ATTACHMENT 1

New Jersey Delivery System Reform Incentive Payment (DSRIP)

Toolkit

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I. General Overview

A. *Overview of DSRIP and Toolkit*

The New Jersey Delivery System Reform Incentive Payment (DSRIP) program provides an opportunity to improve patient care for New Jersey's low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and families they serve. These investments contribute directly to CMS' over-arching Triple Aim and position safety net providers for the emerging healthcare market where data, quality, and pay for performance foster competition among facilities and bend the health care cost curve.

In conjunction with the DSRIP Planning Protocol and the DSRIP Funding and Mechanics Protocol, this toolkit is to provide guidance surrounding both the requirements of the DSRIP Program and the completion of the hospital's DSRIP Plan.

B. *Description of DSRIP Planning Protocol*

The Department developed and submitted to CMS a DSRIP Planning Protocol approved by CMS on August 08, 2013. The DSRIP Planning Protocol is included as Attachment H of the Special Terms and Conditions (STCs) (as Amended) of the New Jersey Comprehensive Waiver ("Waiver"). The Planning Protocol, along with this toolkit:

- Outlines the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
- Specifies the Project Stages and for each Stage specifies a menu of activities, along with their associated actions and milestones, metrics, and minimum submission requirements
- Details the requirements of the Hospital DSRIP Plans
- Includes a Department process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by the STCs.

C. *Description of DSRIP Funding and Mechanics Protocol*

The Department developed and submitted to CMS a DSRIP Funding and Mechanics Protocol approved by CMS on August 08, 2013. The DSRIP Funding and Mechanics Protocol is included as Attachment I of the STCs of the Waiver. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Funding and Mechanics Protocol and this toolkit, using the format and process agreed upon by the Department and CMS. The Funding and Mechanics Protocol, along with this toolkit:

- Includes guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
- Provides minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provides that hospitals must include documentation of public input in their Hospital DSRIP Plans;

- Specifies a Department review process and criteria to evaluate each hospital's individual Hospital DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
- Specifies a process for obtaining CMS approval for a unique Focus Area that does not appear on the list included in this toolkit in Section III. Quality Projects or a unique project that falls under one of the prescribed focus areas but is not one of the 17 projects included in the project array;
- Allows sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
- Describes, and specifies the role and function, of a standardized, hospital-specific application to be submitted to the Department, and renewed on an annual basis for the utilization of DSRIP funds that outlines the hospital's DSRIP plan, as well as any databooks or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- Specifies that hospitals must submit periodic reports to the Department using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- Specifies a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the Department and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- Specifies an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5 and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
- Specifies that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- Includes a yearly application process that allows for potential hospital plan modification and an identification of circumstances under which a plan modification may be considered;

II. Calendar - Timelines

A. Timeline of DSRIP Events

The following events represent hospital, Department, and CMS timelines for the DSRIP Program. Unless otherwise specified, denoted dates throughout the document refer to calendar days and any specified date that falls on a weekend or holiday is due the prior business day.

DSRIP Activity	Timeline
Hospital DSRIP Plan review and approval steps	
Target approval date by CMS of the NJ DSRIP Planning Protocol submitted to CMS	TBD
Target approval date by CMS of the NJ DSRIP Funding and Mechanics Protocol submitted to CMS	TBD
Hospital DSRIP Plan must be submitted to New Jersey Department of Health (NJDOH) if project is a unique focus area or "off-menu" from pre-defined list	September 9, 2013
Hospital DSRIP Plan submitted to NJDOH	September 20, 2013
Department completes initial review of Hospital DSRIP Plan; submits questions in writing to hospital	Within 45 days
Hospital responds in writing to Department questions	By timeframe indicated, but no later than 15 days from Department notification
Department finalizes review and submits approved hospital DSRIP Plans to CMS	December 13, 2013
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans; CMS may conditionally approve a plan with a requirement to modify deficiencies	January 31, 2014
Hospital's DSRIP Plan re-submitted to NJDOH upon conditional approval by CMS	By timeframe indicated, but no later than 15 days from Department notification
Department completes review and submits revised Hospital DSRIP Plan to CMS	Within 30 days from CMS notification
Target approval/denial date by CMS of conditionally approved Hospital DSRIP Plans	March 17, 2014
Hospital DSRIP Plan due ONLY if that hospital meets the criteria for an Exceptional Circumstance	May 15, 2014
Department finalizes review and submits approved hospital DSRIP Plans that meet criteria for an Exceptional Circumstance to CMS	June 13, 2014
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans that meet criteria for an Exceptional Circumstance	August 29, 2014
Standardized reporting form and databook	
Toolkit is updated with the standardized reporting form and databook	November 15, 2013
Claims-based (i.e. MMIS) metric baseline results calculated and provided to hospitals	December 13, 2013
Hospital submits attestation of verification for claims-based measure results used in calculating the New Jersey Low Income baseline dataset	January 7, 2014
New Jersey Low Income Improvement Target Goals and Baseline Performance Thresholds established	January 31, 2014

B. Reporting Periods and Frequency

The following reporting periods shall be followed by the hospitals participating in the DSRIP Program.

Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
Quarterly Progress Report	Report Progress of Stage I, II, III, and IV Metrics by submitting all minimum submission requirements for each completed Stage I, II, III, and IV metric/milestone for the Demonstration Year in which the activity was completed.	April 30, 2014 (DY2) July 31, 2014 (DY3) October 31, 2014 (DY3) January 31, 2015 (DY3 April 30, 2015 (DY3) July 31, 2015 (DY4) October 31, 2015 (DY4) January 31, 2016 (DY4) April 30, 2016 (DY4) July 31, 2016 (DY5) October 31, 2016 (DY5) January 31, 2017 (DY5) April 30, 2017 (DY5)	• Progress Report submitted includes: o The progress of each process metric o Verification of Department calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports). o The progress of current activities, including whether the stage activity has been completed, is in progress, or has not been started o Documentation supporting the completion of milestones during the report period o The infrastructure developments made and outcomes of those developments o The project developments and outcomes as they relate to the pilot populations o How rapid-cycle evaluation was used for improvement o Summary of the hospital's stakeholder engagement and activities o Work accomplished with external partners o How the project tools and processes were modified based on the pilot testing results o A timeline of future activities o Budget and return on investment analysis
Application Renewal for Demonstration Year 3	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2014 (for DY3)	• Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include: o Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year o Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation

Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
			o For DY3 application, a description of the infrastructure expansions and the hospital's plan to begin utilizing them in Demonstration Year 3 o A timeline of future activities o Annual budget analysis that provides project budget estimation including line item expenditure information
Application Renewal for Demonstration Year 4	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2015 (for DY4)	• Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include: o Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year o Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation o For DY 4, a description of the project developments and outcomes as they relate to the pilot populations o For DY 4, a description of how the project tools and processes were modified based on the pilot testing results o A timeline of future activities • Annual budget analysis that provides project budget estimation including line item expenditure information
Application Renewal for Demonstration Year 5	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2016 (for DY5)	• Annual application renewal should be submitted to New Jersey DOH and include: o Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year o Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation o Any changes/modifications to the project's infrastructure is documented along with the rationale for making such changes o A timeline of future activities o Annual budget analysis that provides project budget estimation including line item expenditure information

III. Quality Projects

A. *Overview*

In this section there are 17 pre-defined projects identified by the New Jersey Department of Health as the projects from which a participating DSRIP hospital can base their DSRIP Plan. These projects fall into one of the following project focus areas determined by the Department as being significant to the health and welfare of the State of New Jersey.

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addictions/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia

Should a hospital deem another medical condition that does not fall under any of the above 8 focus areas unique to their hospital, or chooses to select a project within the eight conditions but is not one of the pre-defined projects (i.e. off-menu), the hospital may submit a DSRIP Plan under the application Focus Area labeled "Other." A hospital choosing to submit a DSRIP Plan under the Focus Area "Other" is advised that by doing so, the plan will be subject to higher scrutiny since the project has not been approved by both the Department and CMS. Required application elements for "Other" Focus Area or off-menu projects are discussed in more detail under section ***C. Project Elements*** below.

B. *Pre-defined Project Selection Process*

The pre-defined projects were developed based on project ideas submitted by the hospital industry, the U.S. Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange[1] project profiles, or a combination thereof.

AHRQ profiles describe successful evidence-based innovation activities. If a DSRIP project was developed based on an AHRQ profile, the profile link is footnoted on the project detail sheet along with its applicable Evidence Rating. As defined by AHRQ, the Evidence Rating is an assessment of the quality and strength of the evidence that the results described in the profile are due to the innovation and not to other factors. This information can be used to assist the hospital in selection and development of a project.

C. *Project Elements*

Each project detail sheet presents the project's title, defined objective, high level methodology, anticipated outcomes and clinical performance measures. This information must be included within the hospital's application submission. This will be *pre-populated* in the application based on the pre-defined project selected. The hospital is responsible

[1]Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange; http://www.innovations.ahrq.gov/index.aspx

for describing in further detail the manner and means by which the hospital will fulfill the project.

Hospitals may select an "off-menu" project related to the focus area selected, however, this project will need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review through the approval process. CMS approval will be required for all hospital unique focus areas and "off menu" projects. If the hospital chooses to select an "off-menu" project that is not one of the pre-defined projects, the hospital will be required to develop the project's defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The application contains descriptions for each field that the hospital must complete. Required application elements for "Other" Focus Area or off-menu projects are discussed in more detail in Section V of the Planning Protocol.

For each performance measure listed in Addendums 1 and 2, the Measure Steward is indicated. The Measure Steward is the entity that developed the performance measure and applicable measurement criteria. The calculation of the measure shall follow the technical specifications established by the Measure Steward. These technical specifications will be strictly followed, except for deviation as necessary based on patient population (e.g. Medicare vs New Jersey Low Income) and as approved by the Department and CMS. Each Stage 3 performance measure indicates whether it is tied to pay for performance (P4P).

Measurement specification instructions will be included in the Planning Protocol, Attachment 1: Toolkit. The Toolkit will be updated no later than November 15, 2013 with the standardized reporting form and databook. The databook will include measure reporting periods, baseline periods and will denote any modifications to the Measure Steward's technical specifications in order to comply with the New Jersey Low Income attribution model.

