Domain 2*: System Transformation Projects*

Project ID*: 2.a.i*

Project Title*: Creating an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management*

Objective:

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

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.

Actively Engaged Patients for DSRIP Reporting Purposes:

N/A (DSRIP Project Implementation and Patient Engagement Speed and Scale requirements do not apply to Project 2.a.i.)

Providers Expected to Participate:

All members of BPHC are required to participate in the integrated provider network, as a prerequisite to involvement in other DSRIP projects. This includes primary care physicians, non PCP practitioners, hospitals, clinics, health homes / care management organizations, behavioral health / substance abuse treatment providers, skilled nursing facilities / nursing homes, pharmacies, hospice, community based organizations, and others.

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
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use

standards by the end of DY 3.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
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.

Domain 2: *System Transformation Projects*

Project ID*: 2.a.iii*

Project Title*: Health Home At-Risk Intervention Program: Proactive management of higher risk patients, not currently eligible for Health Homes, through access to high quality primary care and support services*

Objective:

Expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients.

Description:

There is a population of Medicaid members who do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but who are on a trajectory that will result in them becoming Health Home super-utilizers. This project represents the level of service delivery and integration for the complex super-utilizer population who fall in between the patient-centered medical home and the Health Home general population. Some risk stratification systems refer to these patients as "the movers." Early intervention through this project shall result in stabilization and reduction in health risk and avoidable service utilization.

Target Patient Population:

Complex patients with a high degree of healthcare utilization, not qualifying for Health Home status under NYS eligibility rules, but with care management needs exceeding those typically offered by the patient-centered medical home. This includes patients with a single chronic condition who are at risk for developing another due to medical and/or social factors.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients who completed a new or updated comprehensive care management plan.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, pharmacies, community based organizations, and others.

Project Milestones
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.
Ensure all participating primary care providers in project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year 3.
Ensure that all participating providers are actively sharing EHR systems with local health information exchange/ RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.
Ensure EHRs used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).
Implement evidence-based practice guidelines to address risk factor reduction and ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

Domain 2: *System Transformation Projects*
Project ID*: 2.b.iii*
Project Title*: ED Care Triage for at-risk Populations*

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.

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.

Target Patient Population:

Patients with frequent ED utilization and those presenting in the ED with minor illnesses who do not have a primary care provider.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients presented at the ED and after medical screening examination were successfully redirected to PCP as demonstrated by a scheduled appointment.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, , community based organizations, and others.

Project Milestones
Establish ED care triage program for at-risk populations
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 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
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate 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).
Established 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.)
Use EHRs and other technical platforms to track all patients engaged in the project.

Domain 2: *System Transformation Projects*

Project ID*: 2.b.iv*

Project Title*: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions*

Objective:

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.

Description:

A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager 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.

Target Patient Population:

Patients discharged from in-patient hospitalization who are considered to be at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders, in addition to individuals who are Health Home eligible or dual eligible, as these populations experience high social needs and co-morbidities that present additional readmission risk factors.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients with a care transition plan developed prior to discharge.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, community based organizations, and others.

Project Milestones
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
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.
Ensure required social services participate in the project.
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.
Ensure that a 30-day transition of care period is established.
Use EHRs and other technical platforms to track all patients engaged in the project.

Domain 3*: Clinical Improvement Projects*

Project ID*: 3.a.i*

Project Title*: Integration of Primary Care and Behavioral Health Services*

Objective:

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

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.

Target Patient Population:

Patients aged 12 years old and over who visit a project-participating primary care provider or behavioral health professional in our PPS network, with particular attention to patients living in neighborhoods with the highest rates of residents reporting psychological distress.

Actively Engaged Patients for DSRIP Reporting Purposes:

The total of number of patients engaged per each of the three models in this project, including:

a) PCMH Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SU.
b) Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site.
c) IMPACT: Number of patients screened (PHQ-2 / SBIRT)

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, behavioral health providers, substance abuse treatment providers, community based organizations, and others.

Project Milestones
Model 1: Behavioral Health Services Co-located at Primary Care Practices Sites
Co-locate behavioral health services at primary care practice sites. Primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY3.
Develop collaborative evidence-based standards of care including medication management and care engagement process.
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.
Use EHRs or other technical platforms to track all patients engaged in this project.
Model 2: Primary Care Services Co-located at Behavioral Health Sites
Co-locate primary care services at behavioral health sites.
Develop collaborative evidence-based standards of care including medication management and care engagement process.
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.
Use EHRs or other technical platforms to track all patients engaged in this project.
Model 3: IMPACT Model
Implement IMPACT Model at Primary Care Sites.

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

Domain 3: *Clinical Improvement Projects*

Project ID: *3.b.i*

Project Title: *Evidence-based strategies for disease management in high risk/affected populations (adult only) – Cardiovascular Disease*

Objective:

To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions

Description:

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

Target Patient Population:

Adults with a CVD-related diagnosis, including hypertension (HTN), congestive heart failure (CHF), angina, and high cholesterol.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.)

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, pharmacies, community based organizations, and others.

