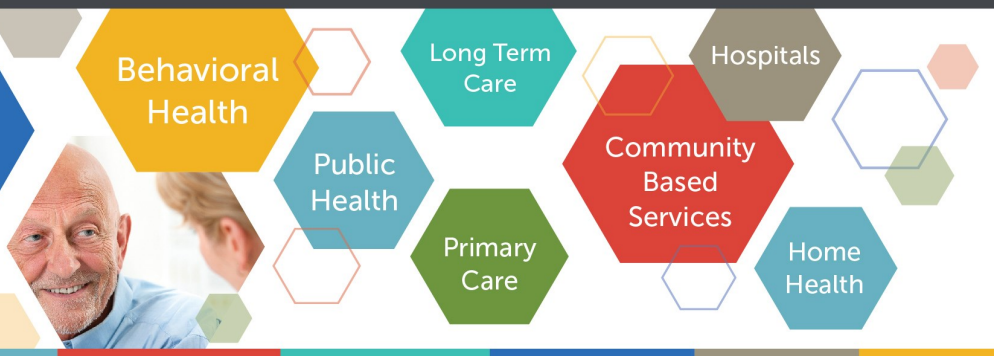
AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE



DSRIP Project Fact Sheets

October 2015

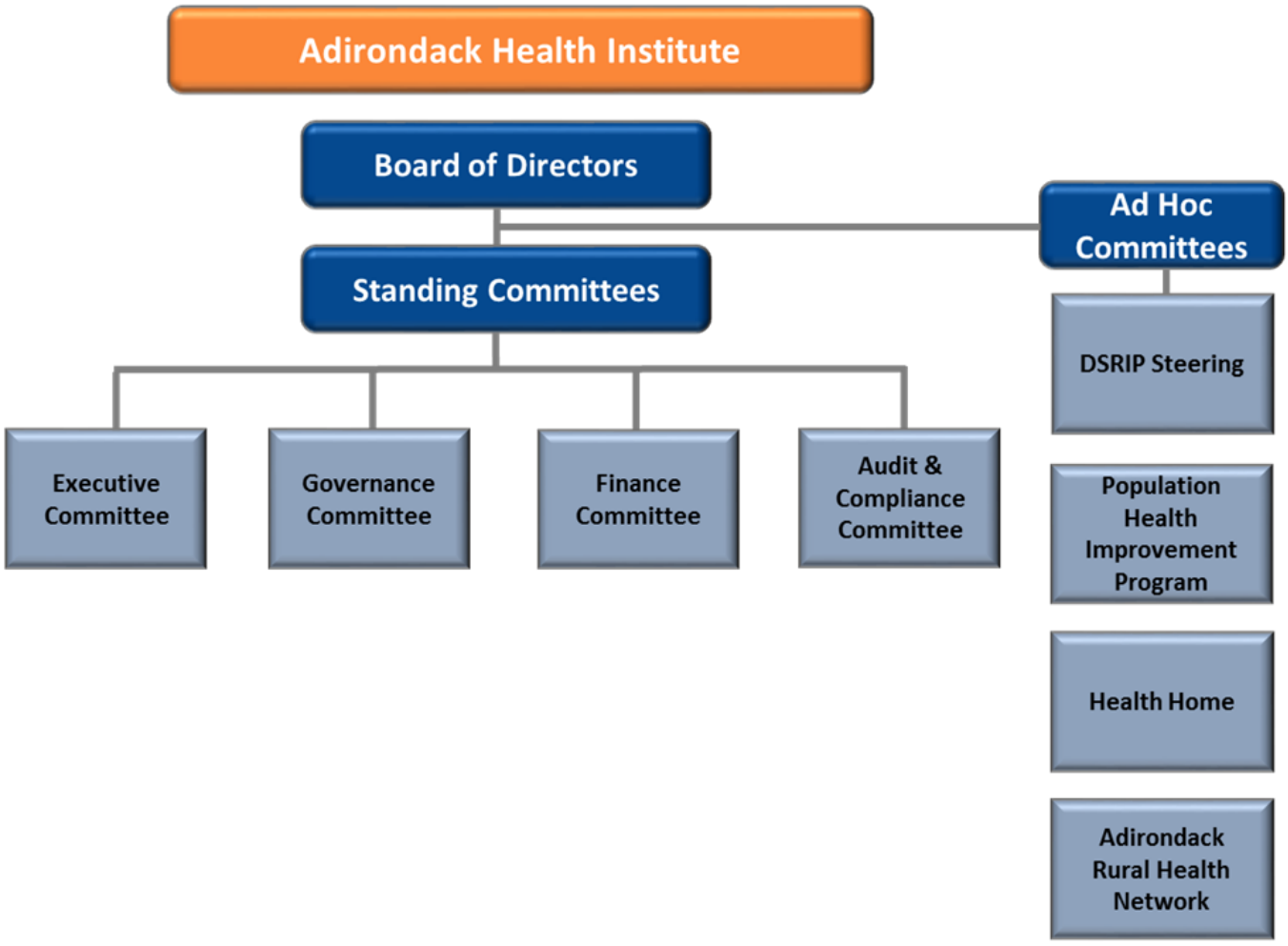
a·H·I
Adirondack Health Institute

For more information, visit www.ahihealth.org/ahipps