D. Pre-Defined Quality Projects

The pre-defined quality projects, from which the hospitals may choose, are included on the following pages.

Condition	**Asthma**
Project Count	**1**
Project Title	Hospital-Based Educators Teach Optimal Asthma Care[2]

Project Objective

Hospital-Based Asthma Educators provide education to patients, providers, and community members on optimum asthma care resulting in a decrease in inpatient admissions and Emergency Department visits.

Project Methodology

Develop a program where hospital-based certified asthma educators may perform any of the following:

- Internal training of hospital staff on up-to-date asthma care including new medications and/or guidelines; educators also participate in grand rounds and provide copies of literature (i.e. Heart, Lung and Blood Institute clinical guidelines or other evidence-based literature) for the treatment of asthma in the Emergency Department and inpatient care settings.
- Training of Primary Care Practices on up-to-date asthma care including new medications and/or guidelines. Staff also provides practices with various tools to assist clinicians with the management of asthma patients such as: clinical guidelines, patient questionnaires, triage questions, new asthma encounter forms, patient flow models, follow-up encounter forms, and/or a template for review of the chart, including billing and coding.
- Education sessions with staff in childcare centers.
- Work with nurses within the school system(s) to provide education on up-to-date asthma care and champion use of asthma action management and school plans.
- Provide pharmacists with a web-based form they can use to alert physicians when a patient is frequently refilling a quick-relief asthma medication or has failed to refill an asthma controller medication.
- Face-to-face meetings with individuals with asthma and their families to provide self-management instructions Educator also contacts patient or parent/guardian for minors XX month(s) after the initial session to check on the patient's status and assess further educational needs.
- Work with patient to ensure he or she has access to medications.

Project Outcomes

1. Reduce admissions
2. Reduce emergency department visits
3. Improve medication management
4. Increase patient satisfaction

Project Specific Metrics	**P4P**	**Measure Steward**
1. *CAC-1: Relievers for Inpatient Asthma*: Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.	No	Joint Commission
2. *CAC-2 systemic corticosteroids for Inpatient Asthma*: Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.	No	Joint Commission
3. *Use of Appropriate Medications for People with Asthma:* The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	No	NCQA
4. *Medication Management for People with Asthma:* The percentage members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the	P4P	NCQA

[2] *Based on a project study found on the (AHRQ) website: http://www.innovations.ahrq.gov/content.aspx?id=2476*

Condition	**Asthma**		
Project Count	**1**		
Project Title	Hospital-Based Educators Teach Optimal Asthma Care[2]		
	treatment period. *The percentage of members who remained on an asthma controller medication for at least **75%** of their treatment period.*		
	5. The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
	6. CMS Core Adult measure PQI-15 (Asthma admission rate)	P4P	AHRQ
	7. *Adult Asthma Admission Rate:* This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

Agency for Healthcare Research and Quality (AHRQ) Evidence Rating: Moderate *- The evidence consists of pre- and post-implementation comparisons of key asthma outcomes, including medication compliance, asthma-related ED visits and hospitalizations, and workplace absenteeism, along with post-implementation patient survey results.*

Condition	**Asthma**
Project Count	**2**
Project Title	Pediatric Asthma Case Management and Home Evaluations[3]

Project Objective

To implement Case Management and Home Evaluations in an effort to reduce admissions, Emergency Department visits and missed school days related to Asthma

Project Methodology

Hospital develops (utilizes national asthma guidelines) asthma education program. Hospital electronic data system identifies children who had an inpatient admission or emergency department visit for asthma or asthma-related symptoms and generates a list. This list is sent to a Nurse Case Manager or Asthma Educator who may perform any the following services:

- Complete a patient needs assessment using a standardized questionnaire (may be performed while patient is inpatient or at home)
- Perform allergy testing if deemed appropriate by the physician
- Conduct Home visits which may include:
  - Asthma medication education
  - Development of a asthma action plan (includes information regarding symptoms and appropriate treatment for symptoms)
  - Assessment of environmental triggers
  - Removal of environmental triggers as appropriate (e.g. extermination services)
  - Providing equipment (e.g. garbage can with lids, air conditioning units, vacuum cleaners) and supplies (cleaning supplies etc.)
  - Education on available community resources and specialty care services
- Communication with primary care physicians on patient care and referrals as needed
- Perform educational workshops at various locations within the community
- Advocacy for public policy asthma care issues

Hospital may consider having a number of parents of children who have participated in the program participate on a board to offer input on the program and plan community forums.

Project Outcomes

1. Reduce admissions
2. Reduce emergency department visits
3. Improve medication management
4. Reduce missed school days
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *CAC-1: Relievers for Inpatient Asthma*: Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.	No	The Joint Commission
2. *CAC-2 systemic corticosteroids for Inpatient Asthma*: Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.	No	The Joint Commission
3. *Use of Appropriate Medications for People with Asthma:* The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	No	NCQA
4. *Medication Management for People with Asthma:* The percentage of members (patients) 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they	P4P	NCQA

[3] *Based on a project study performed in an urban setting found on the AHRQ website: http://www.innovations.ahrq.gov/content.aspx?id=3220*

Condition	**Asthma**		
Project Count	**2**		
Project Title	Pediatric Asthma Case Management and Home Evaluations[3]		
	remained on during the treatment period. *The percentage of members who remained on an asthma controller medication for at least **75%** of their treatment period.*		
5.	The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6.	The percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	P4P	HRSA
7.	*Adult Asthma Admission Rate:* This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

AHRQ Evidence Rating: Moderate *- The evidence consists primarily of pre- and post-implementation comparisons of key outcomes measures, including asthma-related hospitalizations, ED visits, physical activity limitations, and missed school and parent work days, along with estimates of associated cost savings and the return on investment to all stakeholders.*

Condition	**Behavioral Health**
Project Count	**3**
Project Title	Integrated Health Home for the Seriously Mentally Ill (SMI)[4]

Project Objective

To fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

Project Methodology

- Ensure that each SMI-diagnosed patient has an ongoing relationship with a Medical and Psychiatric Licensed Independent Practitioner (LIP) in a co-located facility.
- Ensure coordination and access to chronic disease management, including self-management support to those SMI individuals and their families.
- Ensure the development of a single Treatment Plan that includes the member's behavioral health issues, medical issues, substance abuse and social needs. This includes incorporating traditional medical interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching.
- Ensure that the Plan is maintained in one ambulatory Electronic Health Record (EHR) to ensure that information is shared across the treatment team and continuum of care spectrum.
- Ensure that the treatment outcomes are evaluated and monitored for quality and safety for each patient.

Project Outcomes

1. Reduce readmissions
2. Reduce emergency department visits
3. Improve patient adherence to their treatment regimen
4. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Follow-up After Hospitalization for Mental Illness **30 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	No	NCQA
2. *Antidepressant Medication Management – Effective **Continuation Phase** Treatment:* The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	No	NCQA
3. Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	No	NCQA
4. *Major Depressive Disorder (MDD)*: Suicide Risk Assessment	No	AMA-PCPI
5. *Mental Health Utilization:* The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED.	No	NCQA
6. *Follow-up After Hospitalization for Mental Illness **7 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P	NCQA
7. *Antidepressant Medication Management – Effective **Acute Phase** Treatment:* The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who	P4P	NCQA

[4] *Based on a project submitted by a New Jersey hospital.*

Condition	**Behavioral Health**		
Project Count	**3**		
Project Title	Integrated Health Home for the Seriously Mentally Ill (SMI)[4]		
	remained on an antidepressant medication treatment.		
8.	*Bipolar Disorder and Major Depression*: Appraisal for alcohol or chemical substance use.	P4P	CQAIMH
9.	*Depression Remission at 12 Months*: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.	P4P	Minnesota Community Measurement

Condition	**Behavioral Health**
Project Count	**4**
Project Title	Day Program and School Support Expansion[5]

Project Objective

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting.

This pilot program has two primary objectives. The first is to provide space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. The second is to expand the relationships and linkages between the behavioral health provider and the school district to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses.

Project Methodology

Children aged 6 through 19 years of age who have been suspended from classrooms due to severe behavioral health issues (i.e. violence, uncontrolled anger, inability to work in the school environment) will receive therapy through an expanded day program. All patients receive evidence-based therapeutic care and grade-appropriate education instruction. Children eligible for full-day sessions with progression to step down to half-day sessions (half-day attendance at the school) will receive care at the health center.

This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to school.
Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Lesson plans are per the school district, therapeutic intervention is per established evidence-based practice. The school district provides staff for instruction. Children return to school on the recommendation of the behavioral health staff and in consultation with school staff.

In addition to enhancement of support for the individual student, the program will increase support mechanisms with the school district. This will ensure, at a minimum that the school personnel have effective referral, communication and education linkages available to assist them with supporting their students with behavioral health diagnoses in the school setting.

Project Outcomes

1. Reduce readmissions
2. Improve patient adherence to their treatment regimen
3. Improve care processes
4. Improve school education regarding behavioral health programming and referral processes
5. Lengthen the uninterrupted student tenure within the school setting

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Follow-up After Hospitalization for Mental Illness **30 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	No	NCQA
2. *Mental Health Utilization:* The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED	No	NCQA
3. *Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment:* Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	No	AMA-PCPI

[5] *Based on a project submitted by a New Jersey hospital.*

Condition	**Behavioral Health**		
Project Count	**4**		
Project Title	Day Program and School Support Expansion[5]		
4.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:* The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	No	NCQA
5.	*Follow-up After Hospitalization for Mental Illness **7 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P	NCQA
6.	*Screening for Clinical Depression and Follow-up Plan*: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	P4P	CMS
7.	*Follow-Up Care for Children Prescribed ADHD Medication (ADD):* The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P	NCQA
8.	*Adolescent Well-Care Visit*: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No	NCQA

Condition	**Behavioral Health**
Project Count	**5**
Project Title	Electronic Self-Assessment Decision Support Tool[6]

Project Objective

Implement an electronic self-assessment decision support tool that patients complete prior to visits with outpatient mental health providers in order to improve mental health consultations and treatment including efficiency and effectiveness of treatment planning, adherence and communication between the patient and the provider.

