**Domain 3: Clinical Improvement Project**

3.a.i Integration of primary care and behavioral health services

Integration of primary care and behavioral health services helps to ensure coordination of care for both services. It helps to identify behavioral health diagnoses early, allowing rapid treatment and make sure that treatments for medical and behavioral health conditions are compatible and do not cause adverse effects. Care for all conditions is delivered under one roof by known health care providers.

3.a.ii  Behavioral health community crisis stabilization services

This is an integration project based on the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model. The IMPACT model, which originates from the University of Washington in Seattle, integrates depression treatment into primary care and improves physical and social functioning, while cutting the overall cost of providing care.

3.a.iii   Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance

Medication adherence is particularly important for persons with psychiatric conditions to maintain health and function. Other evidence based tools and educational materials may be used. Various factors influence what we call “non-compliance” including health literacy, cultural values, language, and side effects of treatment. The goal of this program is to assist patients identify these issues and resolve them with motivational interviewing and structured conversations around medication compliance.

3.a.iv  Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

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, then, 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.

3.a.v  Behavioral Interventions Paradigm (BIP) in Nursing Homes

Many patients in long term care have behavioral health issues as a primary disease or as the result of other ongoing chronic diseases. Despite the prevalence of such problems within the SNF, staff may have inadequate formal training to manage these problems or rely on medication to manage these patients. These patients are a significant cause of avoidable admissions and readmissions to hospitals from SNF. This program provides a pathway to avoid these transfers and to ensure better care for the SNF patient with these diagnosis. Interventions that rely on increased training of the usual care staff to identify and address behavioral health concerns have been found to be effective management tools.

**B. Cardiovascular Health—Implementation of Million Hearts Campaign**

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

The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management.

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

This project focuses on developing community resources that will work collaboratively with community practitioners to assist patients with primary and secondary preventive strategies to reduce their risk factors and ameliorate the longterm consequences of cardiovascular diseases and other associated chronic diseases.

**C Diabetes Care**

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

The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. These projects are focused on improving practitioner population management, including consistent implementation of evidence based guidelines for the management of diabetes, and implementation of activities that will increase patient self-efficacy and confidence in self-management.

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

This project focuses on developing community resources that will work collaboratively with community practitioners to assist patients with primary and secondary preventive strategies to reduce their risk factors for diabetes and ameliorate the long term consequences of diabetes and other co-occurring chronic diseases.

**D. Asthma**

3.d.i  Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication

It is generally thought that emergency department visits and hospitalizations for exacerbations should be considered avoidable events with good asthma management. Often, despite the best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. Home-based services can address the factors that contribute to these exacerbations.

3.d.ii  Expansion of asthma home-based self-management program

This project addresses asthma management issues related to compliance with clinical asthma practice guidelines and to lack of access to pulmonary and allergy specialists in areas of New York State. Asthma action plans and patient self-management are key cornerstones in asthma management. Unfortunately, not all patients are using these tools. In addition, those with difficult to manage asthma may not have ready access to asthma specialists that would be needed for better control.

3.d.iii  Implementation of evidence-based medicine guidelines for asthma management

**E. HIV/AIDS**

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

There are effective strategies to manage viral loads of HIV, slow progression of the disease and reduce transmission. These strategies need to be available to all persons currently infected with HIV and all persons at risk for HIV infection. HCV infection can also be addressed in this scenario.

**F. Perinatal Care**

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

High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child’ life.

**G. Palliative Care**

3.g.i  Integration of palliative care into the PCMH Model

3.g.ii  Integration of palliative care into nursing homes

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.

**H. Renal Care**

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

The prevention and management of renal failure requires early identification and implementation of evidence based care, close monitoring, anticipatory guidance and education for the patient, and proactive interventions for ports in anticipation of need for dialysis. A medical home for chronic renal failure would ensure primary care, specialty care including behavioral health, nursing, dialysis, nutritional education services and social supports would be coordinated to optimally manage declining renal function and support improved quality of life for these patients.

**Domain 4: Population-Wide Projects**

1. **Promote Mental Health and Prevent Substance Abuse (MHSA)**

4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders (Focus Area 2) Substance abuse, depression and other MEB disorders hurt the health, public safety, welfare, education, and functioning of New York State residents. In addition to evidence substance abuse and other MEB disorders can be prevented, there is confirmation that early identification and adequate societal support can prevent and alleviate serious consequences such as death, poor functioning and chronic illness.

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

MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches, and cross-disciplinary collaborations need to be strengthened.

4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health. (Focus Area 2; Goal #2.2)

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health.

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

Delivery of high-quality chronic disease preventive 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. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications.

**4.c.i Decrease HIV morbidity**

4.c.ii Increase early access to, and retention in, HIV care (Focus Area 1; Goal #2)

4.c.iii Decrease STD morbidity

The same behaviors and community characteristics associated with HIV also place individuals and communities at risk for STDs and viral hepatitis. STDs increase the likelihood of HIV transmission and acquisition. Epidemiological data increasingly point to HIV, STDs and HCV as "syndemics", or infections which occur in similar groups of people with the same behavioral risk factors. Notably, in the United States in 2010, the leading cause of death among people with HIV was liver disease from co-4.c.iv Decrease HIV and STD disparities (Focus Area 1; Goal # 4)

4.d.i Reduce premature births

**Reference:**

Department of Health. (n.d.). Retrieved April 26, 2018, from

<https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/d4guidance_2015-06-08_final.htm#introc>

New York State Delivery System Reform Incentive Payment Program Project Toolkit. (n.d.). Retrieved April 26, 2018, from

<https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf>