DSRIP Domain 2-4 Projects for FQHCs

In this document, CHCANYS presents information on select DSRIP projects from Domains 2, 3, and 4. These are projects that FQHCs should or could play a leadership or central role in designing and implementing. The following three tables provide information on "Top Projects for FQHCs" as well as a few alternates to consider. Click here for New York State's DSRIP Project Toolkit, which includes more detailed project descriptions: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

Domain 2	**System Transformation Projects** • Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation scoring purposes. • All DSRIP plans *must* include *at least two* Domain 2 projects based on their community needs assessment. • **REQUIRED:** *At least one* project must be from Strategy A. Create Integrated Delivery Systems (IDSs) **AND** at least one project must be from Strategy B. Implementation of Care Coordination and Transitional Care Strategies **OR** Strategy C. Connecting Settings		
	FQHC Project	**FQHC Project**	**FQHC Project**
Strategy Area and Project	**B. Care Coordination and Transitions** **2.b.ii** **Development of co-located primary care services in the ED**	**B. Care Coordination and Transitions** **2.b.iv** **Care transitions intervention model to reduce 30-day readmissions for chronic conditions**	**B. Care Coordination and Transitions** **2.b.i** **Ambulatory ICUs**
Valuation Score	40	43	36
FQHC attributes that would support this project	Patient mix with diabetes, asthma, CHF, COPD, other ambulatory sensitive conditions; linkages with regional hospitals	High patient mix of elderly, people with behavioral health (BH)/ substance abuse (SA) conditions; linkages with hospitals, psych hospitals, SNFs	Patient mix with diabetes, asthma, CHF, COPD, other ambulatory sensitive conditions; linkages with community supports
Population that project targets	Patients without a medical home; Patients with history/risk of poorly managed chronic conditions or with mental/substance abuse comorbidity	Patients with history/risk of readmission for poorly managed BH/SA and/or health conditions	Patients with history/risk of poorly managed chronic conditions

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	FQHC Project	**FQHC Project**	**FQHC Project**
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Evidence to reduce (inappropriate or avoidable) hospitalizations	Mixed to strong; some evidence to reducing future preventable ED visits and avoidable hospital admissions	Mixed to strong; managing transitions linked with cutting readmissions, especially after psych/ SA discharges	Limited; some evidence for improving clinical outcomes for people with diabetes and improving satisfaction
Existing models to build on	Voices of Detroit Initiative; General Practitioners embedded in UK EDs	Care Transitions Intervention (CTI) Transitional Care Model (TCM)	Union Health Center (in NYC)
Interdependence with other entities	Medium to high	Medium to high	Low
Key entities involved in project design	FQHC, Hospital	Hospital, FQHC, SNF	FQHC
Likely FQHC staffing requirements	Clinical and/or care coordination staff embedded at ED	Clinical and care coordinators to participate in Interdisciplinary Care Teams (ICTs) with other provider-site staff	Patient care assistants (PCAs), health coaches; "floor" coordinators, patient support service staff, and greeters
HIT requirements	Functional EHR; HIE capability between ED and FQHC; instant messaging	Functional EHR; HIE capability across settings, providers; near real-time alerts to PCP/ICT when admission occurs	Functional EHR; HIE capability across settings, providers; near real-time alerts to PCP/ICT when admission occurs

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	FQHC Project	**FQHC Project**	**FQHC Project**
Strategy Area and Project	**B. Care Coordination and Transitions** **2.b.ii** **Development of co-located primary care services in the ED**	**B. Care Coordination and Transitions** **2.b.iv** **Care transitions intervention model to reduce 30-day readmissions for chronic conditions**	**B. Care Coordination and Transitions** **2.b.i** **Ambulatory ICUs**
Considerations, challenges	Capacity to embed FQHC staff at ED; contractual relationships and reimbursement	Importance of e-notifications; remaining as the PCMH post-discharge; capacity to make visits to the patient's home setting, as needed	Model has same goals and structure as a PCMH; requires significant staff training and reorientation to team-based care model; requires recruiting and training of PCAs, Health Coaches; and intense staff training on model implementation