Project Methodology

Create, or implement an off-the-shelf decision support tool that a client completes immediately prior to their outpatient mental health visit. This tool would be available and utilized at the practitioner's office (via a private computer terminal, I-pad, etc.).

This tool should have the ability to generate a consultation report that both the clinician and the client may immediately refer to during the office visit. The electronic tool must allow the patient to report on their symptoms and functioning, medication compliance, concerns related to psychiatric medicine side-effects, eating, sleeping and social support network. The tool should immediately graph and trend the key indicators allowing the clinician to quickly determine areas of concern that must be addressed during the visit. This tool should allow the client to list and rate the relative importance of the benefits and drawbacks of recommended treatment regimens, recommend solutions to offset the drawbacks, and provide educational resources for the client to access.

This survey allows the communication between the client and clinician to be focused as well as improve discussions around treatment plan options and efficacy. This shared decision-making allows the client to more fully engage in treatment planning, identifying both non-pharmacological strategies and medication therapies to improve patient wellness. This can improve adherence due to the patient's stronger sense of engagement, control and responsibility to the treatment regimen. Because the survey is completed at each visit, the tool helps clients monitor their recovery. At subsequent visits, clients and clinicians can use the tool to track trends in symptoms and links between symptoms and medication use.

Project Outcomes

1. Reduce readmissions
2. Improve patient-provider communication
3. Increase shared decision-making
4. Improve patient adherence to their treatment regimen
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Follow-up After Hospitalization for Mental Illness **30 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	No	NCQA
2. *Bipolar Disorder and Major Depression*: Appraisal for alcohol or chemical substance use	No	CQAIMH
3. *Screening for Clinical Depression and Follow-up Plan*: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	No	CMS
4. *Mental Health Utilization:* The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED	No	NCQA
5. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:* The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the	No	NCQA

[6] *Based on a project study found on the AHRQ website: http://www.innovations.ahrq.gov/content.aspx?id=2870*

Condition	**Behavioral Health**	
Project Count	**5**	
Project Title	Electronic Self-Assessment Decision Support Tool[6]	
measurement year: • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.		
6. *Adult BMI Assessment:* This measure is used to assess the percentage of members 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	No	NCQA
7. *Adolescent Well-Care Visit*: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No	NCQA
8. *Follow-up After Hospitalization for Mental Illness **7 days** post discharge:* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P	NCQA
9. *Depression Remission at 12 Months:* Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.	P4P	Minnesota Community Measurement
10. *Follow-Up Care for Children Prescribed ADHD Medication (ADD):* The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P	NCQA
11. *Antidepressant Medication Management – Effective **Acute Phase** Treatment:* The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	P4P	NCQA

AHRQ Evidence Rating: Suggestive *- The evidence consists of post-implementation analysis of use of the program and the shared decision-making approach (including analysis of 98 audiotaped transcripts from clinic visits), feedback from clinician and client focus groups on the efficiency and effectiveness of consultations, and the results from client surveys exploring various aspects of their satisfaction with the program.*

Condition	**Cardiac Care**
Project Count	**6**
Project Title	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions [7,8]

Project Objective

To create an evidence–based Care Transitions Intervention Model for cardiac care. This includes the development and support of the use of hospital Patient Navigators to assist in accessing prevention and follow-up treatment for patients experiencing chronic cardiac illness.

Project Methodology

The hospital will implement an evidence–based Care Transitions Intervention Model for cardiac care, such as the model developed by Dr. Eric A Coleman, MD, MPH, Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences, aimed at improving quality and safety during times of care "hand-offs".
The model will focus on patient education before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications and their uses, as well as red-flag indications in their condition and how to respond.

The model is composed of the following components:

- A patient-centered health record that may include productive interdisciplinary communication during the care transition.
- A discharge preparation checklist of critical activities

A patient self-activation and management session with a hospital-based cardiac care coach or navigator. This session is designed to help patients and their caregivers understand their role in managing the transition. The coach will follow-up with visits in the Skilled Nursing Facility (SNF) and/or in the home and accompanying phone calls designed to provide continuity across the transition.
The hospital-based cardiac care coach will:

- Provide linkage to services.
- Provide innovative outreach to public and private sectors to effectively link discharged hospital patients to educational and clinical services for ongoing prevention and treatment.
- Will collaborate with inpatient Social Workers and Nurse Case Managers to coordinate the proposed discharge planning with the outpatient service, public or private, and/or agency needed to ensure positive outcome after discharge.

Project Outcomes

1. Reduce readmissions
2. Reduce admissions
3. Increase patient satisfaction
4. Improve medication management
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):* Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).	No	AMA-PCPI
2. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age	No	NCQA

[7] *As submitted by a New Jersey Hospital **m**odeled by: http://innovativecaremodels.com/care_models/12/leaders Eric A. Coleman, MD, MPH, is Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences Center. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care "hand-offs". As a board-certified geriatrician, Dr. Coleman maintains direct patient care responsibility for older adults in ambulatory, acute, and subacute care settings.*

[8] *Based on a project submitted by a New Jersey hospital.*

Condition	**Cardiac Care**
Project Count	**6**
Project Title	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions [7,8]

	who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		
3.	*Post-Discharge Appointment for Heart Failure Patients:* Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).	No	AMA-PCPI
4.	*Medication Reconciliation:* Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	No	NCQA
5.	*Care Transition Measure (CTM-3): Care Transition Measure- CTM-3:* 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P	University of Colorado Health Sciences Center
6.	*30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:* The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
7.	*30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:* The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
8.	*Heart Failure Admission Rate:* Percent of county population with an admission for heart failure.	P4P	AHRQ
9.	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	P4P	AMA-PCPI

Condition	**Cardiac Care**
Project Count	**7**
Project Title	Extensive Patient CHF-Focused Multi-Therapeutic Model[9]

Project Objective

To decrease the number of readmissions for patients with Congestive Heart Failure.

Project Methodology

The hospital will develop an extensive patient Congestive Heart Failure focused multi-therapeutic medical home.

The patients will be identified at the point of admission through a newly designed system that captures the patients who present to the hospital with acute CHF. The program begins immediately by the initiation of a focused assessment by inpatient and outpatient Nurse Practitioners. Inpatient and Outpatient Nurse Practitioners will be specifically recruited to allow for an extensive patient congestive heart failure-focused multi-therapeutic approach. The program may include:

- Education and introduction to the outpatient program involving caregivers, family, and primary physicians.
- Prior to discharge, there will be a careful reconciliation of all medications for adherence and appropriateness.
- An immediate discharge follow-up at the free clinic will be scheduled prior to discharge. The clinic will provide referrals to a cardiologist, as needed.
- Home visits by dedicated outpatient Nurse Practitioners that begin on discharge day-one and coordination with the primary physician through the early identification and education about the program benefits amongst the community physician.
- A nurse practitioner and physician contract involving continuous communication for each targeted program participant.

Project Outcomes

1. Reduce readmissions
2. Reduce admissions
3. Increase patient satisfaction
4. Improve medication management
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Left Ventricular Ejection Fraction (LVEF) Assessment:* Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, OR documentation in the hospital record that LVEF assessment is planned for after discharge.	No	AMA-PCPI
2. *Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):* Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).	No	AMA-PCPI
3. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.	No	NCQA
4. *Post-Discharge Appointment for Heart Failure Patients:* Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).	No	AMA-PCPI
5. *Medication Reconciliation:* Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by	No	NCQA

[9] *Based on a project submitted by a New Jersey hospital.*

Condition	**Cardiac Care**		
Project Count	**7**		
Project Title	Extensive Patient CHF-Focused Multi-Therapeutic Model[9]		
	the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.		
6.	*Care Transition Measure (CTM-3): Care Transition Measure- CTM-3:* 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P	University of Colorado Health Sciences Center
7.	*30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:* The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
8.	*30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:* The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
9.	*Heart Failure Admission Rate:* Percent of county population with an admission for heart failure.	P4P	AHRQ

Condition	**Cardiac Care**
Project Count	**8**
Project Title	The Congestive Heart Failure Transition Program (CHF-TP)[10,11]

Project Objective

The hospital will develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Project Methodology

The Congestive Heart Failure Transition Program (CHF-TP) will incorporate a number of components to ensure a safe transition to home or another health care setting. Key elements of the program include, but are not limited to:

- Enhanced admission assessment
- Enhanced discharge planning through inpatient education and caregiver communication process
- Early and ongoing assessment of a patient's medical and educational needs
- Providing patient/family friendly handoff communication tools that may include written instructions and a Congestive Heart Failure-TP (CHF) teaching booklet
- An established medical home through the development of an outpatient Congestive Heart Failure Transition Program (CHF-TP) with a patient-centered multi-disciplinary team
- Follow-up appointments in the outpatient CHF-TP clinic are scheduled prior to discharge
- Patients will be invited to attend a class held XX per month
- Patients will be provided a scale and calendar and taught the appropriate methods for logging their weight as well as other information to help patients maintain awareness of critical self-management issues.

Project Outcomes

1. Reduce readmissions
2. Reduce admissions
3. Increase patient satisfaction
4. Improve medication management
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Left Ventricular Ejection Fraction (LVEF) Assessment:* Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, **OR** documentation in the hospital record that LVEF assessment is planned for after discharge.	No	AMA-PCPI
2. *Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):* Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).	No	AMA-PCPI
3. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.	No	NCQA
4. *Post-Discharge Appointment for Heart Failure Patients:* Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).	No	AMA-PCPI

[10] *Based on a project submitted by a New Jersey hospital.*

[11] *Based on a project study found on the AHRQ website* http://www.innovations.ahrq.gov/content.aspx?id=2206

Condition	**Cardiac Care**		
Project Count	**8**		
Project Title	The Congestive Heart Failure Transition Program (CHF-TP)[10,11]		
5.	*Medication Reconciliation:* Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	No	NCQA
6.	*Care Transition Measure (CTM-3): Care Transition Measure- CTM-3:* 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P	University of Colorado Health Sciences Center
7.	*30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:* The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
8.	*30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:* The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
9.	*Heart Failure Admission Rate:* Percent of county population with an admission for heart failure.	P4P	AHRQ

AHRQ Evidence Rating: Moderate *- The evidence consists of a before-and-after comparison of heart failure readmission rate within 30 days.*

Condition	**Chemical Addiction/Substance Abuse**
Project Count	**9**
Project Title	Hospital–Wide Screening for Substance Use Disorder[12]

Project Objective

Hospital wide-screening tools to assess the severity of substance use disorder, detect for withdrawal for inpatient admissions and identification of level of treatment needed. Hospital may provide any of the following services:

- Brief intervention to focus on increasing the patient's knowledge about substance use and motivation toward behavioral change.
- Algorithm-based treatment included in order sets for withdrawal, if required.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care

Project Methodology

Hospital workgroup would need to be established to determine screening tools, interventions, and algorithms to be included in the order sets to achieve hospital-wide screening for substance abuse disorder. Workgroup to educate clinicians on tools and algorithms.

