQHC Whitney Young	HRSA/Fed-330 supplemental	11/14	08/16	Quality Initiative
FQHC Whitney Young	HRSA/Fed-330 supplemental	pending NOA	3 years	Re-engage clients, expand HIV services
FQHC Whitney Young	HRSA/Ryan White Part C	05/14	04/15	Early intervention for HIV+ individuals
FQHC Whitney Young	Centers for Disease Control and Prevention (CDC)	07/14	05/15	High impact HIV prevention
FQHC Whitney Young	SAMHSA	10/14	09/15	Integration of HIV primary care with behavioral health and addiction services
FQHC Whitney Young	USDA/WIC	10/14	09/15	Nutrition program for women, infants and children
FQHC Whitney Young	HRSA/Ryan White Part D	08/14	07/15	Family centered case management for HIV+ clients



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
VNS of Schenectady	Health Home	ongoing	ongoing	Provide NYS Health Home services to designated Medicaid patients – will not conflict with DSRIP as patients are known and designated by NYS or MCO
Ellis Hospital	Hospital – Medical Home Project	2012	2014	Funded attainment of NCQA PCMH Level 3 (2011 standards) at Family Health Center – will not conflict with DSRIP as project ends 12/31/14
Ellis Hospital	Doctors Across New York	various	various	Fund medical school loan forgiveness for doctors practicing in medically underserved areas; fund expansion of Family Medicine Residency (Rural Track) – will not conflict with DSRIP as support is based on geographic physician need, not on displacement/retraining
Ellis Hospital	H1-B RN to BSN scholarships grant	2012	2015	Fund tuition for nurses taking courses to achieve BSN – will not conflict with DSRIP as nurses are selected based on current skills need, not on displacement/retraining
Ellis Hospital	Empire State Development – Dental Clinic	2004	2014	Fund expansion of pediatric dental clinic to expand services to children on Medicaid – will not conflict with DSRIP as project ends 2014
St. Peter's Health Partners Medical Associates	CMS – office of Innovation			Case management in Primary Care
ST Mary's Amsterdam Ascension Health & CMS	Readmission LEAPT Pilot			Reduce readmission



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
FQHC Whitney Young Home Town Health	HRSA/Fed-330 base	04/14	03/15	Health center funding to support uninsured populations
FQHC Whitney Young Home Town Health	HRSA/Fed-330 supplemental	07/14	03/15	Outreach and enrollment for health insurance marketplace

- 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.

The St. Mary's project will complement the PPS' DSRIP efforts and was considered by St. Mary's staff at the time of Project development. The focus is not as direct. Together they will be stronger. This is not available at other hospitals but the PPS can learn from the collaboration. Some of Whitney Young's grants provide base line money for support of uninsured and is not duplicative. The two funds enhance each other fund's purpose.

Whitney Young's federal program to support enrollment was taken into account when planning the DSRIP project. The enrollment process is an important but small part of the PPS' DSRIP projects. The PPS' DSRIP projects will not duplicate this effort, rather it will aid in identifying people who wish to enroll, and encourage engagement in healthy living before, during and after the enrollment. Enrollment will only be part of the DSRIP project not included in the federal grants referenced above.

In reference to the St. Peter's grant, staffing case managers in the PPS' DSRIP programs does not relate to this and it will not over lap with this grant target.



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.