Domain 3	**Clinical Improvement Projects** • Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes • All DSRIP plans *must* include *at least two* projects from Domain 3, based on their community needs assessment • **REQUIRED**: *At least one* project must be from Strategy A. Behavioral health • Other Strategies are: B. Cardiovascular Health; C. Diabetes Care, D. Asthma, E. HIV, F. Perinatal, G. Palliative Care, H. Renal Care				
	FQHC Project (see 4.a.i)	**FQHC Project**	**FQHC Project (see 4.d.i)**	**FQHC Project**	**FQHC Project**
Strategy: **Project:**	**A. Behavioral Health** **3.a.i** **Integration of behavioral health (BH) into primary care settings**	**C. Diabetes** **3.c.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**	**F. Perinatal** **3.f.i.** **Increase support programs for maternal and child health (including high-risk pregnancies)**	**D. Asthma** **3.d.i. Medication adherence programs; 3.d.ii. Expansion of asthma home-based, self-management; 3.d.iii. EBM guidelines for asthma**	**B. Cardiovascular** **3.b.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**
Valuation Score:	39	30	29	28, 31, 31	30
FQHC attributes that would support this project:	At least PCMH level 1 or 2 designation; linkages with LCSWs and CHWs in service area	DM experience, disease registries; linkages with endocrinology specialties	Outpatient OB services; prenatal care education; linkages with WIC programs	DM experience, disease registries; linkages with pulmonary/allergy specialties	DM experience; disease registries; linkages with cardiology specialties
Population that project targets	Patients with/at-risk for depression, or serious BH/substance abuse with chronic health conditions	Patients with/at-risk of diabetes, pre-diabetes, hypertension, heart disease/ CHF, COPD	Women, including teens with a high-risk pregnancy; new mothers at risk for post-partum depression	Patients diagnosed with or at risk for asthma (children and adults)	Patients with/at-risk of hypertension, heart disease/ CHF, and/or conditions that risk heart health

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	FQHC Project (see 4.a.i)	**FQHC Project**	**FQHC Project (see 4.d.i)**	**FQHC Project**	**FQHC Project**
Strategy: **Project:**	**A. Behavioral Health** **3.a.i** **Integration of behavioral health (BH) into primary care settings**	**C. Diabetes** **3.c.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**	**F. Perinatal** **3.f.i.** **Increase support programs for maternal and child health (including high-risk pregnancies)**	**D. Asthma** **3.d.i. Medication adherence programs; 3.d.ii. Expansion of asthma home-based, self-management; 3.d.iii. EBM guidelines for asthma**	**B. Cardiovascular** **3.b.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**
Evidence to reduce (inappropriate or avoidable) hospitalizations	Mixed; best results limited to reducing ED visits	Mixed; strongest for self-management programs for highest risk patients	Some for: reducing pre-term births, esp. associated with specific medical interventions (e.g., 17 OHP), when high-risk is identified early; reducing rate of elective deliveries before 39 weeks; see project 2.c.ii	Mixed; strongest for self-management programs for highest risk patients	Mixed; strongest for self-management programs for highest risk patients

Domain 3	**Clinical Improvement Projects** • Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes • All DSRIP plans *must* include *at least two* projects from Domain 3, based on their community needs assessment • **REQUIRED**: *At least one* project must be from Strategy A. Behavioral health • Other Strategies are: B. Cardiovascular Health; C. Diabetes Care, D. Asthma, E. HIV, F. Perinatal, G. Palliative Care, H. Renal Care				
	FQHC Project (see 4.a.i)	**FQHC Project**	**FQHC Project (see 4.d.i)**	**FQHC Project**	**FQHC Project**
Strategy: **Project:**	**A. Behavioral Health** **3.a.i** **Integration of behavioral health (BH) into primary care settings**	**C. Diabetes** **3.c.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**	**F. Perinatal** **3.f.i.** **Increase support programs for maternal and child health (including high-risk pregnancies)**	**D. Asthma** **3.d.i. Medication adherence programs; 3.d.ii. Expansion of asthma home-based, self-management;** **3.d.iii. EBM guidelines for asthma**	**B. Cardiovascular** **3.b.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**
Existing models to build on	IMPACT model; DIAMOND model for adults with depression or Dysthymia.	National Diabetes Prevention Program; Diabetes self-management education (DSME)	Nurse Family Partner-ship; Maternal and Infant Community Health Collaboratives; Centering Pregnancy	Home-based self-management programs; community-based asthma programs	Million Hearts campaign; dedicated DM for CHF; medication management models
Interdependence with other entities	Medium	Low	Medium	Medium	Low
Key entities involved in project design	FQHC, with CMHCs	FQHC	FQHC, with local public health agencies	FQHC, with home health agency	FQHC

