

WMC DSRIP PPS Project Plans

Application Section 4

Submitted December 22 2014

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

Project Response & Evaluation:

Partnering with Entities Outside of the PPS for this Project

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

Entity Name
Cancer Services Program of the Hudson Valley (operated by Hudson Information Technology for Community Health (HITCH))
Cancer Services Program of Delaware Otsego and Schoharie Counties
Cancer Services Program of Orange County

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

Despite widely accepted guidelines on cancer prevention from the U.S. Preventive Services Task Force (USPSTF) and other bodies, there are areas in our region with low cancer screening rates among specific groups of Medicaid beneficiaries within target gender and age groups for respective screenings. Breast cancer screening rates are generally low (<50%) in the northern PPS region (Sullivan, Dutchess, and Ulster Counties). Cervical cancer screening rates are low (<50%) in much of Dutchess and Ulster Counties, as well as specific zip codes in each of the remaining counties. Colorectal cancer screening rates are generally low (<50%) in all PPS counties, with particularly low rates (<40%) dominating Dutchess, Ulster, and Sullivan Counties.

The CNA revealed racial and ethnic disparities in outcomes related to these cancers which are also found statewide (NYS Minority Health Surveillance Report 2012). In our region, White non-Hispanic women have a higher rate of breast cancer (140 per 100,000) compared to Black non-Hispanic women (116), but the mortality rate for Black non-Hispanic women is higher than that of White non-Hispanic (28.3 compared to 22.6). Cervical cancer incident and mortality rates are twice as high among Black non-Hispanic and Hispanic women compared to White non-Hispanic

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women. Likewise, Black non-Hispanic adults in the region also have higher incident and mortality rates for colorectal cancer.

Combined, these findings indicate a deficit of both screening and follow up. Obstacles to cancer screening and follow up include geographic isolation, limited health literacy or self-efficacy, a lack of patient understanding regarding the benefits of screenings, language barriers, and a lack of provider coordination. The experience of our safety net providers indicates that even the need for a mammogram or colonoscopy order can be a barrier to service, as can the need for a patient to make a separate appointment to obtain the screening or follow up service.

Our project aims to increase access to cancer prevention care in clinical and community settings. Cancer screening is one of the “gaps in care” for which many providers do currently assess patients to ensure they are getting timely access to high quality care. However, new resources need to be developed to support more providers to reach a higher proportion of patients, especially in those communities with particularly low screening rates. We will work directly with primary care providers (PCPs), building on the model of the New York State (NYS) Cancer Services Program (CSP), a statewide, comprehensive cancer screening program that provides breast, cervical, and colorectal cancer screening services to uninsured and underinsured individuals. Among the benefits of the CSP model is that in addition to connecting patients to local cancer screening services, it coordinates follow up for diagnostic testing if necessary. The CSPs also work with provider networks to train them on and reinforce screening guidelines, collaborate with community-based organizations to promote the importance of cancer screening and the availability of CSP services, and participate in awareness-raising and screening events. Our plan is to leverage CSPs’ best practices to improve outcomes in the target Medicaid population.

Our PPS, under the umbrella of the Regional Clinical Council, comprised of representatives of all three PPSs in our region, will coordinate region-wide project implementation with local health departments and other community partners. The Council will also work with hospitals across the region to incorporate Prevention Agenda goals and objectives into hospital community service plans and with Medicaid MCOs and health plans to seek enhanced reimbursement for cancer screening and prevention services.

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

The target population will be adult Medicaid patients of our PPS Participants in the eight county region we serve. We will target people for screening based on USPTF guidelines, specifically: for cervical cancer, women aged 21 to 64 years will be screened with cytology (pap smear) every 3 years; for breast cancer, women aged 50 to 64 will be screened by mammogram every other year; for colorectal cancer, adults aged 50 to 64 years will be screened using fecal occult blood test or colonoscopy, depending on the patient’s profile. Note that the age criteria and

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timeframes will be modified in cases where patients are at increased risk, including patients who show symptoms or have a family or personal history of cancer, are being actively treated for cancer, or who are otherwise ineligible for clinical reasons.