Program may include the following elements:

- Upon inpatient admission, the nurse administers a validated risk assessment tool for substance use disorder. If the screening is positive, the nurse asks the patient additional questions and performs an assessment for withdrawal symptoms; if screening is positive the physician is notified.
- The physician may initiate either a precaution or treatment algorithm.
  - The Precaution algorithm directs nurses to continue to assess for withdrawal symptoms and if the patient's score changes to be greater than a pre-determined threshold, then the nurse initiates the treatment algorithm.
  - The Treatment Algorithm specifies medication to be administered and continued assessment of patient's response to medication for possible medication adjustments. The nurse also monitors vital signs and performs other assessments as ordered in the algorithm.
- Brief intervention will be performed to assess the patient's awareness about their substance use and willingness to change these behaviors.
- Nurses are to notify the physician if specified issues with the patient arise.
- Prior to discharge, patients are referred to participate in more extensive treatment with access to specialty care.

Project Outcomes

1. Decrease length of stay
2. Decrease use of restraints
3. Decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU)
4. Increased referral/ admissions to substance abuse treatment programs/ facilities
5. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use.	No	Joint Commission
2. Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period.	No	AMA-PCPI
3. *Initiation of alcohol and other drug treatment*: Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.	P4P	NCQA
4. *Engagement of alcohol and other drug treatment :* The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD	P4P	NCQA

[11] *Based on a project study found on the AHRQ website:* http://www.innovations.ahrq.gov/content.aspx?id=3164

Condition	**Chemical Addiction/Substance Abuse**		
Project Count	**9**		
Project Title	Hospital–Wide Screening for Substance Use Disorder[12]		
diagnosis within 30 days after the date of the Initiation encounter (inclusive).			

AHRQ Evidence Rating: Moderate *- The evidence consists of pre- and post-implementation comparisons of key outcome measures, including the percentage of patients diagnosed with alcohol withdrawal, the percentage of patients with alcohol withdrawal developing delirium tremens, length of stay, restraint use, and intensive care unit transfers of patients with delirium tremens.*

Condition	**Chemical Addiction/ Substance Abuse**
Project Count	**10**
Project Title	Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients[13]

Project Objective

Offer alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.

Project Methodology

- An ED nurse conducts an initial examination of all patients who present to the ED with acute alcohol intoxication, assessing his or her intoxication level and performing a preliminary health evaluation.

- If the patient has any acute health issues aside from alcohol intoxication (e.g., open wounds, broken bones, breathing difficulties), ED staff deliver all necessary medical care. If the nurse concludes that the patient does not have any acute health issues, the next available physician examines the patient to verify that he or she is medically stable. If so, a nurse calls staff at the Residential Treatment Facility to let them know that a medically stable, intoxicated patient has come to the ED.

- The Residential Treatment Facility sends a staff member who has successfully completed treatment for alcoholism to the ED in a transport van. Upon arrival, the representative introduces himself or herself to the patient, describes the programs available at the Residential Treatment Facility (which include an overnight shelter, a detoxification program lasting several weeks, and an X- month residential treatment program), and offers to transport the patient to the center. Their past experience with alcoholism helps them to develop a rapport with the patient. Patients, who agree to be transferred, are discharged from the ED to the treatment facility. The residential treatment facility staff member drives them to the facility, where they receive support and treatment in a safe environment. Patients who decline transfer to the residential treatment facility stay in the ED until their blood alcohol level reaches the legal limit and ED staff determines they have another safe environment to which they can return.

Project Outcomes

1. Lower emergency department length of stay for intoxicated patients
2. Increased referral/ admissions to substance abuse treatment programs/ facilities
3. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period.	No	AMA-PCPI
2. *Screening for Clinical Depression and Follow-up Plan*: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	No	CMS
3. *Initiation of alcohol and other drug treatment*: Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.	P4P	NCQA
4. *Engagement of alcohol and other drug treatment :* The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	P4P	NCQA

[13] *Based on a project study found on the AHRQ website:* http://www.innovations.ahrq.gov/content.aspx?id=3250&tab=1

AHRQ Evidence Rating: Moderate *- The evidence consists of pre- and post-implementation comparisons of emergency department length of stay for acutely intoxicated patients, along with estimates of cost savings due to this reduced length of stay and post-implementation anecdotal reports from The Healing Place staff.*

Condition	**Diabetes**
Project Count	**11**
Project Title	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension[14]

Project Objective

The objective for this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

Project Methodology

Develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension. Patients will be entered into the program via the ambulatory care department, emergency department, inpatient services, same day service locations and community health screenings conducted by hospital staff.

The program may include:

- Utilizing multi-therapeutic outpatient evidence based management,
- Lifestyle modification,
- Nutritional consultation,
- Intensive hospital discharge planning,
- A dedicated patient navigation system,
- Improve social services

Project Outcomes

1. Reduce admissions
2. Reduce emergency department visits
3. Improve care processes
4. Increase patient satisfaction

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Lipid Management*: Percentage of patients who received at least one lipid profile (or ALL component tests).	No	AMA-PCPI
2. *Foot Examination:* Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).	No	AMA-PCPI
3. *Eye Examination:* Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.	No	AMA-PCPI
4. *Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing:* The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	No	NCQA
5. *Uncontrolled Diabetes Admission Rate (PQI 14):* The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ
6. *Diabetes Short-Term Complications Admission Rate (PQI 1):* The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	P4P	AHRQ
7. *Hypertension Admission Rate:* All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypertension (see below).	P4P	AHRQ
8. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.	P4P	NCQA
9. *Diabetes Long-Term Complications Admission Rate (PQI 3):* The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ

[14] *Based on a project submitted by a New Jersey hospital.*

Condition	**Diabetes**
Project Count	**12**
Project Title	Diabetes Group Visits for Patients and Community Education[15]

Project Objective

The objective for this project is twofold, first, to ensure that all newly diagnosed diabetics have a clear understanding of their plan of care and are knowledgeable regarding expected outcomes and disease management. Secondarily, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

Project Methodology

- Develop a diabetic education model that serves to education patients as well as to facilitate endocrinologists educating Primary Care Physicians (PCPs) and other medical staff on best-practice guidelines in Diabetes care, and move towards an innovative model of inter-professional learning in undergraduate and graduate medical education.

- Enroll patients to participate in a new group visit model for managing chronic disease. Patients will be enrolled in group visits; sessions of xx minutes each, whereby a primary care physician along with medical specialists that could include an endocrinologist, medical students, residents, fellows, RN, LPN, psychologist, and nurse practitioner provide a 'focused care model that is patient-centered, evidenced-based, and enables peer-to-peer empowerment and education.'

- Group visit patients receive not only medical therapy during the sessions, but also screening for depression and individual counseling services.

Project Outcomes

1. Reduce admissions
2. Reduce emergency department visits
3. Improve care processes
4. Increase patient satisfaction

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Lipid Management*: Percentage of patients who received at least one lipid profile (or ALL component tests).	No	AMA-PCPI
2. *Foot Examination:* Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).	No	AMA-PCPI
3. *Eye Examination*: Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.	No	AMA-PCPI
4. *Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing:* The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	No	NCQA
5. *Hemoglobin A1c Testing for Pediatric Patients:* Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.	No	NCQA
6. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.	P4P	NCQA
7. *Diabetes Short-Term Complications Admission Rate (PQI 1):* The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	P4P	AHRQ
8. *Uncontrolled Diabetes Admission Rate (PQI 14):* The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ

[15] *Based on a project submitted by a New Jersey hospital.*

Condition	**Diabetes**	
Project Count	**12**	
Project Title	Diabetes Group Visits for Patients and Community Education[15]	
9. *Diabetes Long-Term Complications Admission Rate (PQI 3):* The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ

Condition	**Diabetes**
Project Count	**13**
Project Title	Develop Intensive Case Management for Medically Complex High Cost Patients[16]

Project Objective

Implement a comprehensive, intensive case management and care coordination program for the most costly (top 1 percent), medically complex patients who lack insurance.

Project Methodology

- Key elements of the program include identification of the target population. To qualify for inclusion in the program, a patient must have a diagnosis of diabetes and be among the costliest X percent of inpatient admissions and emergency department patients. (Exclusions to the target could include patients admitted with a primary diagnosis of trauma or those who live outside of the hospital's treating area, both may indicate a one-time treatment event rather than an ongoing cost).

- The identified population is made available to the program for contact. This may be via letter or phone contact which will include a description of the program and an invitation to participate.

- Each participant is assigned to a care team that includes a physician/medical director (who serves as team leader), pharmacist, shepherd/case manager, social worker, and behavioral health specialist. Each patient also has a primary care physician. The team serves as a support for the primary care physician, providing intensive case management and often taking the lead in managing the patient's care and appointments. Each patient meets with the entire team for an initial assessment to identify and prioritize needs, define health and life goals, and outline next steps. The team also uses the meeting to begin scheduling any necessary medical appointments with the patient's primary care physician or appropriate specialists. The team will provide each patient with ongoing case management and care coordination services. The frequency with which a patient receives services is determined by the patient's individual health needs and may include assistance with any of the following areas: financial, medication, counseling, appointment scheduling, and community resources.

- At defined intervals, the program participants who have not been in contact with the team will be contacted, verifying their health status and determining whether they need ongoing services and thus should remain in the program.

