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

Project Response & Evaluation:

1. Project Description and Justification

1a. 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.

Our PPS region spans 4,800 square miles and includes urban centers, suburban bedroom communities and remote rural communities, and is home to 2.3 million residents and nearly 544,000 Medicaid beneficiaries. In many ways, it is a microcosm of the State's Medicaid population. As our CNA demonstrates, the region is home to an all-ages Medicaid population that has experienced marked growth over the past 10 years, especially among minority populations.

There are significant health care workforce shortages in our region, including primary care providers (PCPs) (in some areas the rate of active PCPs per 100,000 population is 90.8 compared to 120 in New York State (NYS)), psychiatrists (in some areas as low as 15.7 compared to 36 in NYS) and other professionals who care for vulnerable populations and the homeless. As a result, many Medicaid and uninsured patients in our region face significant challenges accessing primary, specialty, and other care, and the broader behavioral and social needs of many of these vulnerable residents go unmet. Access to community-based services varies widely by county and community. Limited access is due in large part to fragmentation in the health care system, which results in beneficiaries with unmanaged chronic health conditions, preventable readmissions following inpatient care, inappropriate utilization of high cost services, and under-treated behavioral health comorbidities.

Our CNA revealed specific geographic areas – zip code level "hot spots" - of chronic condition prevalence region-wide that necessitate reducing fragmentation and integrating care. Geographically, areas of high need correlate with high levels of poverty, including Newburgh, Poughkeepsie, New Rochelle, Yonkers, and Kingston. Diabetes, congestive heart failure, coronary atherosclerosis, hypertension, asthma, chronic obstructive pulmonary disease, HIV, bipolar disorder, depression, schizophrenia, chronic alcohol abuse, and opioid abuse are all conditions that occur at increased rates.

To meet the need for a truly integrated delivery system (IDS), our PPS will build an organized, coordinated and collaborative network that links health care, behavioral health and social services in a community-based system that delivers accessible evidence-based, quality care in

the right setting at the right time. Medicaid patients in our communities will be supported by providers with access to systems to manage and improve clinical outcomes and the health status of the population.

Eight elements will provide the foundation for the IDS: (1) robust data analytics, including ongoing hot spotting, outcome evaluation, and the integration of non-clinical data that address the broader determinants of health; (2) "supporting excellence," wherein evidence-based protocols are disseminated throughout the network, and adherence is tracked and facilitated through the use of rapid cycle evaluation mechanisms; (3) quality oversight and clinical governance, including standing committees, project-specific work groups and region-wide multi-PPS collaborations/councils; (4) achieving National Committee for Quality Assurance (NCQA) patient centered medical home (PCMH) Level 3 certification among eligible providers in the PPS; (5) creating medical neighborhoods comprised of diverse networks of medical, behavioral health, Health Homes, and community-based organizations; (6) linking appropriate care management to delivery of care; (7) developing value-based payment models and incentives; and (8) data sharing, leveraging health information exchange (HIE), shared care plans, and technologies that enable actionable information to providers and their 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.

Our PPS includes the two largest providers of inpatient and emergency services for Medicaid patients in our region - Westchester Medical Center (WMC) and Good Samaritan Hospital of Suffern. WMC, an academic medical center, is the region’s only public hospital, the only Level 1 Trauma provider between NYC and Albany, and has the highest patient acuity case mix in the country. Our PPS also includes inpatient psychiatric services with specialized units for children, adults, and behavioral health, and the region’s largest practice association of behavioral health service providers as well as county Departments of Mental Health.

Many of our PPS Participants have begun care integration initiatives which we plan to build upon. Our PPS includes three Health Homes whose operations will be expanded through our Health Home At-Risk Intervention Program, enabling the expansion of best practices and key infrastructure and processes. Several of our participants have formed accountable care organizations (ACOs), participate in CMS Shared Savings Programs and have accordingly begun coordinating patient care across conditions, providers, and settings, shifting their models from fee-for-service (FFS) to value-based and risk bearing models. Several primary care practices and FQHCs in our network are Level 3 PCMHs; several participate in the CMS Comprehensive Primary Care initiative, and virtually all of these organizations have launched initiatives to improve the quality of care for patients with chronic conditions. Others have implemented innovative approaches such as co-location to integrate primary and behavioral health care services.

