



2.b.iii ED Care Triage for At-Risk Populations

Project Objective: To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Project Description: Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
 - a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
 - b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
 - c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
 - a. Patient navigators will assist the presenting patient to receive a **timely** appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
 - b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
 - c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. Use EHRs and other technical platforms to track all patients engaged in the project.



Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

- a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

Potentially preventable visits to the ED (PPV-ED) per 100 beneficiaries for Medicaid beneficiaries are 38 in the Bronx, 29 in Brooklyn, 42 in Manhattan, and 27 in Queens. Twenty- one UHF neighborhoods have risk-adjusted O/E ratios of PPV-ED above 1.0 indicating a gap in care (high of 1.18 in Bedford/Stuyvesant/Crown Heights). These 21 neighborhoods, which encompass 61% of our PPS's Medicaid population, will be targets for patient engagement.

Our PPS conducted analyses which found that an estimated 41% of patients who had an ED visit did not have their own PCP. Several of the top 10 diagnoses of patients who present to HHC EDs could often be treated by a PCP (e.g., viral infections, acute upper respiratory infections). Alcohol-related substance abuse is among the top 10 conditions for EDs at Bellevue, Coney Island, and Woodhull, especially among patients without an HHC PCP. Patients using the ED to obtain prescription refills have, on average, 1.4 ED visits per year for refills.

CNA focus groups revealed four gap areas contributing to potentially avoidable ED visits: access to a PCP prior to an ED visit, access to a PCP post-ED discharge, limited access to care management programs, and, lack of effective and culturally responsive patient education. \

The CNA revealed that patients often do not know how to find a PCP, or how to contact their PCP during/after hours. Appointments with PCPs may not be available for weeks, they may involve lengthy waits during the visit, and require follow-up visits to complete diagnostic tests. This was also a challenge post-ED discharge for a number of reasons (e.g., challenges in contacting PCPs to arrange for care, lack of advanced access and/or centralized scheduling systems, and lack of data connectivity among providers which results in delayed transfer of standardized discharge summaries to follow-up care providers). Limitations on primary care capacity compound these issues. For example, our service areas have many medically underserved areas (MUAs), and health professional shortage areas (HPSAs): the Bronx has 18 and 8, Brooklyn has 15 and 9, Queens has 7 and 4, and Manhattan has 8 and 4, respectively.

ED care management programs often inadequately to address the follow-up care needs of discharged patients who have complex conditions or socio-economic challenges (i.e., homelessness, chronic pain, behavioral health). At-risk patients may lack referrals and warm hand-offs to specialty providers or other partners able to address socio-economic factors that create barriers to follow-up care (e.g., lack of transport). Finally, there is a lack of effective patient education materials that address management of chronic diseases, how to access PCPs, and availability of specialized programs (e.g., behavioral crisis



management) and also meet patient's language, culture and health literacy needs (see CNA need 3).

To address these gaps, the PPS has developed an approach to ED care management which will strengthen patient relationships with PCPs (see CNA need 2), provide triage and navigation support for patients with non-emergent illnesses (see CNA need 5), and care coordination for patients treated and released from the ED (see CNA need 5).

- b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

We expect to engage the following patient population: all attributed patients with one or more ED visits of Emergency Severity Index (ESI) level 3 or higher (moderate-low severity visits potentially appropriate for diversion or usually treated and released from the ED) and combined with some risk stratification. This will include patients with ambulatory sensitive chronic conditions and at-risk patients requiring more intensive ED care management services post discharge (see CNA needs 1, 5).

The project will intensify efforts to engage patients in 21 neighborhoods where PPV-ED risk-adjusted O/E ratios are greater than 1.0: Bedford/Stuy/Crown Heights; Central Harlem/Morningside Hgt; Flatbush/E. Flatbush; Highbridge/Morrisania; Crotona/Tremont; East New York; Hunts Point/Mott Haven; NE Bronx; Canarsie/Flatlands; Fordham/Bronx Park; E. Harlem; Port Richmond; Williamsburg/Bushwick; Rockaway; Washington Hgts/Inwood; Pelham/Throgs Neck; Chelsea/Clinton; Downtown/Heights/Slope; Stapleton/St. George; SE Queens; and Kingsbridge/Riverdale. Project efforts will be closely coordinated with 2.d.i activities to engage low- and non-utilizers.

Among the 21 targeted neighborhoods, the 10 poorest have 25%-43% of the population below 100% federal poverty level (FPL). These 10 neighborhoods also have 13%-26% who are non-U.S. citizens, 7% - 36% who speak English "less well," 20%-40% of adults with less than a high school education, and 9%-17% who live with a disability.

At-risk patients will be identified using a standardized risk assessment tool which will look at prior hospitalizations and ED patterns, high alert medications/polypharmacy, multiple chronic conditions/co-morbidities, behavioral health/substance abuse, health literacy, limited English proficiency, socio-economic support/status, and need for chronic pain management (see CNA needs 3, 4, 5). For example, among others, at-risk patients will include the homeless, substance users, patients with behavioral health issues often coupled with chronic conditions, and patients with chronic pain.

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

We have a range of assets and resources that will support implementation of this initiative. We have tested ED Care management pilots in a number of PPS hospitals (e.g., Elmhurst, Bellevue, Queens). In addition, there are telephone triage centers (Lincoln, Woodhull), open PCP panels



(North Central Bronx, Jacobi), risk assessment tools (North Bronx Health Network), and “expedited passes” for ED patients to access their PCPs (Lincoln).