Project Outcomes

1. Reduce admissions
2. Reduce emergency department visits
3. Improve care processes
4. Increase patient satisfaction

Project Specific Metrics	**P4P**	**Measure Steward**
1. *Lipid Management:* Percentage of patients who received at least one lipid profile (or ALL component tests).	No	AMA-PCPI
2. *Foot Examination:* Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).	No	AMA-PCPI
3. *Eye Examination*: Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.	No	AMA-PCPI
4. *Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing:* The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	No	NCQA
5. *Hemoglobin A1c Testing for Pediatric Patients:* Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.	No	NCQA
6. *Controlling High Blood Pressure:* The percentage of members 18 to 85 years of age	P4P	NCQA

[16] *Based on a project study found on the AHRQ website: http://www.innovations.ahrq.gov/content.aspx?id=2675*

Condition	**Diabetes**		
Project Count	**13**		
Project Title	Develop Intensive Case Management for Medically Complex High Cost Patients[16]		
	who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		
7.	*Diabetes Short-Term Complications Admission Rate*: The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	P4P	AHRQ
8.	*Uncontrolled Diabetes Admission Rate (PQI 14):* The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ
9.	*Diabetes Long-Term Complications Admission Rate (PQI 3):* The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ

AHRQ Evidence Rating: Moderate *- The evidence consists of pre- and post-implementation comparisons of inpatient admissions and emergency department (ED) visits, along with anecdotal feedback from program participants.*

Condition	**HIV/ AIDS**
Project Count	**14**
Project Title	Patient Centered Medical Home for Patients with HIV/AIDS[17,18]

Project Objective

Improve the overall quality of care for patients who have been diagnosed with HIV through the development and implementation of a patient centered medical home.

Project Methodology

Develop and implement a patient centered medical home for patient with HIV by utilizing interdisciplinary outpatient management, intensive hospital discharge planning and dedicated patient navigation and social services. Services may include: screening and education regarding high risk sexual behaviors and injection drug use; Screening and treatment for Tuberculosis (TB) and Depression; Assessment of need for Hepatitis B and Hepatitis C vaccinations.
Specifically, plan may including the following services:

- Develop a multi-therapeutic support model whereby community-based PCPs working in different health centers receive support in the ongoing management and treatment of HIV-positive patients.

- Depending on doctor needs and patient circumstances, support includes:
  - Case discussions between PCP and a specialist physician,
  - Patient visits to the specialist, and/or
  - Patient visits to members of a dedicated multi-therapeutic HIV team

- PCPs also receive regular reminders and updates from a center-based clinical champion.

- Support from a physician specializing in HIV care: Physicians and residents will work at community-based internal and family medicine practices and receive ongoing support from a physician specializing in HIV care with training in internal or family medicine. Available support includes as-needed case discussions and direct specialist-patient contact, as outlined below:
  - As needed, PCP's hold case discussions with specialists. While they can ask for a consultation at any time, protocols specify that consultations be held whenever the PCP is considering a change to the HIV treatment regimen. Consultations may occur in person at larger centers (which have a physician specializing in HIV care onsite), often as part of weekly meetings with PCPs and residents. At the smaller sites, consultations and case discussions may generally occur via e-mail or phone, with communication facilitated through an electronic health record (EHR). Once every few months, the lead physician specializing in HIV care should visit the smaller sites to hold case discussions, often with members of the multidisciplinary team (see bullet below for more details on this team).
  - As the PCP sees fit, patients can have direct visits with a specialist. If no specialist works regularly in the health center, a visit with a specialist should be arranged at the center for a scheduled time. Following the visit, the specialist briefs the PCP on his or her findings and recommendations.

- Access to traveling multidisciplinary team: A multidisciplinary team dedicated to HIV care travels to the centers according to a set schedule, with the larger centers hosting the team up to several days a week and the smaller centers hosting team members less frequently (weekly, biweekly, or monthly) depending on the volume of HIV patients. Led by a medical director, the team includes a psychiatrist, psychologist, clinical consultation pharmacist, nutritionist, treatment educator, and several patient navigators, all with expertise in HIV care. PCPs coordinate team services and set up appointments for their patients with one or more team members based on the visit schedule. If a patient needs team services before the next scheduled visit, the doctor notifies relevant team members via email about the need to set up a separate appointment.

Clinic-based champion to support colleagues: At each participating clinic, a clinical champion (usually a physician, but

[16] *Based on a project study found on the AHRQ website:* http://www.innovations.ahrq.gov/content.aspx?id=3296&tab=1
[17] *Based on a project submitted by a New Jersey hospital.*

Condition	**HIV/ AIDS**
Project Count	**14**
Project Title	Patient Centered Medical Home for Patients with HIV/AIDS[17,18]

could be a nurse practitioner) keeps up with the latest HIV treatment information and disseminates it to colleagues. The Champion also reminds physicians to consult with experts as necessary, particularly if their patients' viral loads do not react as expected after initiation (or change in) treatment.

Project Outcomes

1. Reduce readmissions
2. Improve patient adherence to their treatment regimen
3. Improve care processes
4. Increase patient satisfaction

Project Specific Metrics	**P4P**	**Measure Steward**
1. *CD4 T-Cell Count:* Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.	No	HRSA-HAB
2. *HARRT:* Percentage of clients with AIDS who are prescribed HAART	No	HRSA-HAB
3. *Hepatitis C Screening*: Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom Hepatitis C screening was performed at least once since the diagnosis of HIV infection, or for whom there is documented immunity.	No	AMA-PCPI
4. *Gap in HIV Visits*: Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	P4P	HRSA-HAB
5. *Medical Case Management:* Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year.	P4P	HRSA-HAB
6. *HIV viral load suppression:* Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	P4P	HRSA-HAB
7. *PCP Prophylaxis*: Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	P4P	NCQA

AHRQ Evidence Rating: Moderate *- The evidence consists of a retrospective, nonrandomized cohort study that compared key treatment outcomes and disease progression at initiation of treatment in 423 HIV-positive patients seen in participating primary care clinics to 431 similar patients treated in a hospital-based specialty clinic.*

Condition	**Obesity**
Project Count	**15**
Project Title	After-School Obesity Program[19]

Project Objective

Develop community partnership to create a school-based wellness program for overweight children between the ages of X yrs to X yrs old that provide education, exercise, medical assistance and support.

Project Methodology

To implement this program, the hospital must determine the number of weeks the program will run and the number of **X** days after school per week. The target population for this program is school age children ages **X-X** years of age with a BMI of **X** percentile.

Development and maintenance of the program may include the following:

- Determination of staffing needs which may include, but may not be limited to physicians, dietitian(s) and exercise physiologist(s).
- Determination of pre-program assessment participants must complete (i.e. physical, cholesterol and lipid screening, hypertension screening).
- Development of education materials.
- Assessment of technology needs and if/how technology will be utilized.
- Monitoring attendance, compliance and BMI of participants.
- Develop a survey for the patient/guardian on identifying overweight children and caring for them. Survey parent/guardian using a pre- and post-education assessment.
- Maintain a current referral management system for referrals to access care options (physicians, social worker, pharmacists, counselors, etc.).
- Supply equipment such as daily logs and exercise equipment (water bottles, jump ropes, balls, pedometers, etc.).
- Educate school administrators, teachers, students, parents and/or guardians.

Project Outcomes

1. Reduce patient body mass index (BMI)
2. Improve patient adherence to their treatment regimen
3. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	No	ICSI
2. *Children and Adolescents' Access to Primary Care Practitioners:* The percentage of members 12 months–19 years of age who had a visit with a PCP.	No	NCQA
3. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:* The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	P4P	NCQA
4. *Children Age 6-17 Years who Engage in Weekly Physical Activity:* Measures how many times per week child 6-17 years exercises vigorously (based on AAP and CDC recommendations)	P4P	HRSA – MCHB

[19] *Based on a project submitted by a New Jersey hospital*

Condition	**Obesity**
Project Count	**16**
Project Title	Wellness Program for Parents and Preschoolers [20,21]

Project Objective

Develop wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index.

Project Methodology

Behavioral health clinicians to lead a XX-week program for obese preschoolers and their overweight or obese parent(s). Known as LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)[21], the program consists of alternating group-based sessions focused on improving behaviors related to diet and physical activity and in-home, one-on-one consultations designed to support, demonstrate, reinforce, and build on the concepts and strategies covered in the group sessions. The initial phase consists of XX weekly sessions focused on dietary education, physical activity, and parenting skills, followed by a second phase of X sessions designed to help families continue to make and maintain positive changes.

- Identifying and enrolling participants by using a systematic chart review, the medical center identifies preschool-aged children with a BMI at or above the 95th percentile at their last well-child visit. The parents of eligible children receive a letter from their child's pediatrician introducing them to the program and inviting them to enroll. Those interested undergo a baseline assessment.

Intensive, initial phase focused on promoting and reinforcing healthy behaviors:

- The initial, intensive phase consists of XX weekly sessions that alternate between group-based clinic sessions and in-home visits in which a therapist meets one-on-one with individual families. Focusing on teaching strategies and skills for improving behaviors related to diet and physical activity for parents and preschoolers, while the in-home sessions strive to provide practical assistance to help parents implement the general lessons and concepts discussed in the group sessions.

Clinic-based group visits:

- These XX minute sessions feature two concurrent groups-one for parents and one for preschools.

Sessions for parents:

- These XX sessions led by licensed clinical psychologist focus on dietary education, physical activity and parenting skills. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions. Features could include separate sessions targeting snack and beverage intake, breakfast and lunch, and dinner. The psychologist or dietitian works with parents to set calorie goals for the child. Intensive, initial phase focused on promoting and reinforcing healthy behaviors.

In-home sessions:

- During weeks when group sessions do not meet, a home therapist (a psychology postdoctoral fellow) leads a XX to XX minute session in the home with parent and child. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions related to diet and to physical activity.

Then the second phase focused on maintaining progress:

- The second XX-week period consists of six biweekly sessions that again alternate between clinic-based group visits and in-home, one-on-one sessions between therapist and family. This phase focuses on helping parents identify ongoing barriers to engaging in healthy behaviors, along with strategies for overcoming them, typically based on the material taught during the initial phase.

Staff to include clinical psychologist, pediatric psychologist, master's level professional or trained graduate student in psychology; the key is to use someone training and experience in child behavioral management, dietitian, and social worker.