Domain 3	**Clinical Improvement Projects** • Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes • All DSRIP plans *must* include *at least two* projects from Domain 3, based on their community needs assessment • **REQUIRED**: *At least one* project must be from Strategy A. Behavioral health • Other Strategies are: B. Cardiovascular Health; C. Diabetes Care, D. Asthma, E. HIV, F. Perinatal, G. Palliative Care, H. Renal Care				
	FQHC Project (see 4.a.i)	**FQHC Project**	**FQHC Project (see 4.d.i)**	**FQHC Project**	**FQHC Project**
Strategy: **Project:**	**A. Behavioral Health** **3.a.i** **Integration of behavioral health (BH) into primary care settings**	**C. Diabetes** **3.c.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**	**F. Perinatal** **3.f.i.** **Increase support programs for maternal and child health (including high-risk pregnancies)**	**D. Asthma** **3.d.i. Medication adherence programs; 3.d.ii. Expansion of asthma home-based, self-management; 3.d.iii. EBM guidelines for asthma**	**B. Cardiovascular** **3.b.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**
Likely FQHC staffing requirements	Psychologists and/or psychiatrists in FQHC setting, peer support specialists	Health educators; DM care managers, coordinators dieticians; linkages to endocrinology specialists	Advanced nurse practitioners, CHWs; linkages to home-visiting nurses;	Health educators; DM care managers, coordinators; linkages to allergy/pulmonary specialists	Health educators; DM care managers, coordinators; linkages to cardiology specialists
HIT requirements	Functional EHR w/registry; systems for hot-spotting; near real-time HIE to monitor prescription adherence	Functional EHR w/registry; near real-time HIE to monitor prescription adherence	Functional EHR, with registry; HIE with hospital providers to monitor birth outcomes	Functional EHR w/registry; near real-time HIE to monitor prescription adherence	Functional EHR w/registry; near real-time HIE to monitor prescription adherence

Domain 3	**Clinical Improvement Projects** • Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes • All DSRIP plans *must* include *at least two* projects from Domain 3, based on their community needs assessment • **REQUIRED**: *At least one* project must be from Strategy A. Behavioral health • Other Strategies are: B. Cardiovascular Health; C. Diabetes Care, D. Asthma, E. HIV, F. Perinatal, G. Palliative Care, H. Renal Care				
	FQHC Project (see 4.a.i)	**FQHC Project**	**FQHC Project (see 4.d.i)**	**FQHC Project**	**FQHC Project**
Strategy: **Project:**	**A. Behavioral Health** **3.a.i** **Integration of behavioral health (BH) into primary care settings**	**C. Diabetes** **3.c.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**	**F. Perinatal** **3.f.i.** **Increase support programs for maternal and child health (including high-risk pregnancies)**	**D. Asthma** **3.d.i. Medication adherence programs; 3.d.ii. Expansion of asthma home-based, self-management; 3.d.iii. EBM guidelines for asthma**	**B. Cardiovascular** **3.b.i** **Evidence-based strategies for disease management (DM) in high-risk populations (adults only)**
Considerations, challenges	Role of existing Health Homes in service area; BH provider supply; potential need for telepsychiatry	Coordination, integration with existing health plan DM programs; requires strong patient engagement component, adequate specialty capacity	Need to demonstrate expansion of MICHC, if already implemented	Coordination, integration with existing health plan DM programs; requires strong patient engagement component, adequate specialty capacity	Coordination, integration with existing health plan DM programs; requires strong patient engagement component, adequate specialty capacity