Health information technology (IT), which is key to our IDS strategy, has been deployed to various degrees across the PPS. Many practices are advanced users of EHRs, whereas others are in the early stages of technology adoption. Data sharing through the local regional health information organization (RHIO) has been challenging, however the Taconic Health Information Network and Community (THINC) RHIO is currently joining with Southern Tier HealthLink (STHL) to create HealthLinkNY. This partnership will bring to bear robust technical and operational capabilities that we will leverage to connect PPS Participants to the RHIO and Statewide Health Information Network for New York (SHIN-NY), and foster technology adoption throughout the region. PPS Participants will be called upon to share data through Direct connections, or by accessing a RHIO-based provider portal.

Our IDS will use a Hub governance approach (described more fully below) to implement quality improvement efforts across the large number of attributed patients in our region. While strategy can be centrally determined, actual care delivery is ultimately local and smaller networks can be more nimble and sensitive to local needs, concerns, and cultures. Accordingly, PPS Participants will be enlisted to lead and staff several geographically-based Hubs, enabling stakeholders to represent and address an area's unique needs, mobilize providers, and build relationships that underpin medical neighborhoods and other IDS components.

We will also look beyond our current PPS network of over 275 community-based and provider organizations to engage new partners including medical equipment suppliers, local charities, and others. Workforce development, in partnership with local unions and professional associations, will be a priority as the IDS creates and modifies health care jobs and skills required over the course of the program.

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 barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Connectivity to the RHIO will be complicated by various levels of readiness – technical and operational – among providers, and the rate at which the RHIO can establish connections. Interim solutions using Direct connections and provider portals will be facilitated, as will associated workflows. A robust plan to obtain patient consent to share data is as important as the technical connections themselves and a comprehensive plan to seek (and manage) patient consent will be implemented. Role-based access to patient data will be strictly managed and information shared only on a need to know basis.

Existing Health Home infrastructure is challenged by inadequate connections to medical care. Hospitals have built some care management capacity but it is not typically connected to either primary care or Health Homes. Among primary care practices, care management capacity is limited. Expanding and integrating appropriate care management support for patients will

require linking these siloed resources. A plan for care management is detailed in Project 2.a.iii, "Health Home At-Risk Intervention Program."

Changing the health care payment model will require providers to look at their performance using cost and clinical outcomes data and many will need technical assistance to do so. Training and change management techniques will facilitate adjustment to a value-based model and engage clinical champions to anticipate and respond to frustration among providers whose services are newly evaluated for cost and quality. By tying financial incentives and aligning provider compensation to DSRIP milestones and clinical quality outcomes early in the project, our PPS will lay the groundwork for value-based contracting.

Integration of the health care delivery system will impact the workforce, as new jobs are created and staff retrained or redeployed. Our PPS, in partnership with local unions including 1199SEIU, New York State Nurses Association (NYSNA), and the Civil Service Employees Association (CSEA), is developing a strategy to address these changes as part of a dedicated workforce initiative; this strategy is detailed in the Workforce Section of our PPS' Organizational Application.

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

As a patient-centered model of care, DSRIP allows patients to receive care from any provider, some of whom may participate in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and New York State. The three PPSs in our region led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project plans and implementation plans and make recommendations to align overlapping project approaches. Region-wide coordination, common requirements, and similar expectations will minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and its payers.

Continuing the cooperation that resulted in the creation of a common Community Needs Assessment, the PPSs in our region have embraced cross-PPS collaboration throughout the selection, design, and development phases of their respective DSRIP projects. To date, the PPSs have committed to coordinate implementation in three critical areas: behavioral health crisis intervention and coordination with local County Departments of Health and Mental Health;

protocols for patient consent and physician connectivity to HealthlinkNY (RHIO); and a tobacco cessation public health campaign.