Project Outcomes

[20] *Based on a project found on the AHRQ website: http://www.innovations.ahrq.gov/content.aspx?id=2914*

[21] *LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)[2] project submitted by hospital*

Condition	**Obesity**	
Project Count	**16**	
Project Title	Wellness Program for Parents and Preschoolers [20,21]	
1. Reduce patient body mass index (BMI) 2. Improve patient adherence to their treatment regimen 3. Improve care processes		
Project Specific Metrics	**P4P**	**Measure Steward**
1. Percentage of mature adolescent and adult patient with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	No	ICSI
2. *Children and Adolescents' Access to Primary Care Practitioners:* The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	No	NCQA
3. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who receive education and counseling for weight loss strategies that include nutrition, physical activity, life style changes, medication therapy and/or surgery.	P4P	ICSI
4. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:* The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	P4P	NCQA

AHRQ Evidence Rating: Strong *- The evidence consists primarily of an RCT that compared key metrics for 7 families (parent and preschooler) participating in the LAUNCH program and 10 families receiving "enhanced" usual care, which consisted of one 45-minute counseling session led by a pediatrician; metrics evaluated include changes in dietary habits (e.g., caloric intake, availability of high-calorie foods, fruits, and vegetables in the home), level of physical activity, weight, BMI z-score, and BMI percentile.*

Condition	**Pneumonia**
Project Count	**17**
Project Title	Patients Receive Recommended Care for Community-Acquired Pneumonia[22]

Project Objective

Implement a set of strategies to ensure that all patients with community-acquired pneumonia receive recommended care as measured by The Joint Commission/ CMS Pneumonia Core Measure Set.

Project Methodology

Develop a hospital-based program for patients with community-acquired pneumonia (CAP) that may include the following elements:

- Establish a multi-therapeutic hospital workgroup (including physicians, pharmacists, respiratory therapists etc.) to determine interventions to be included on the standardized order forms. Order sets include:
  - ED Order set to include algorithm to assist clinicians in identification of appropriate care setting (i.e. outpatient vs. inpatient).
  - Medication order forms one for the ED and one for the inpatient setting which would include checklist of recommended medications as determined by the workgroup.
  - Diagnostic testing order form (one for the ED and one for the inpatient setting) containing a checklist of tests, as determined to be appropriate by the workgroup.
- Inclusion of prompt for smoking cessation and vaccine administration to appropriate hospital forms and checklists.
- Hospital to perform chart reviews to determine physician compliance with meeting CAP performance measures and report findings to the physician with XX hours.
- Development of individual laminated pocket cards with listings of formulary appropriate drugs of choice dependent on patient type.

Project Outcomes

1. Reduce readmissions
2. Decrease length of stay for Community-Acquired Pneumonia (CAP)
3. Improve care processes

Project Specific Metrics	**P4P**	**Measure Steward**
1. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed.	No	AMA
2. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia for whom mental status is assessed.	No	AMA
3. To assess non-intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.	No	The Joint Commission
4. To assess intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.	No	The Joint Commission
5. To assess pneumonia patients who received an initial antibiotic regiment consistent with current guidelines during the first 24 hours of their hospitalization.	P4P	CMS
6. *30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization:* Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia at the time of index hospitalization	P4P	The Joint Commission

AHRQ Evidence Rating: Moderate *- The evidence consists of before-and-after comparisons of key outcomes measures related to pneumonia care, including antibiotic administration, performance of blood cultures, assessment of arterial oxygenation, smoking cessation counseling, and pneumococcal vaccination.*

[22] *Based on a project study found on the AHRQ website:* http://www.innovations.ahrq.gov/content.aspx?id=2565

IV. Hospital DSRIP Plan Template

The Hospital DSRIP Plan Template was developed to serve as a companion document to the application. The Template's purpose is to assist hospital DSRIP participants in the completion of their DSRIP application. The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

Hospital DSRIP Plan – Executive Summary
Focus Area: [Pre-populates based on initial selection]

Project Title – [The user is prompted to select from a pre-defined menu.]

Objective – [Pre-populated based on project selected, however the user will be required to enter the specific outcome they intend to accomplish with obtainable resources.]

Methodology – [Pre-populated based on project selected, however the user will be required to enter how they will achieve the outcome(s). The methodology must be clear and detailed as to how the hospital plans to achieve their stated objective and outcomes.]

Goals/ Outcomes – [Pre-populated based on project selected, however the user will be required to enter the goal(s) of their project for both their hospital and the targeted population. Goals for each Demonstration Year are to be included.]

Significance – [The user will be prompted to enter the rationale for their project selection based on significance of the population their hospital serves and results of their community needs assessment (for further detail on the Community Needs Assessment please see the Application Instructions and the Planning Protocol). User must state how the project will measurably improve health outcomes for their patient population, how the activities selected will demonstrate significant measurable improvement in health outcomes, and how the DSRIP project they selected is consistent with their hospital's mission or quality goals and the Department's DSRIP vision. Significant measurable improvement will be based on the hospital's baseline project-specific measures meeting the Baseline Performance Threshold provision. The user should present a case that its chosen project is in an area that shows an opportunity for improvement. This case must include supporting evidence and data.]

Challenges – [The user will be prompted to enter what they consider to be the challenges in implementing their projects. Hospitals will need to include a brief description of the major delivery system solution identified to address those challenges. If one of the hospital's challenges is that it cannot provide all or part of the baseline data, the hospital will be required to describe in this section, the hospital's plan, including a timeline for obtaining and submitting the baseline data for non-claim based measures to the Department. Please note, all hospital metric data submissions must be received by the Department no later than **October 31, 2014, unless otherwise stated in the databook**. Challenges must be specifically listed such as "search for additional qualified staff to hire" or "large population of uninsured patients" etc.]

Starting Point – [The user will be prompted to enter their starting point for their selected project. The starting point should include the identification of project needs, such as funding, data, the project team, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the hospital, or significantly enhances an existing health care initiative.

Hospital DSRIP Plan – Executive Summary
Focus Area: [Pre-populates based on initial selection]

Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. Hospitals must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.]

Public Input – [The user will be prompted to enter a description of the processes used to engage and reach out to stakeholders (as defined in the Application Instructions and Planning Protocol) regarding the DSRIP plan. At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders.]

Project Monitoring – [The user will be prompted to enter a description of the efforts that will be used to review and manage DSRIP outcomes, make rapid-cycle changes, identify lessons learned, contribute to and implement best practices from the learning collaboration, and link to the Department's quality improvement efforts. Project monitoring description will also include efforts that will be used to review and document project budget, and return on investment.]

(Special Terms and Conditions, 93.g.i., page 77)

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
1.	Identify key program components and goals.	Conduct a gap analysis in preparation for the inception of the project.	September 20, 2013	*Gap analysis conducted and results reported* • State hospital's current competencies and performance levels • Identify the hospital's current and expected clinical performance • Description of how the project selected will reduce the gap between current and expected clinical performance
		Complete budget analysis to be performed for project.		*Budget analysis developed and completed* • Provide project budget estimation that includes line item expenditure information. • Provide estimates of health-care dollars savings.
		Identify partners who would be beneficial to the project development and maintenance.		*Identification of partners for the project completed* • Provide comprehensive documentation on partner(s) including name, address, business type (for profit, non profit), services provided, National Provider Identifier (NPI) number, Tax ID # and corporate ownership information. • State how the partner will participate in the plan.

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
1.	Identify key program components and goals. **Continued.**	Identify target population to include in the project.	September 20, 2013	*Project target population documented* • Target population inclusion/exclusion criteria and size • Documentation of rationale for o Target population o Target population size
2.	Identify project protocols and interventions.	Develop discharge planning interventions.	September 20, 2013	*Discharge planning interventions are described* • Description of current and updated discharge planning processes • Description of expected outcomes
		Determine case management/care coordination needs of the target population for the project.		*Case management/care coordination processes documented* • Description of current and updated case management processes • Description of expected outcomes
		Determine patient/caregiver education tools to be utilized for the project.		*Patient/caregiver education tools to be utilized are documented* • Description of patient/caregiver education plan including rationale for plan selection and anticipated tools to provide effective patient/caregiver education
		Determine provider education tools to be utilized for the project.		*Provider education plan is outlined* • Description of provider education plan, including rationale for plan selection and anticipated tools to provide effective provider education

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
2.	Identify project protocols and interventions. **Continued.**	Perform social support assessment and identify referral interventions to be developed for the project.	September 20, 2013	*Social support assessment completed and referral interventions identified* • Description of current social support assessment and referral processes • Outline of new/revised social support assessment and referral process • Description of expected outcome based on social support assessment and referral process changes
		Outline patient self care skills plan.		*Patient self care plan is outlined* • Documentation of objectives for a patient self care plan, including rationale for plan. • Description of expected patient outcomes
		Outline scope and design of the telemedicine program.		*Telemedicine program assessment completed* • Completed needs assessment, which includes technology to be utilized, telecommunication processes, development of an infrastructure, operational challenges and staffing resources and expected training. • Description of expected program goals and patient outcomes

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
2.	Identify project protocols and interventions. **Continued.**	Determine assessment/ checklist/ screening tools required to meet the objectives of the project.	September 20, 2013	*Determination of assessment/checklist and/or screening tools* • Documentation requirements include: o Number of tools to be developed or modified o Modifications made if applicable o Rationale for new or modified tools o Documentation standards for tools
		Outline a medical home model.		*Medical home model outline developed* • Provide plan that addresses the following: o Identification of access to care issues o Description of expected patient outcome based on medical home implementation o Identification of Medical Home project team and champions o Project plan implementation timeframes
		Outline patient group visits plan assessment.		*Patient group visit plan outline completed* • Provide plan that addresses the following: o Identification of access to care issues o Description of expected patient outcomes
		Outline a nutritional support plan.		*Nutritional support plan outline completed* • Nutritional support plan outline, including rationale for plan selection and implementation strategy. • Description of expected patient outcomes

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
2.	Identify project protocols and interventions. **Continued.**	Outline a plan for a home visits program.	September 20, 2013	*Home visit plan outline completed* • Provide comprehensive plan of care detailing what anticipated activities will be performed during each home visit. • Description of expected patient outcomes
3.	Identify multi-therapeutic medical and support team.	Determine project staffing needs, including identifying whether project requires utilizing existing staff or hiring new staff or a combination of the two.	September 20, 2013	*Staffing needs are documented* • Provide staffing plan that includes: o Type and number of health care professionals required (MD, RN, and RD etc.) o Type and number of administrative/support staff needed o Estimated project time per week per project staff member o Identification of project leader o Identification of need of project champion o Project organization chart
4.	Identify staff education needs.	Assess education needs and determine education/communication methods, including duration, frequency and timelines.	September 20, 2013	*Education plan design completed* • Describe staffing education needs, training methods, duration and frequency. • Plan includes a timeline for education plan to be completed and implemented.