Adirondack Health Institute

Collaboration Catalyst Community

AHI Governance

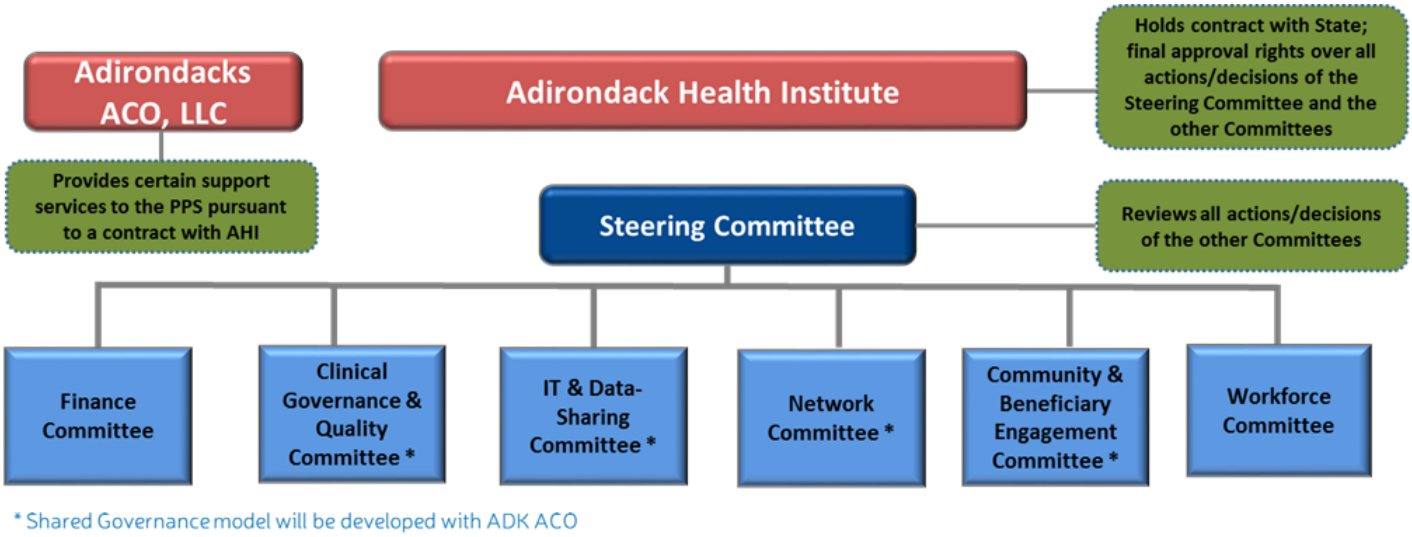


AHI PPS

TRANSFORMING
the APPROACH
to HEALTH CARE

Behavioral Health
Long Term Care
Hospitals
Public Health
Community Based Services
Primary Care
Home Health