2. System Transformation Vision and Governance

2a. 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 care mangers, etc._. The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

IDSs should be easy for patients to navigate and include access to a quality-driven network of service providers as close to where patients reside as possible. Redesigning the safety net in our region to build a system of care that puts the patient at the center and ensures the patient receives the "right care at the right place at the right time" will require a paradigm shift. The end result of this framework will be a right-sizing of acute care beds and an increase in access to primary and behavioral health care and preventive services. We recognize that key to the creation of an IDS is paying special attention to patients with behavioral health needs. These individuals experience higher than average admission and emergency department (ED) visit rates, challenges adhering to complex psychoactive medication protocols, and an overall lack of connection to primary care. Our health service interventions will be tailored to take into account the special needs of behavioral health patients across all areas of DSRIP – delivery system transformation, chronic disease management, and preventive care.

Our IDS strategy is to create a diverse network of community partners committed to and accountable for key principles including: (1) timely access to appropriate medical, behavioral health and social services resources; (2) clear accountability and responsibility for patient care across care transitions, including the sharing of patient information; (3) optimization of patient self-care, through patient activation, engagement, education and peer supports; (4) data-driven quality improvement, including transparency, performance feedback, and accountability; (5) service utilization that is based on value and defined by cost and quality as measured by patient outcomes; and (6) a culture of supporting excellence.

The action plan to realize this strategy entails several concurrent areas of focus. One focus area is supporting our PPS network of providers to improve their processes. To ensure provider capability to operate in the IDS, we will: (1) actively engage and expand the network of quality-driven providers across the continuum of care who collaborate to deliver evidence-based care, improve quality and efficiency, and coordinate care; (2) identify metrics and set performance targets to achieve meaningful clinical practice improvement across the continuum of care; (3) advance technology-enabled performance improvement through the deployment of health IT

tools including certified EHRs, registries, and clinical decision support; (4) ensure that PPS providers connect to HealthlinkNY RHIO by the end of DY 3 via certified EHRs, Direct connections, or a web-based provider portal; (5) ensure that eligible providers in the IDS achieve PCMH Level 3 accreditation (including adoption of Meaningful Use certified EHRs) by the end of DY 3; and (5) ensure the IDS develops tools and resources to help Medicaid beneficiaries play a more active role in managing their care.

A second focus area for the IDS is right-sizing acute care beds while building primary care and behavioral health capacity. These are addressed through the PPS's project 2.a.iv, "Create a Medical Village Using Existing Hospital Infrastructure" wherein the PPS PAC Executive Committee will be responsible for overseeing the closure of 125 inpatient beds, the creation of six observation beds, the creation of a new health center, and the expansion of current outpatient services. For expanded use of behavioral health services, our PPA will implement Project 3.a.i, "Behavioral Health/Primary Care Integration," and we will physically integrate medical and behavioral health services at 22 sites.

A third area of focus for the IDS is to lay the ground work for value-based contracting. We have created a Sustainability Taskforce to partner with local Medicaid Managed Care Organization (MCO) stakeholders charged with identifying, testing, and evolving sustainability strategies for the PPS. The Taskforce may address such alternative payment arrangements as pay-for-reporting, pay-for-performance, shared savings, and capitation, and evaluate successful models within the region and nationally.

It may not be desirable or feasible for our PPS to pursue a single contracting strategy. Our governance will evolve and likely vary based on different geographies. We anticipate our PPS will support the evolution to value-based purchasing in four primary ways: (1) providing centralized services to advance the IDS' capabilities to manage population health; (2) creating a value-based contracting vehicle for the IDS; (3) providing the infrastructure to help other PPSs in the region develop value-based contracting platforms; and (4) providing the infrastructure to help ACOs and other provider-driven accountable care collaborations in the region enter into risk-based Medicaid contracts.

The fourth area of focus is the development of a centralized PPS organization responsible for the execution of the DSRIP initiatives and, ultimately, ensuring that the IDS that can successfully enter into value-based contracts. Our PPS has established a broad stakeholder governance model that centers on clinical governance, financial governance and IT governance to lay the foundation for value-based contracting. The Center for Regional Healthcare Innovation (CRHI) at WMC is the centralized services and project management organization for our PPS and is developing a capability to support practice transformation, to achieve DSRIP's technical and functional goals, to recruit and manage the network, and to collaborate with Medicaid MCOs in the region to test and advance payment reform strategies.