Domain 4	**Population-wide Projects** • Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes • All DSRIP plans *must* include at least one project from Domain 4, based on their community needs assessment • DSRIP plans are *not* required to include a project from any one of the four Strategies • The four Strategies are: A. Promote Mental Health and Prevent Substance Abuse (MHSA), B. Prevent Chronic Diseases, C. Prevent HIV and STDs, and D. Promote Healthy Women, Infants and Children	
	Combine with Top 5 3f.i Perinatal project	**Combine with Top 5 3.a.i. Integration of behavioral health**
Strategy: **Project:**	**D. Promote Healthy Women, Infants and Children** **4.d.i** **Reduce premature births**	**A. Promote Mental Health/Prevent Substance Abuse** **4.a.i. Promote mental, emotional and behavioral (MEB) well-being in communities**
Valuation Score:	24	23
FQHC attributes that would support this project:	Outpatient OB services; prenatal care education; telemedicine for women discharged after preterm labor; linkages with hospital-based high-risk pregnancy programs	Strong community linkages with schools, Agencies on Aging, SNFs, CMHCs
Population that project Targets	High-risk pregnant women; women at-risk for high-risk pregnancy	At-risk youth; pregnant teens; parents with children involved in child welfare; children involved in child welfare agencies (foster care, juvenile justice), frail elderly;
Evidence to reduce (inappropriate or avoidable) hospitalizations	specific medical interventions (e.g., 17 OHP) are associated with reducing pre-term births, especially when high-risk is identified early	Needs further research
Existing models to build on	Nurse family Partnership; Maternal and Infant Community Health Collaboratives (MICHC); March of Dimes Centering Pregnancy	SAMHSA-sponsored System of Care communities; Positive parenting; targeted school-based curricula
Interdependence with other health care entities	Low to medium	Low; high for dependence with non-medical agencies and organizations
Potential leadership entity in project design	FQHC	FQHC, with a school, AoA or other community partner
Likely FQHC staffing requirements	Advanced nurse practitioners, CHWs; linkages to home-visiting nurses;	Community relations specialists; CHWs, Peer/family support specialists

Domain 4	**Population-wide Projects** • Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes • All DSRIP plans *must* include at least one project from Domain 4, based on their community needs assessment • DSRIP plans are *not* required to include a project from any one of the four Strategies • The four Strategies are: A. Promote Mental Health and Prevent Substance Abuse (MHSA), B. Prevent Chronic Diseases, C. Prevent HIV and STDs, and D. Promote Healthy Women, Infants and Children	
	Combine with Top 5 3f.i Perinatal project	**Combine with Top 5 3.a.i. Integration of behavioral health**
Strategy: **Project:**	**D. Promote Healthy Women, Infants and Children** **4.d.i** **Reduce premature births**	**A. Promote Mental Health/Prevent Substance Abuse** **4.a.i. Promote mental, emotional and behavioral (MEB) well-being in communities**
HIT requirements	Functional EHR, with registry; HIE with hospital providers to monitor birth outcomes	Functional EHR; registry and/or HIE capability to track participation and admission outcomes
Considerations, challenges	Need to demonstrate expansion of MICHC if already implemented	Determine whether or how this project may tie into BH integration

DSRIP Domain 2-4 Projects Most Relevant to FQHCs - Appendix

Attachment J - NY DSRIP Strategies Menu and Metrics

Part I – Projects Menu

Each Performing Provider System will employ multiple projects both to transform health care delivery as well as to address the broad needs of the population that the performing provider system serves. These projects described in Attachment J are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

Each project selected by a Performing Provider System will be developed into a specific set of focused milestones and metrics that will be part of the Performing Provider System's DSRIP project plan. Project selection will be driven by the mandatory community needs assessment, and the rationale and starting point for each project must be described in the DSRIP project plan, as described in Attachment I.