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
5.	Identify physical space/ settings/ supplies.	Determine program requirement for physical space/ setting/ supplies or a combination of both.	September 20, 2013	*Physical space, setting and supplies assessment completed* • Description of physical space(s) including operational tasks (e.g. setting up phone line, and purchase of office equipment) • Description of the project setting(s) • Listing of any supplies required for the project
6.	Identify patient supplies and equipment.	Determine the patient supplies and equipment required for the project in the outpatient and home settings.	September 20, 2013	*Necessary patient supplies and equipment for implementation of the project have been determined* • Description of patient supplies and equipment needed, as well as, the means to procure the supplies and equipment (as applicable). • Statement as to whether the member supplies or equipment will be billable or a hospital absorbed cost.
7.	Identify technical needs.	Assess available software/ hardware and determine need for new software/hardware or other technology.	September 20, 2013	*Software/hardware and technology needs for the project have been determined* • Description of existing software/hardware sources • Description of new technology, including software/hardware to be utilized, including the method for obtaining the new technology, the estimated cost, timeline for acquisition, and rationale

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metric(s)* (Minimum Documentation Requirements)**
8.	Identify data needs.	Assess available data sources to determine if additional data sources are required.	September 20, 2013	*Data sources required for the project are documented* • Description of existing data sources to be utilized for the project • Description of new data, including the method for obtaining the data source, the estimated cost, timeline for acquisition, and rationale
9.	Identify marketing/ outreach needs.	Assess and determine marketing and outreach materials needed for the project.	September 20, 2013	*Completion of an assessment of required marketing/outreach needs* • Anticipated marketing/outreach plan, including the intended audience (e.g. patient, provider, or community), communication methods, communication frequency and timelines.
10.	Report Baseline Data for Non-Claims Based Stage 3 and Stage 4 Metrics.	Provide baseline data in accordance to the directives from the Department.	September 20, 2013[23]	*Submission of baseline data* • Baseline data information for non-claims based metrics • For any baseline data that is not currently being collected, the hospital shall provide a plan outlining the means and timeline to collect and submit the data per the reporting requirements

[23] If hospital cannot provide one or more non-claim based metrics, the hospital will be required to include in the application and future progress reports the rationale for omission of the metric and a plan for obtaining the metric by the **October 31, 2014** (DY3), unless otherwise stated in the databook.

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
1.	Develop methodology to identify pilot population.	Select all applicable population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources) and develop algorithms to determine pilot population.	User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014.**	*Target population determined* • Documentation of the target population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources)
2.	Develop health assessment/ risk stratification tool to assist in identifying the health risk of project participants.	Develop algorithms and/or decision tree to assist clinician in identifying the health risk of project participants.		*Algorithms and/or decision tree developed* • Documentation of the algorithms and/or decision tree

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
3.	Procure multi-therapeutic medical and support team that will be dedicated to the DSRIP project.	Utilize existing staff. Utilize new staff.	User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014]**	*Staffing in place for initiation of the project* • List the number of health care professionals initially identified in the application as required (MD, RN, RD etc.) and for each professional, indicate o The health care professionals hired o The employment status (full-time, part-time, contracted) o The approximate expected project hours worked per week • List the number of administrative/support staff initially identified in the application as required and for each staff. • List the administrative/support staff hired and for each, indicate o Employment status (full-time, part-time, contracted) o The approximate expected project hours worked per week • Project leader(s)' credentials and weekly project time commitment • Project champion(s)' credentials and weekly project time commitment
4.	Procure partners.	Partnerships required to conducting the project are established.		*Partnerships are in place for initiation of the project* • Contracts/memorandums of understanding/letters of engagement with partners

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
5.	Procure staff education needs.	Determine education/communication method. Determine education groups (Governing Board, Medical Staff, Management, etc.) Determine education duration and frequency and timelines.	[User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014]**	*Staff education plan documented* • Provide completed educational plan. Documentation should include: o Training topic o An overview of the training topic, including the overall goal of the training o Identification of education group o Staff level required to attend o Estimated training dates and times o Place of training
6.	Procure physical space/ settings/ supplies.	Physical space, setting and/or supplies are in place.		*Physical space, setting and/or supplies are utilized* • Floor plan of existing space that will be used for the project • Lease agreement for new space • Purchase orders for supplies and equipment
7.	Procure patient supplies and equipment.	Patient supplies for both the outpatient and home setting are purchased.		*Patient supplies inventory completed* • List of patient supplies procured • Purchase orders for patient supplies and equipment
8.	Procure technical needs.	Technical resources are in place (may include software, hardware or other technology).		*Technical resources are operational* • List of technical resources procured. • Purchase order for technical resources (software, hardware, other technology, etc)
9.	Procure data needs.	Existing and new data sources are in place.		*Data sources are operational* • List of data sources acquired • Documentation on data query development and data validation processes

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
10.	Procure marketing/ outreach needs.	Marketing and outreach tools are produced.	[User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014]**	*Marketing materials are sent to intended audience* • Copies of materials developed • Advertisements for outreach events • Dates for outreach events and number of attendees
11.	Establish project protocols and interventions.	Develop new or enhanced discharge planning tools.		*Discharge planning tool completed* • All discharge planning documents developed for project
		Establish new or enhanced care coordination processes.		*Care coordination processes plan completed.* • All documentation pertaining to the care coordination processes plan for project
		Establish patient/caregiver education.		*Patient/caregiver education completed* • Examples of patient/caregiver materials given to patients and/or caregivers
		Establish provider education.		*Provider education plan completed.* • Provide documentation of completed educational offerings. Documentation should include date, time and place of training, an overview of the training topic, number of staff trained and number of staff to yet be trained
		Establish social support and referral processes.		*Social support and referral processes plan completed* • Documentation of social support and referral processes developed for project
		Develop patient self care skills plan.		*Patient self care skills plan completed.* • Submit patient care skills plan

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
11.	Establish project protocols and interventions. **Continued.**	Determine telemedicine program.	[User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014]**	*Telemedicine program plan completed* • Provide documentation that equipment has been ordered and installed, testing of the equipment performed and staff training completed
		Develop or enhance hospital and/or patient screening tools (checklists, assessments etc.).		*Hospital and/or patient screening tools development completed* • Copies of hospital screening tools • Copies of patient checklists
		Establish medical home plan.		*Medical home plan completed* • List of physician participants • Description of care improvement strategies • Project roll-out timelines • Description of physician education on initiative • Description of community outreach plan
		Establish patient group visit(s) plan.		*Patient group visits plan developed* • Number of staff who will conduct visits • Frequency of visits • Expected patient outcomes
		Establish nutritional support plan.		*Nutritional support plan completed.* • Nutritional support plan including documentation on roll-out procedures of the plan
		Determine home visit plan.		*Home visits plan developed* • Home visits plan including services to be performed and expected patient outcomes

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
12.	Develop quality improvement activities.	Development of a comprehensive quality improvement plan.	[User will be prompted to enter the expected month/year each activity will be completed. **Stage I Activities must be completed by September 30, 2014]**	*Completion of quality improvement plan* • Quality improvement plan including: o Aim statement o Rationale for quality plan tools and methods o Any documentation used from other sources to create the plan o Driver diagram o Rapid-cycle evaluation
13.	Conduct patient satisfaction survey.	Conduct patient satisfaction survey to track the patient satisfaction of DSRIP patients.	Quarterly throughout the Demonstration	*Patient satisfaction surveys conducted.* • Provide documentation of the patient satisfaction survey results. Documentation should include: o The number of surveys sent to patients o The method of survey delivery (email, text, mail, etc) o Incentives provided to patients/family members to complete the survey o The number of surveys returned o The satisfaction scale (satisfied/not satisfied; good/fair/bad) used o Summary of survey results, by question

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
14.	Conduct staff education/training sessions on all applicable project tools, checklists, processes, protocols and intervention procedures.	Training/education sessions on applicable project tools, checklists, processes, protocols and intervention procedures are conducted.	Quarterly throughout the Demonstration	*Project staff education/training conducted* • Documentation should include: o Name and overview of the training topic, including the overall goal of the training o Staff level required to attend o Training dates and times o Place of training o List of attendees (i.e. sign in sheets) o Plan for training project staff members who were absent during training

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
15.	Project Staff Evaluation/Assessment.	Perform an evaluation of project staff member's performance on the project.	Quarterly throughout the Demonstration	*Evaluation completed for each project staff member* • List of all project staff members • Identify whether staff member should be retained for project and the rational for the decision to retain • Identify whether staff member's project hours should be increased, reduced or eliminated and the rationale • Identify the number (if any) additional staff members required for the project, noting the type of staff required (i.e. health care professional, administrative/support) and the rationale for the addition • Identify additional project staff hired since last submission and for each, indicate o Employment status (full-time, part-time, contracted) o The approximate expected project hours worked per week

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage II. Chronic Medical Condition Redesign and Management

Project Stage II: Piloting, testing and replicating of innovative care models

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
1.	Initiate pilot program.	Pilot program started.	User will be prompted to enter the expected month/year each Stage II activity will be completed. **These Stage II Activities must be completed by March 31, 2015.**]	*Pilot program initiated* • Documentation supporting pilot program was started including any challenges encountered during the start-up process
2.	Evaluate pilot program and re-engineer and/or re-design based on pilot results.	Determine metric-driven changes and initiate adjustments and redesign of program requirements as needed.		*Evaluation documented* • Documentation indicating all project changes made and the rationale for those changes • Documentation supporting the decision-making process for changes to DSRIP project plan including program requirements and collection of data for metrics
3.	Initiate program protocols and interventions for entire population.	Full implementation of the project performed.		*Implementation of the project to the entire population completed* • Documentation showing total number of patients in the program • Documentation supporting protocols and interviews have been initiated for the entire population • Documentation indicating that the intervention(s) has been initiated for the entire population **Please note: Protected Health Information (PHI) should not be included in submitted documentation.**