Milestones for these IDS efforts include: (1) the creation of a technology plan that supports data sharing, RHIO connections, analytics, relevant PCMH Level 3 metrics, Meaningful Use Stage 2 EHRs, shared care plans, and other enabling technology procurement(s); (2) integration of the Medical Village Project into our PPS' regional approach; (3) integration of PPS required quality and outcomes measures across the region; and (4) development of a strategy to support value-based contracting, including integrating information on cost and outcomes to determine value, incentive payments, upside and downside risk, and a campaign to educate providers about the value-based model.

2b. 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.).

Our PPS has established a strong and effective organizational and governance structure that will enable the PPS to evolve into an integrated and high-functioning provider network. WMC has made a significant investment to support the startup of our PPS through the establishment and staffing of CHRI which will provide clinical supervision services by hiring, contracting with and/or leasing clinical staff who will collaborate with care coordinators and health care professionals working with Participants throughout the PPS. CRHI will supply necessary IT services to support our PPS, providing or arranging for the provision of staffing necessary for the operation of the PPS, training Participant staff as necessary to support achievement of PPS goals, data analytics necessary to support PPS operations, and back office and administrative services necessary to ensure a high-functioning, high-performing DSRIP operation.

Our model allows for clear delineation of responsibilities and individual performance goals through detailed schedules and accountability for incentive payments and any supplemental payments for services rendered. It is a cooperative agreement as the IDS will be a learning system and both the centralized services organization and individual Participants will benefit from the flexibility and rapid course correction our Collaborative Contracting model affords. Relatedly, a central pillar of our PPS care transformation framework is to develop a learning organization. Our PPS will continually monitor performance and identify opportunities for improvement and transformation – including the effectiveness of our governance approach – regardless of DSRIP year. We adopted a Hub model precisely because it drives accountability to the point of care and fosters the development of true medical neighborhoods with local clinical leaders, serving the needs of our region's residents. Our Hub governance structure will be in regular communication with the PPS Executive Committee and vice versa. We will learn from our successes and failures and share best practices through both formal and informal information sharing platforms. Our financial model includes funds for training and peer-to-peer networking and education.

PPS governance is built around an inclusive, transparent committee structure that includes representation from a broad range of Participants. The structure features both centralized and localized governance, with the aim of maximizing Participant engagement, and balancing the need for centralized structure with the necessity of meeting local needs and areas of focus. The PPS will be organized into four Hubs, which will be comprised of Participants located within a defined geographic area.

Goals for DYs 1-3 will focus on providing oversight of DSRIP milestones, enforcing Participant obligations, evaluating/tracking PPS and Participant performance relative to established metrics, and developing the foundational capabilities and competencies for clinical and financial integration. The associated milestones include the creation and convening of approved formal committees, advisory committees, workgroups, and regional councils. These will be evidenced by: (1) charters and meeting minutes; (2) the formalization of the Hubs, including membership, board composition, operating plans and budgets, as well as meeting schedules and minutes; (3) the establishment of contracts between WMC, CRHI and PPS Participants, including payment and reimbursement terms, as well as business associate and data use and sharing agreements; (4) finalization of the IT and clinical governance structures; and (5) DSRIP implementation plans, specifying program and project-level activities and deliverables, and the roles and responsibilities of Participants.

We envision a transition to value-based contracting before DY5, based on our experience in DYs 1-3, with the goal of ensuring sustainable transformation. Our PPS recognizes its governance and organizational structure will need to change as DSRIP objectives and goals evolve toward sustainability and value-based contracting. As our PPS evolves from program management to a true IDS with the supporting processes and infrastructure to measure quality and outcomes, a newly formed entity/entities will likely be established as a vehicle/vehicles for value-based contracting. In addition, our PPS plans to support local ACOs as well as other PPSs in the region to access the data and analytics capabilities necessary to successfully pursue alternative Medicaid contracting models.

3. Scale of Implementation

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:

3a. Please indicate the total number of sites, programs, and/or providers the PPS intends to include in this project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.

See accompanying Speed & Scale Excel document

b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.

See accompanying Speed & Scale Excel document

4. Speed of Implementation/Patient Engagement

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 foals. 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:

4a. Please indicate the Demonstration Year (DY) and Quarter by which all participating providers will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS "total committed" scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

See accompanying Speed & Scale Excel document

b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.