DSRIP project plans must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project). As described further in Attachment I, a maximum of 10 projects will be considered for project valuation scoring purposes. Additional projects can be included in the application, but they will not affect the project valuation.

Domain 2: System Transformation Projects

All DSRIP plans must include at least two of the following projects based on their community needs assessment. At least one of those projects must be from sub-list A and one of these projects must be from sub-list B or C, as described below. Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation scoring purposes (as described in attachment I).

A. Create Integrated Delivery Systems (required)

2.a.i Create Integrated Delivery Systems that are focused on Evidence Based Medicine / 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 New York State Health Innovation Plan (SHIP))

2.a.iii Health Home At-Risk Intervention Program –Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services. 2.a.iv Create a medical village using existing hospital infrastructure

2.a.v Create a medical village/ alternative housing using existing nursing home

B. Implementation of care coordination and transitional care programs

2.b.i Ambulatory ICUs

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2.b.ii Development of co-located of primary care services in the emergency department (ED)
2.b.iii ED care triage for at-risk populations
2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.v Care transitions intervention for skilled nursing facility residents
2.b.vi Transitional supportive housing services
2.b.vii Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii Hospital-Home Care Collaboration Solutions
2.b.ix Implementation of observational programs in hospitals

C. Connecting settings

2.c.i. Development of community-based health navigation services
2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

Domain 3: Clinical Improvement Projects

All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health project from sub-list A, as described below. Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes (as described in Attachment I).

A. Behavioral health (required)

3.a.i Integration of primary care services and behavioral health
3.a.ii Behavioral health community crisis stabilization services
3. a.iii. Implementation of evidence based medication adherence program (MAP) in community based sites for behavioral health medication compliance
3.a.iv Development of withdrawal management (ambulatory detoxification) capabilities within communities
3.a.v Behavioral Interventions Paradigm in Nursing Homes (BIPNH)

B. Cardiovascular Health

Note: Performing provider systems selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (http://millionhearts.hhs.gov/index.html).

3.b.i Evidence based strategies for disease management in high risk/affected populations (adult only)

DSRIP Domain 2-4 Projects Most Relevant to FQHCs - Appendix

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3.b.ii Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

3.c.i Evidence-based strategies for disease management in high risk/affected populations (adults only)

3.c.ii Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adults only)

D. Asthma

3.d.i Development of evidence-based medication adherence programs (MAP) in community settings –asthma medication
3.d.ii Expansion of asthma home-based self-management program
3. c.iii Evidence based medicine guidelines for asthma management

E. HIV

3.e.i Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS

F. Perinatal

3.f.i Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. **Palliative Care**

3.g.i IHI "Conversation Ready" model
3.g.ii Integration of palliative care into medical homes
3.g.iii Integration of palliative care into nursing homes

H. Renal Care

3.h.i Specialized Medical Home from Chronic Renal Failure

Domain 4: Population-wide Projects

The following represent priorities in the State's Prevention Agenda with health care delivery sector projects to influence population-wide health (available at :

Partnership Plan - Approval Period: August 1, 2011 – December 31, 2014; as Amended April 14, 2014

DSRIP Domain 2-4 Projects Most Relevant to FQHCs - Appendix

Attachment J - NY DSRIP Strategies Menu and Metrics

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm). The alignment of these projects with the New York State Prevention Agenda (including focus areas, etc.) is described further in the Project Description Supplement.

All DSRIP plans must include at least one project from this domain, based on their community needs assessment. Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes (as described in Attachment I).

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities
4.a.ii. Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

4.b.i. Promote tobacco use cessation, especially among low SES populations and those with poor mental health

4.b.ii. Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3.b., such as cancer)

C. Prevent HIV and STDs

4.c.i Decrease HIV morbidity
4.c.ii Increase early access to, and retention in, HIV care
4.c.iii Decrease STD morbidity
4.c.iv Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

4.d.i Reduce premature births