Patients who are eligible and due for screenings according to the USPTF guidelines outlined above will be identified via medical record data in the office setting, or via health assessments conducted by Health Homes or in other clinical settings. All primary care practices in our PPS will be called upon to identify and address cancer screening gaps among their patient populations, and to track their patients in an EHR-linked cancer screening registry. Providers without an EHR will be provided with a basic computer-based tool for tracking their patients. The registry will enable providers to identify patients in need of services, flag patients for referrals at upcoming visits, and send patient reminders.

Secondarily, we will assist the subpopulation of patients whose screening results indicate the need for follow up diagnostic testing. These patients will be provided with care management assistance to facilitate referrals to appropriate specialists, follow up primary care visits, and other services as needed.

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

The NYS CSP is a valuable model and resource for our PPS to efficiently establish best practices in cancer screening and follow up. The CSP of the Hudson Valley, operated by Hudson Information Technology for Community Health (HITCH), is a PPS Participant and serves Dutchess, Putnam, Rockland, Ulster, and Westchester Counties; we will also partner with the CSP of Delaware Otsego and Schoharie Counties and the CSP of Orange County. The CSP model that empowers culturally-competent care coordinators to assist patients with follow up care can be applied to this project's target population targeted. The CSPs can assist our PPS with workflows, data collection strategies, talking points, and lessons learned, so that we may establish a comprehensive cancer screening function.

There is some care management capacity in our PPS, but it is limited. Existing care management programs are primarily focused on post-discharge transitions of care, or are Health Home-based and concerned with managing multiple chronic conditions and/or behavioral health comorbidities. Accordingly, we will need to establish more extensive care management capabilities in our region, ultimately aiming to adopt medical home and team-based care models among all PPS Participants by the end of DY3. We will work through the established Hubs to develop detailed cancer screening project implementation plans that take into consideration staffing needs, community resources, and social and environmental factors.

In addition to the CSPs, our region includes other cancer screening capabilities that can be expanded or modeled. For example, Memorial Sloan Kettering (MSK) Cancer Center is a PPS

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Participant that provides high-risk cancer screening services in West Harrison. Open Door Family Medical Centers and the Institute for Family Health are under contract with the CSP of the Hudson Valley to provide cancer screening services within their Health Homes as part of the model to be expanded as described above. WMC and Good Samaritan Regional Medical Center offer special screening events in adult outpatient clinics in addition to regular screening services. We propose to build on these and other PPS Participants' capabilities, for example, by establishing venues for walk-in mammograms at dates and times convenient to patients, so that in one stop a patient can obtain an order, be tested, and be referred back to her PCP.

Existing health information technology (IT) tools can be mobilized to achieve improved screening and follow up. PCPs using certified EHRs are able to track and report on screening activity as well as use clinical decision support features for alerts and reminders. As part of the initiative, we will expand enabling technologies to connect providers to Healthlink NY, the local RHIO, and the SHIN-NY, allowing providers to see a community patient record including cancer screening and other services, as well as engage in data sharing and electronic referrals either through the RHIO or Direct connections. Providers without an EHR will be provided with a basic computer-based tool for tracking their patients, enabling providers to identify patients in need of services, flag patients for referrals at upcoming visits, and send patient reminders. We will ensure that all PPS Participants are connected to the Healthlink NY RHIO by the end of DY 3 via certified EHRs, Direct connections, or a web-based provider portal.

We will establish a PPS-wide cancer registry to track patients eligible for cancer screening services. The PPS is evaluating analytics and population health management platforms and during DY 1 will implement a system to identify and track patients, and monitor patient and provider adherence to treatment guidelines. The platform will draw from claims data, EHRs, care management systems, and other data sources to enable identification and outreach to patients.