See accompanying Speed & Scale Excel document

5. Project Resource Needs and Other Initiatives

5a. Will this project require Capital Budget funding? (Please mark the appropriate box below)

Yes	No
X	

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

The WMC-led PPS will seek capital funds to develop a shared health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry/registries; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of Participant's EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations and will facilitate the development of an integrated and accountable care delivery structure. This capability will be shared across all 11 DSRIP projects.

To facilitate effective and efficient patient triage, specialty and community-based services referrals, appointment tracking, and care management, our PPS will seek capital funding to establish a call center and expand space to train PPS staff.

Our PPS will also require capital funds to support: (1) the expansion of facilities for the co-location of behavioral health and primary care services, and (2) the renovation of inpatient facilities and the acquisition of additional capital equipment to accommodate expanded outpatient services that will be part of our two Medical Village projects.

5b. 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
X	

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.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Dominican Sisters Family Health Service, Inc.	Community-based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other

				settings and reducing readmissions for high-risk Medicare beneficiaries.
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation center	Community- based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
The Greater Hudson Valley Family Health Center, Inc.	Partnerships for Care HIV grant (CDC & HRSA)	9/1/14	8/31/15	The Partnerships for Care HIV grant supports the identification of undiagnosed HIV infection, establishes new access points for HIV care and treatment, and improves HIV outcomes along the continuum of care for people living with HIV (PLWH). The grant helps to support required staffing and equipment.
The Greater Hudson Valley Family Health Center, Inc.	Supplemental Funding for Expanded Services (HRSA) 9/1/14	9/1/14	8/31/15	Expanded Services Supplemental Funding supports increased access to preventive and primary health care services, including oral health, behavioral health, pharmacy, and/or vision services at existing Health Center Program grantee sites for underserved populations in the service area. Specifically, funding supports a pediatrician and

				internist staff and provides a Mobile Health Van for sheltered homeless patients.
Mental Health Association in Orange Co., Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to

				ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Open Door Family Medical Center, Inc.	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation center	Hospital Medical Home Demonstration Program	2012	2016	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get

				PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
The Institute for Family Health	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Visiting Nurse Service of New York	Health Workforce Retraining Initiative	2014	2015	The Health Workforce Retraining Initiative supports organizations that train or retrain health care workers to obtain the necessary qualifications for new or changing positions. Funding supports the training of Population Care Coordinators and certified home health aides through the Partners in Care Program.
The Children's Village	Bridges 2 Health	2009	NA	Bridges 2 Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization

				and other out-of-home care. Funding supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.
Cerebral Palsy of Westchester	OPWDD People First Waiver	2014	2019	New York's Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) program provides enhanced care coordination to developmentally disabled Medicaid populations through qualified managed care plans.

5c. 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.

Our PPS will build upon current efforts ongoing in our region in pursuit of an integrated delivery system by expanding services offered by the entities listed above beyond those above currently targeted to limited patient groups to our PPS's larger Medicaid and attributed population. This project will not supplant or replace current funding, but rather will look to these providers as experts in providing care to underserved populations and leveraging the skill and experience these entities have garnered through their services to ensure our project is successful.

For example, The Community-based Care Transitions program targets Medicare patients. Our PPS will build on Participants' experiences and expertise to establish standard care transitions models across the region and expand the model to support Medicaid patients. The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, and will serve a larger group of Medicaid patients who are not currently eligible for Health Home services in New York State, specifically Medicaid beneficiaries who have a chronic condition requiring ongoing management, are at risk for deteriorating health status, and/or are likely to be hospitalized or use the emergency department (ED). Our PPS will work closely with Open Door, for example, to leverage the organization's expertise gained from this demonstration as we seek to expand care coordination, care teams and team communication, and smooth care transitions. This DSRIP

project will expand these services to a much larger population, including to our Participant hospitals and many other Participant sites. Further, this funding is ending and therefore will not be supplanted or duplicated through DSRIP. This DSRIP project will work alongside the Bridges to Health program, but DSRIP funding will not be provided to Bridges to Health participating providers if doing so would supplant or duplicate other federal or State funding. DISCO service providers and enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider, not plan level, and is distinct from and will supplement DISCO services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in DISCO plans.