PPS Governance Structure



* Shared Governance model will be developed with ADK ACO

Collaborative Contracting Model

AHI will enter into a DSRIP Participation Agreement with each participant in the AHI PPS that will govern the operation of the PPS

Among other things, the DSRIP Participation Agreement will:

- Set forth the responsibilities of AHI and the participants with respect to the establishment and operation of the PPS
- Establish the governance model set forth above

a·H·I

Adirondack Health Institute

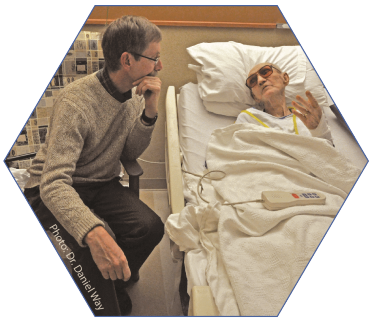
For more information, visit www.ahihealth.org/ahipps

Delivery System Reform Incentive Payment (DSRIP) Program Overview

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five (5) years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

The AHI PPS is the DSRIP Lead in the nine-county region of Clinton, Essex, Franklin, Hamilton, Warren, and Washington, and portions of Fulton, Saratoga, and St. Lawrence counties. The organization is joined by fourteen hospitals and approximately 1,400 providers, from 100 unique organizations, that work together to:

- **Improve population health**
- **Reform the health care delivery system**
- **Improve the quality of care**
- **Improve the experience of care for patients**
- **Reduce the cost of care**



The AHI PPS is a collaborative partnership between hospitals, treatment centers, physicians, community-based organizations, and others who work together to advance innovative projects and meet the DSRIP goals. Payments will be based on performance and linked to achievement of project milestones. AHI PPS projects address system transformation, clinical improvement, and population health.

a·H·I
Adirondack Health Institute

For more information, visit www.ahihealth.org/ahipps

Community Health Needs Assessment Projects

The purpose of the Delivery System Reform Incentive Payment (DSRIP) Program Community Health Needs Assessment of the Adirondack Region is to provide a solid understanding of the health status of the population and the components of the health care system and available community resources to ensure that selected DSRIP projects address the greatest needs of the community.

The service area includes the nine-county region of Clinton, Essex, Franklin, Hamilton, Warren, and Washington, and portions of Fulton, Saratoga, and St. Lawrence counties.

Project Selection	Project Title
2.a.i	Create Integrated Delivery Systems Focused on Evidence-Based Medicine and Population Health Management.
2.a.ii	Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP).
2.a.iv	Create a Medical Village Using Existing Hospital Infrastructure.
2.b.viii	Hospital-Home Care Collaboration Solutions.
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.
3.a.i	Integration of Primary Care and Behavioral Health Services.
3.a.ii	Behavioral Health Community Crisis Stabilization Services.
3.a.iv	Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services with Community-Based Addiction Treatment Programs.
3.g.i	Integration of Palliative Care into the PCMH Model.
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure Across Systems.
4.b.ii	Increase Access to High-Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings.

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

Project Objective

Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to align provider incentives. This project will facilitate the creation of this structure by incorporating the 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 centered on community-based care. 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. These organized IDSs will commit to devising and implementing comprehensive population health management strategies and be prepared for active engagement in New York State's payment reform efforts.

Project Details

To achieve an integrated delivery system, the PPS must collaborate as a network providing a coordinated continuum of services to ultimately achieve the goals of improving efficiency, quality and access to care. Project 2.a.i aims to increase the opportunity to align provider incentives through the use of population health management strategies and active collaboration. The goal of the project is to transition the health care delivery focus to value-based and evidence-based care by incorporating medical, behavioral health, post-acute and long-term needs.