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

Improve Medication Adherence: Prescribe once-daily regimens or fixed-dose combination pills when appropriate.
Optimize Patient Reminders and Supports: Document patient driven self-management goals in the medical record and review with patients at each visit.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.
Develop and implement protocols for home blood pressure monitoring with follow up support.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
Facilitate referrals to NYS Smoker's Quitline.
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.
Adopt strategies from the Million Hearts Campaign.
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
Engage a majority (at least 80%) of primary care practices in this project.

Domain 3*: Clinical Improvement Projects*

Project ID*: 3.c.i*

Project Title*: Evidence-based strategies for disease management in high risk/affected populations (adult only) - Diabetes*

Objective:

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

Description:

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

Target Patient Population:

Adults with a diabetes diagnosis, with particular attention to residents of neighborhoods with the highest rates of diabetes.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, pharmacies, community based organizations, and others.

Project Milestones
Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
Engage at least 80% of primary care practices within the PPS in the implementation of disease management evidence-based best practices.
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy,
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
Ensure coordination with the Medicaid Managed Care organizations serving the target population.
Use EHRs or other technical platforms to track all patients engaged in this project.
Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.

Domain 3*: Clinical Improvement Projects*

Project ID*: 3.d.ii*

Project Title*: Expansion of asthma home-based self-management program*

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.

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.

Target Patient Population:

Adult and pediatric patients with an asthma diagnosis. The patient population will include adults and children with newly diagnosed or preexisting asthma, with a special emphasis on children and patients who have had either three or more PCP visits or an ED visit or hospital discharge with asthma as the primary diagnosis in the past year.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients who completed a new or updated comprehensive care management plan.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, pharmacies, community based organizations, and others.

Project Milestones
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
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.
Develop and implement evidence-based asthma management guidelines.
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.
Ensure coordinated care for asthma patients includes social services and support.
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.
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
Use EHRs or other technical platforms to track all patients engaged in this project.

Domain 4*: Population-Wide Strategy Implementation*

Project ID*: 4.a.iii*

Project Title*: Strengthen Mental Health and Substance Abuse Infrastructure across Systems*

Objective:

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

Description:

Support collaboration among leaders, professionals, and community members working in mental, emotional and behavioral (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.

Performing Providers Systems, schools, PCPs, CBOs, NYCDOHMH and NYC Department of Education (DOE) will work as partners to strengthen the infrastructure that screens, assesses, refers, treats, and manages the care of young people ages 12-25 with mild to moderate mental health and substance abuse (MHSA) needs, as well as those at risk of developing such needs. The Project aims to prevent and reduce mental health conditions, risky substance use and inappropriate use of emergency departments (EDs) by expanding the skills of school-based staff.

Target Patient Population:

This project will target youth ages 12-25 with mental, emotional, and behavioral (MEB) health diagnoses or substance use disorders, as well as those at high risk for developing mental health or substance abuse disorders and who have other health and social factors linked to risky substance use and MEB needs.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, pharmacies, community based organizations, and others.

Metrics/Indicators include:
Increased referrals for school-based screenings/assessments
Increased identification of mild- and moderate-severity mental health and substance abuse needs within schools
Increase in quality of referrals to partners community mental health and substance abuse providers
Improved linkages and follow-up for referred cases
Decline in referrals to emergency departments
Decline in school suspensions
Decline in drop-out rates
Decline in 911 calls

Domain 4*: Population-Wide Strategy Implementation*

Project ID*: 4.c.ii*

Project Title*: Increase early access to, and retention in, HIV care*

Objective:

This project will increase early access to, and retention in, HIV care.

Description:

This project is targeted at increasing the percentage of HIV-infected persons with a known diagnosis who are in care by 9% to 72% by December 31, 2017. It is also targeted at increasing the percentage of HIV-infected persons with known diagnoses who are virally suppressed to 45% by December 31, 2017. The project will implement a viral load suppression (VLS) initiative that employs a tiered set of evidence-based HIV treatment adherence supports including aggressive intake case management triage, integrated case conferencing and linkage to wrap-around behavioral and social supports as needed to achieve and sustain suppression of HIV viral load to an undetectable level.

The proposed VLS initiative is an individualized, stepped approach to ARV adherence support that moves from the least intensive tools (adherence planning, case management support, harm reduction recovery readiness for viral suppression) to the most intensive (home or community-based directly observed therapy [DOT]). This approach is based on the assumption that many patients will only require modest support to achieve the desired outcome while a smaller proportion of patients will require a higher level of support to achieve or maintain viral suppression, and that a stepped system will ensure the most efficient and cost-effective use of available resources. Participating providers in the PPS will pair eligible clients with a case manager or care coordinator who will work with the primary care provider and the client to create and implement an individualized adherence plan and coordinate behavioral health services and other adherence supports, or "tools" as needed. The ratio of patients to case manager will vary depending on the intensity of the support required as initially assessed by the Intake Coordinator.

Target Patient Population:

HIV-infected individuals, particularly those with new diagnoses; those who have been diagnosed but have fallen out of treatment; and those at high risk of becoming infected.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, pharmacies, community based organizations, and others.

Project Milestones
Implement evidence based best practices for disease management, specific to HIV and viral load suppression, in community and ambulatory care settings
Participate in a NYC cross-PPS Collaborative
Engage with Health Homes and Care Management agencies to develop adherence protocol and staffing plans for Population Health Management to improve retention in care and medication adherence to support viral load suppression.
Develop and implement peer-based educational support and self-management programs