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

The adaptation of the NYS CSP to our PPS will be challenging, but we believe it will provide a strong foundation for the project. Because the program serves the uninsured, it includes specific eligibility criteria, intake processes, and data collection and reporting systems outside of the Medicaid system; these will need to be revised for the Medicaid population. Coordination with the CSP will also be a challenge and an imperative because we expect that a proportion of underserved patients cycle between Medicaid and uninsured status, and that coordination will be key to providing comprehensive care. Our PPS will work closely with the local CSPs to design the implementation plan for our cancer screening project, identifying

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additional resources, systems, and other requirements to ensure the project's success. We will convene a working committee that meets regularly to ensure an integrated approach.

Another challenge we anticipate is that of competing priorities for both providers and patients. Providers, while they recognize the importance of cancer screening, may be compelled to postpone discussion or ordering of cancer screening services if their patients have more urgent needs (e.g., acute health condition, or behavioral health crisis) at the time of a visit. Patients may be overwhelmed by other health issues or social and environmental factors that prevent them from addressing preventive care (e.g., job instability, transportation concerns, or lack of child care). We believe that our approach of reinforcing screening guidelines, providing supportive technical and human resources, and implementing a system of both provider and patient-facing alerts and reminders will enable us to mitigate this challenge.

Our PPS will also tie PPS Participant bonus payments to performance relative to the delivery of cancer screening and prevention services to the target population. The PPS Quality Committee will establish clinical benchmarks tied to Participant reimbursement and monitor Participant and individual provider performance. We will publish process and outcome metrics and provide feedback to Participants who fall below expectations.

e. 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 serving the Hudson Valley and Delaware County, 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 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

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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.

The Council may also collaborate on processes for cancer screening as both Montefiore and the WMC-led PPSs are planning to implement this project though specific target populations may vary.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

Key milestones for the cancer screening project in DY1 are: (1) development of a comprehensive implementation plan, (2) an analysis of CSP best practices and lessons learned, (3) development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs; (4) identification of functional requirements for the cancer screening registry; and (5) piloting rapid cycle evaluation of our PPS' care management function. In DY2, milestones include: (1) selection of an analytics platform to support patient identification; (2) roll-out of a one-stop screening pilot; and (3) wider roll-out of CSP-adapted protocols and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team-based care models.

2. Project Resource Needs and Other Initiatives

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:

2a. 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

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management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' 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 for enhanced cancer prevention and management efforts. The capability will be shared across all 11 DSRIP projects and is central to our IDS development.

Additional capital funding will support transportation services to cancer screening clinics, as well as vehicles for mobile screenings.

2b. Are any of the providers within the PPS and included in the Project Plan PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
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
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.	Supplemental Funding for Expanded Services (HRSA)	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

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				and internist staff, and a Mobile Health Van for sheltered homeless patients.
Open Door Family Medical Center, Inc.	CSP of the Hudson Valley, operated by Hudson Information Technology for Community Health (HITCH)	2011	NA	The NYS Cancer Services Program (CSP) provides breast, cervical, and colorectal cancer screenings at no cost to women and men who are uninsured or whose insurance does not cover the cost of screenings and meet other eligibility requirements.
The Institute for Family Health	CSP of the Hudson Valley, operated by Hudson Information Technology for Community Health (HITCH)	2011	NA	The NYS Cancer Services Program (CSP) provides breast, cervical, and colorectal cancer screenings at no cost to women and men who are uninsured or whose insurance does not cover the cost of screenings and meet other eligibility requirements.

2c. 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’s DSRIP project differs from the existing New York State Cancer Services Program (CSP) because it will expand cancer screening and prevention services to the Medicaid population; today the CSP only serves the uninsured population. The proposed project will also increase the scope of CSPs to include respiratory/lung cancer screening. The PPS plans to work with the local CSPs to hire required staff and augment resources as needed to support this expansion to the Medicaid population and enhanced scope of services. The PPS will also expand health center services for the attributed population and will look to providers participating in the Expanding Services initiative as experts in providing care to underserved populations, but will not supplant or replace this project as it will expand access to care to the broader Medicaid population.