Patient Population

Total population.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	All PPS providers must participate in the IDS (medical, behavioral health, post-acute, long-term care, and community-based providers).
2	Utilize Health Homes (HH) and Accountable Care Organizations (ACO) systems to implement strategy towards IDS success.
3	Ensure patients receive appropriate care, including medical and behavioral health, post-acute care, long-term care and public health services.
4	All PPS safety-net providers actively share EHR systems with local health information exchange/RHIO/ SHIN-NY and share health information including directed exchange, alerts and patient record lookup, by end of Demonstration Year 3 (DY 3).
5	EHR systems must meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of DY 3.
6	Perform population health management through utilization of EHRs and other IT platforms.
7	Participating PCPs must achieve the following: (1) 2014 Level 3 PCMH /Advanced Primary Care Models (APCM) certification, (2) expand access to PCPs, and (3) meet EHR meaningful use standards by end of DY 3.
8	Contract with Medicaid Managed Care Organizations and payers to establish value-based payment arrangements.
9	Conduct monthly meetings to discuss utilization trends, performance issues, and payment reform.
10	Reinforce the transition towards value-based payments by aligning provider compensation to patient outcomes.
11	Engage patients in the IDS through outreach and navigation activities utilizing community-based organizations.

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

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Project Objective

To transform all safety net providers in primary care practices into NCQA 2014 Level Three Patient Centered Medical Homes (PCMHs) or Advanced Primary Care (APC) Models.

Project Details

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

Patient Population

Total population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH recognition and/or meet state-determined criteria for Advanced Primary Care models by the end of DSRIP Year 3 (DY3).
2	Identify a physician champion with knowledge of PCMH/APC implementation for each primary care practice included in the project.
3	Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.
4	Ensure 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 record look up by the end of DSRIP Year (DY3).
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 or APC standards by the end of DSRIP Year (DY3).
6	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7	Ensure that all staff are trained on PCMH or APC, including evidence-based preventive and chronic disease management.
8	Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or -9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referrals to appropriate care in a timely manner.
9	Implement open access scheduling in all primary care practices.

2.a.iv: Create a Medical Village Using Existing Hospital Infrastructure

Project Objective

Reduce excess bed capacity and repurpose outdated or unneeded inpatient hospital infrastructure into "medical villages" by creating integrated outpatient service centers to provide emergency/urgent care, as well as access to the range of outpatient medicine needed within the community. The medical village transformation will allow for new space to be utilized as the center of a neighborhood's coordinated health network, supporting service integration and providing a platform for primary care/behavioral health integration. The proposed medical villages should be part of an "integrated delivery system" and be seen by the community as a "one-stop-shop" for health and health care.

Project Details

The PPS will create four Medical Villages to take advantage of existing infrastructure to realign health system capacity and support the behavioral health, substance abuse and outpatient services needed in the communities.

UVM Health Network—CVPH in Plattsburgh:

- Behavioral health child and adult patients in crisis

Adirondack Medical Center in Saranac Lake:

- Patients in need of medical detoxification, chemotherapy and transfusion

Moses Ludington Hospital in Ticonderoga:

- FQHC relocation with chronic conditions focus, including heart disease and respiratory conditions

Glens Falls Hospital in Glens Falls:

- Crisis stabilization unit and observation unit with a behavioral health child and adult focus

Patient Population

Total population.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

2.a.iv: Create a Medical Village Using Existing Hospital Infrastructure

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Convert outdated or unneeded hospital space into an outpatient services center, stand-alone emergency department/urgent care center, or other health care-related purpose.
2	Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.
3	All participating PCPs must meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year 3 (DY 3).
4	All safety net providers participating in Medical Villages 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.
5	Use EHRs and other technical platforms to track all patients engaged in the project.
6	Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2 and PCMH Level 3 standards.
7	Services that migrate to a different setting or location (clinic, hospitals, etc.) must be supported by the comprehensive community needs assessment.

2.b.viii: Hospital-Home Care Collaboration Solutions

Project Objective

Implementation of INTERACT-like program (Interventions to Reduce Acute Care Transfers) in the home care setting to reduce the risk of re-hospitalizations for high risk patients.