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage II. Chronic Medical Condition Redesign and Management

Project Stage II: Piloting, testing and replicating of innovative care models

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
4.	Ongoing monitoring of program outcomes.	Trending and tracking of data reporting.	These Stage II Activities are required to be completed on a quarterly basis throughout the Demonstration, starting with the first quarter DY3 (Sept. 30, 2014).	*Trend report developed and implemented* • Number of data points being monitoring • Trending monitored • Frequency of monitoring
5.	Provide feedback to hospital administrators and participating providers.	Provide review of project to hospital administration and participating providers.		*Communication on project achievement to hospital administrators and participating providers completed* • Documentation, such as meeting minutes, attendees, and supporting correspondence providing feedback with hospital administrators and participating providers
6.	Provide feedback to the learning collaborative.	Participating providers engage in learning collaborative for the DSRIP program to promote sharing of best practices and resolutions to problems encountered.		*Number of monthly phone calls attended* *Number of attended quarterly webinars* • Documentation supporting participation with the New Jersey Learning Collaborative such as copies of correspondence and meeting attendance/attendees • Summary of Learning Collaborative engagement and results

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage III. Quality Improvements

Project Stage III: Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
1.	Report Stage III Project-Specific Metrics for DY2.	Report Stage III Project-Specific Metrics for DY2.	April 2014	*Stage III project-specific Metrics are reported for DY2* o Databook containing project-specific metrics for DY2 o Attestation of verification for all DY2 metrics (both claims-based and non-claims based) o For any metric which cannot be reported, hospital shall submit an updated status report on its plan for reporting the metric by October 31, 2014.
2.	Report Stage III Project-Specific Metrics for DY3.	Report Stage III Project-Specific Metrics for DY3.	October 2014 April 2015	*Stage III project-specific metrics are reported for DY3* o Databook containing project-specific metrics for DY3 o Attestation of verification for all DY3 metrics (both claims-based and non-claims based)

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage III. Quality Improvements

Project Stage III: Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	***Metrics* (Minimum Submission Requirements)**
3.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	October 2015 April 2016	*Stage III project-specific metrics are reported and improvement target for metric is met or exceeded* o Databook containing project-specific metrics for DY4 o Attestation of verification for all DY4 metrics (both claims-based and non-claims based) Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.
4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	October 2016 April 2017	*Stage III project-specific metrics are reported and improvement target for metric is met or exceeded* o Databook containing project-specific metrics for DY5 o Attestation of verification for all DY5 metrics (both claims-based and non-claims based) Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage IV. Population Focused Improvements

Project Stage IV: Requires hospitals to report on population-focused activities which could include the patient's experience, the effectiveness of care coordination, prevention and health outcomes of at-risk populations.

Row ID	Column 1	Column 2		Column 3
	Activity	**Actions/ Milestones**	**Completion Month/Year**	**Metrics (Minimum Submission Requirements)**
1.	Report Stage IV Universal Metrics for DY2.	Report Stage IV Universal Metrics for DY2.	April 2014	*Stage III Universal Metrics are reported for DY2.* o Databook containing universal metrics o For any metric which cannot be reported, hospital shall submit a plan for reporting the metric by October 31, 2014.
2.	Report Stage IV Universal Metrics for DY3.	Report Stage IV Universal Metrics for DY3.	October 2014 April 2015	*Stage* IV *Universal Metrics are reported for DY3.* o Databook containing universal metrics
3.	Report Stage IV Universal Metrics for DY4.	Report Stage IV Universal Metrics for DY4.	October 2015 April 2016	*Stage* Universal *Metrics are reported for DY4.* o Databook containing universal metrics
4.	Report Stage IV Universal Metrics for DY5.	Report Stage IV Universal Metrics for DY5.	October 2016 April 2017	*Stage* IV *Universal Metrics are reported for DY5.* o Databook containing universal metrics

V. Acronym Key

1.	AHRQ	Agency for Healthcare Research and Quality
2.	AMA	American Medical Association
3.	AMA-PCPI	American Medical Association – Physician Consortium for Performance Improvement
4.	CDC	Centers for Disease Control and Prevention
5.	CMS	Centers for Medicare & Medicaid Services
6.	CQAIHM	Center for Quality Assessment and Improvement in Mental Health
7.	EHR	Electronic Health Record
8.	HAB	HIV/AIDS Bureau
9.	HRSA	Health Resources and Services Administration
10.	ICSI	Institute for Clinical Systems Improvement
11.	MCHB	Maternal and Child Health Bureau
12.	MMIS	Medicaid Management Information System
13.	NCQA	National Committee for Quality Assurance
14.	P4P	Pay for Performance
15.	UPP	Universal Performance Pool

VI. Hospital DSRIP Plan Submission Requirements

Each hospital must submit their initial DSRIP documents to the New Jersey Department of Health no later than 5:00 p.m. Eastern Time on **September 20, 2013**. The initial submission must include ALL of the following completed deliverables:

A. DSRIP Checklist

The Checklist, to be included with the hospital's submission of their DSRIP plan, is on the following page.

B. DSRIP Project Application

The Hospital DSRIP Plan must be completed in its entirety and must include the following which may be sent as addendums:

a. Community Needs Assessment

i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
iii. Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]).
iv. Description of any initiatives in which the hospital is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway.
v. Description of changes in the above areas that are expected to occur during the waiver period (especially those related to changes in health care coverage anticipated in 2014, such as Medicaid expansion).
vi. Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.
vii. Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.).

b. Public Input Process

i. Hospitals must consider local public health departments as part of the public input process.
ii. Public stakeholders and consumers, including processes used to solicit public input into hospital DSRIP Plan development and opportunities for public discussions and review prior to plan submission.
iii. A plan for ongoing engagement with public stakeholders.

iv. At a minimum, a description of public meetings that were held and the process for submitting public comment on the hospital DSRIP plan.

C. Signed Attestation

The Attestation, to be included with the hospital's submission of their DSRIP plan, is included after the New Jersey Hospital DSRIP Checklist. This attestation must be signed by a hospital corporate executive, such as the Chief Executive Officer (CEO), Chief Operating Officer (COO), etc.

D. DSRIP Plan Submission

All submissions will be date and time stamped when received by The New Jersey Department of Health. The preferred method of submission is via the Myers and Stauffer Secure File Transfer Protocol (FTP) site: **https://transfer.mslc.com/**

- Use of the FTP requires user to provide Myers and Stauffer with basic information and sign an user agreement form
- Upon receipt of these documents, each individual user would receive a private username and password in order to upload documents to the site; limited to two users per hospital
- User Agreement Forms must be received by August 16, 2013 in order to ensure access to the FTP site
- Request for FTP access may be sent to *NJDSRIP@mslc.com*

If a hospital cannot access the FTP site, the Hospital DSRIP Applications may be sent by:

Regular Mail

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing
NJ Department of Health
PO Box 360
Trenton, NJ 08625-0360

OR

Overnight or Hand Deliveries

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing
NJ Department of Health
8th Floor, Health and Agriculture Building
369 South Warren Street
Trenton, NJ 08608

New Jersey Hospital DSRIP Checklist

Hospital Name:	
Hospital Medicaid ID Number:	
Hospital Contact:	
Hospital Contact Telephone Number:	
Hospital Contact Email Address:	

This checklist must be completed for this submission. This submission to the Myers and Stauffer FTP must include the following:

☐ The copy of the signed attestation form

☐ The copy of the completed New Jersey Hospital DSRIP Checklist

☐ Application, to include the following tabs from the Application file:

- Executive Summary
- Application DY2
- Application Stage I
- Application Stage II
- Application Stage III
- Application Stage IV

☐ Attachments supporting the application

☐ Baseline data for non-claim based metrics for Stage III and Stage IV, or a plan documenting the means and timeline to collect and submit the data per reporting requirements

Submissions submitted **via mail or hand delivery** should include:

☐ 2 hardbound copies of the above Hospital DSRIP Plans

A CD with:

☐ Word[1] file copy or PDF[2] of the completed New Jersey Hospital DSRIP Checklist
☐ Word[1] file copy or PDF[2] of the signed attestation form
☐ Application saved in Excel[1] format
☐ Any Addendums submitted as Word[1], Excel[1] or PDF[2] files

[1] Word and Excel files must be in a Microsoft® Office 2003 or a later version.

[2] PDF files should allow for OCR text recognition.

ATTESTATION OF FINANCIAL AND OTHER DATA REPORTED BY [*HOSPITAL ORGANIZATION*] PARTICIPATING IN THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM TO THE NEW JERSEY DEPARTMENT OF HEALTH (NJ DOH)

Pursuant to the Provider Agreement between the State of New Jersey and [*Hospital Organization*], the undersigned states and warrants, based on its best knowledge, information, and belief, that the information provided by [*Hospital Organization*] to the State is accurate, complete, and truthful, and is consistent with the ethics statements and policies of the New Jersey Department of Health (DOH). This attestation includes information provided by the [*Hospital Organization*] in response to the DOH request for documentation. This attestation also includes data and documentation provided, and statements made to the DOH, Myers and Stauffer, and/or other DOH designated representatives by the management or staff of [*Hospital Organization*] or its subcontractors.

As it pertains to information provided by the undersigned [*Hospital Organization*] I, _____, do hereby attest that the information provided is true and correct to the best of my knowledge, that I will submit data and reports as specified by the DOH, that I will cooperate fully with the DOH (and its contractors) on its evaluation and improvement collaboration efforts, and that I will cooperate fully with any evaluation that the DOH or CMS might conduct. I further acknowledge and understand that I may be subject to sanctions and/or penalties, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding Data, Financial, or other information pursuant to Section 1909 of P.L. 92-603, Section 2428.

_____ _____

Printed Name of Organization Date

_____

Printed Name of Signatory

_____

Signature

_____

Title (CEO, COO, etc.)

VII. Contact Information

Questions regarding the New Jersey DSRIP Toolkit or NJ DSRIP Plan Application may be forwarded to NJDSRIP@mslc.com or contact Brian O'Neill at (609) 292-7874.