Project Details

Many patients who previously were transferred to skilled nursing facilities are now being discharged to lesser restrictive alternatives, primarily their own home. With the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance with 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 this problem. It may be paired with transition care management, but the service would be expected to last more than 30 days.

Patient Population

Chronically ill and/or high risk individuals.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

2.b.viii: Hospital-Home Care Collaboration Solutions

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
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 readmissions, as well as to support evidence-based medicine and chronic care management.
3	Develop care pathways and other clinical tools for monitoring critically 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 this project.

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

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Project Objective

This project focuses on increasing patient activation related to health care paired with increased resources that help the uninsured (UI), as well as non-utilizing (NU) and low-utilizing (LU) Medicaid beneficiaries, gain access to and utilize the benefits associated with DSRIP PPS projects, particularly primary and preventative services.

Project Details

This project is comprised of 17 prescribed milestones created by NYSDOH to guide PPS project development, implementation, monitoring, and evaluation efforts. Increasing patient activation, improving access to healthcare resources, and building partnerships between providers and community-based organizations, are core project components. Patient activation refers to an individual's knowledge, skills, ability, and willingness to manage his or her own health and health care. Insignia Health's Patient Activation Measure (PAM®) survey will be used to assess project beneficiaries' levels of activation, by assigning an activation score and level derived from survey results. Knowing a person's PAM® activation level allows providers to tailor their interactions and interventions to meet the patient's individual needs, increasing the probability of positive health and wellness outcomes. PAM® scores are also predictive of relevant health care outcomes, such as costs, hospital readmissions, and utilization of primary and preventative care services. Each PPS will be required to formally train on PAM®, along with baselining, and regularly updating assessments of communities and individual patients. For purposes of project 2.d.i, "Actively Engaged" is defined as "The number of individuals who have completed PAM® or other patient engagement techniques," however, PAM® is the only patient activation/engagement method being recognized at this time. We are committed to actively engaging more than 200,000 eligible individuals by DY4, Q4. Provider engagement is essential to reaching patient engagement goals, and will include training provider organization staff members on PAM® administration, Coaching for Activation® (Insignia Health's wellness coaching platform to be used in conjunction with PAM® survey results), and other patient activation and engagement methods. The AHI PPS has committed to engaging 75 providers by DY3, Q2.

Patient Population

The uninsured, and non- and low-utilizing Medicaid beneficiaries.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
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 on PAM® and expertise in patient activation and engagement.
3	Identify UI, NU, and LU "hot spot" areas (i.e. emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4	Survey the targeted population about health care 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.
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 preventative care.
9	Measure PAM® components including screening patient status (UI, NU and LU) and collecting contact information when he/she visits the PPS-designated facility or "hot spot" area for health service, and providing member engagement lists to relevant insurance companies (for NU and 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 health care coverage, community health care resources (including primary and preventative 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 handoffs 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 preventative health care services and resources.
15	Inform and educate navigators about insurance options and health care resources available to UI, NU, and LU populations.
16	Ensure appropriate and timely access for navigators when attempting to establish primary and preventative 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.

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

Project Objective

Integration of behavioral health and primary care services to ensure coordination of care. Integration of behavioral health and primary care services can serve 1) to identify behavioral health needs early, 2) to ensure treatments for medical and behavioral health conditions are compatible and are not counterproductive, and 3) to de-stigmatize treatment for behavioral health needs. Care for all conditions is delivered under one roof by known health care providers.

Project Details

The main objectives for this project are to:

- Co-locate each service type
- Obtain NCQA 2014 Level 3 certification
- Have evidence-based standards for medication management
- Have evidence-based standards for care management
- Provide screenings (such as PHQ-2/PHQ-9) or perform SBIRT
- Execute “warm transfers” to a behavioral health provider when a patient screens positive
- Use an integrated EHR

Patient Population

Individuals in need of behavioral health services.

Continued on back...

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health’s Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

Model 1

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by 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-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.
4	Use EHRs or other technical platforms to track all patients engaged in this project.

Model 2

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
5	Co-locate primary care services at behavioral health sites.
6	Develop collaborative evidence-based standards of care including medication management and care engagement process.
7	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.
8	Use EHRs or other technical platforms to track all patients engaged in this project.

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

Project Objective

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

Project Details

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

Patient Population

Any individual in need of crisis services.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Implement a crisis intervention program that, at minimum, includes outreach, mobile crisis, and intensive crisis services.
2	Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3	Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4	Develop written treatment protocols with consensus from participating providers and facilities.
5	Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6	Expand access to observation unit within hospital outpatient or at an off-campus crisis residence for stabilization monitoring services (up to 48 hours).
7	Deploy a mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8	Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts, and patient record look up, by the end of Demonstration Year (DY3).
9	Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10	Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11	Use EHRs or other technical platforms to track all patients engaged in this project.

3.a.iv: Development of Withdrawal Management 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 prior to the substance abuse.

Project Details

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 the 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.

Patient Population

Any individual in need of withdrawal management services.

Continued on back...

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

3.a.iv: Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services Within Community-Based Addiction Treatment Programs

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Develop community-based addiction treatment programs 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 co-located 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 area under this project.
8	Use EHRs or other technical platforms to track all patients engaged in this project.

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

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Project Objective

To increase access to palliative care services.

Project Details

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." 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.

Patient Population

Individuals with serious illness or at the end of life.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

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

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM 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 and protocols developed by the PPS.
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.

4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

Project Objective

To collaborate with traditional and non-traditional providers to promote mental, emotional, behavioral (MEB) wellbeing.

Project Details

- Participate in MEB health promotion and disorder prevention partnerships.
    - ◊ This is be executed by forming a PPS-wide coalition and having sub-region partners in more focused work teams.
- Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
    - ◊ AHI PPS is looking to offer poverty training, trauma informed care training, SEDL (social emotional developmental learning) training, and cross training for medical and behavioral health providers.
- Share data and information on MEB health promotion and MEB disorder prevention and treatment.

Patient Population

Total population.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Participate in MEB health promotion and MEB disorder prevention partnerships.
2	Obtain evidence-based MEB promotion and prevention resources.
3	Have an MEB integration plan.
4	Provide MEB health promotion and disorder prevention trainings.
5	Share data and information on MEB health promotion and MEB disorder prevention and treatment.

4.b.ii: Increase Access to High-Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (COPD)

Project Objective

This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for COPD.

Project Details

The delivery of high-quality chronic disease preventative care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. Many New Yorkers do not receive the recommended preventative care and management that include screening tests, counseling, or medications used to prevent disease, detect health problems early and prevent disease progression and complications.

Patient Population

Any individual with or at risk for COPD.

Delivery System Reform Incentive Payment (DSRIP) Program

The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment Program is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital admissions and ED visits by 25 percent over five years. In partnership with hospitals, public health agencies, physicians, and community-based organizations, the AHI PPS is advancing state-wide projects to transform the health care system, coordinate care, and improve the health and wellness for our population.

Continued on back...

AHI PPS

TRANSFORMING the APPROACH to HEALTH CARE

4.b.ii: Increase Access to High-Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (COPD)

MILESTONE	PROJECT REQUIREMENTS MILESTONES AND METRICS
1	Print media campaign is finalized to build public awareness about COPD prevention and programs.
2	Care teams are fully staffed/trained and have the necessary patient education tools/materials in place.
3	Home monitoring equipment is acquired and fully deployed.
4	Adoption of primary care evidence-based diagnosis and treatment guidelines for COPD.
5	Embedded clinical decision supports for evidence-based care are in place in EHRs/or population health management tools as applicable, all practices.
6	Adoption by skilled nursing facilities of evidence-based diagnosis and treatment guidelines for COPD.
7	Supportive resources are established or enhanced.
8	All primary sites are equipped with adequate spirometry testing.
9	Opportunity to bring additional COPD services to more patients of the Adirondack region.
10	Current pulmonary fitness programs expanded or developed in PPS.