Based on our existing resources and learnings from pilot projects, we have designed an ED care management program which is broadly defined to include triage for patients with non-emergent illnesses and ED care coordination for patients treated and released from the ED. The program will ensure PPS connectivity to community PCPs, especially PCMHs; provide 24/7 care management support; and, provide at-risk patients with intensive ED care management. At-risk patients, identified using a standardized risk-assessment tool, will be provided with 24/7 local or centralized access to care managers, navigators, and community partners to address their specialized needs, and transitioned with “warm hand-offs” for follow-up care.

Our PPS has developed a three-pronged approach to implement this project. First, we will continue to provide EMTALA-compliant screening to patients presenting to the ED with non-emergent conditions and arrange for follow-up care. After verifying non-emergent conditions, ED staff will provide necessary, immediate treatments and prescriptions, and arrange for more extensive follow-up and a timely visit with PCPs and behavioral health providers as appropriate.

Second, in DSRIP Years 1-3, our PPS will focus on implementing the ED Care Management Program in five hospitals (e.g., Coney Island, Harlem, Metropolitan, North Central Bronx, Woodhull), seven psychiatric EDs and six Comprehensive Emergency Psychiatry Programs (CPEPs). In DSRIP Year 4, we will integrate the remaining six hospitals (Bellevue, Elmhurst, Jacobi, Kings County, Queens, Lincoln) which, until that time, will participate in a CMMI initiative focused on testing ED care management tools that target ambulatory sensitive conditions. The program will reconfigure space as needed in order to support navigator services.

Third, to reinforce relationships with PCPs, the PPS will establish a 24/7 central telephone triage program staffed by qualified nurses and physician advisors. The service will avert unnecessary visits to the ED and (re-) connect patients to PCPs for care. Protocols will include transferring patients to 911/EMS as needed. Staff will assist patients in making appointments with PCPs or specialized programs, link patients to navigators, and educate them on accessing a PCP.

IT capabilities will be enhanced to include an enterprise-wide care management platform. Care management staff will be able to arrange follow-up PCP appointments for patients through expanded and enhanced centralized scheduling processes and greater use of open access scheduling. PCPs will expand electronic communication capabilities with patients. Enhanced data connectivity through the RHIO and an encounter notification system will provide real-time data.

With these approaches, our PPS will retrain and redeploy staff as care managers, social workers, navigators, triage nurses, and physician advisors. We will also leverage peer care managers as an effective way to engage patients. For patients needing ambulatory withdrawal management services, the PPS will explore opportunities to expand capacity. A newly developed CSO will house the PPS’s care management and care coordination services.

- d. Describe anticipated project challenges or anticipated issues the PPS will encounter while



implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

One challenge may be limited capacity at primary care clinics that hinder timely appointments (see CNA need 2). This challenge will be mitigated by one or more of the following strategies: increased staffing, increased hours provided at facilities, and increased use of partner primary care capacity. These activities may include developing partnerships with federally qualified health centers and independent community providers, and working with them to coordinate a system of extended hours and improved open access capabilities.

ED care management for homeless patients has also proved challenging (see CNA need 5). We plan to work closely with the NYC Department of Homeless Services to better inform care managers of options for the homeless and to address operational and/or staffing issues that impede homeless patient's access to follow-up care. The CNA noted that providers "have no clue, for the most part, as to where these homeless people are landing... what connection they have to medical services."

Conveying information about accessing PCPs and disease management is complicated by the ethnic and racial diversity in each borough (see CNA need 3). For example, among the 21 targeted neighborhoods, the 13 poorest have 14% - 36% who speak English "less well." To address this challenge, we will coordinate patient outreach and education efforts with local CBOs that can engage in a culturally appropriate manner using the language spoken by that community.

Many aspects of the proposed interventions rely on enhanced IT systems to support: (1) centralized population health management data capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) improve connectivity within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and, (5) health information exchange (HIE) with RHIO/SHIN-NY and private HIE. Currently eight PPS facilities are connected to the RHIO, one to Healthix. Another nine will be connected to the RHIO at year end. To address this challenge we will focus on augmenting existing functionality.

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

As part of planning activities to date, our PPS has collaborated with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and beginning to identify areas for collaboration during implementation and operations.

During implementation and operations, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; developing of workforce strategy, including common job descriptions and functional capabilities; workforce training efforts; data sharing; and



selection of culturally competent patient education resources to support this project.

Post-application, we intend to broaden our collaboration efforts to include other PPSs in our service area. We believe this coordination will be crucial to reduce the burden on providers and CBOs, by addressing key capacity and workforce needs, and improving clinical outcomes and patient experience.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this pro

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

To support the project approach, the PPS will enhance IT systems with required capabilities. Telephone triage teams and ED staff will, for the most part, be able to arrange follow-up PCP appointments for patients through an expanded and enhanced centralized scheduling system and make greater use of open access scheduling. The PPS will work with PCPs to expand capabilities to “see” patients via telephone, email, or video chat. Enhanced data connectivity through the RHIO and encounter notification system that will provide real-time data feeds.



The PPS will reconfigure space as needed within its EDs to improve patient flow to ED care triage and care management staff. This will allow for private triage areas, rapid evaluation areas, and healthcare navigation centers to allow nurses, care managers, and navigators to speak with patients, and physician assistants who can order blood tests or x-rays while freeing up beds for patients with more serious conditions.

Finally, the PPS will require capital to establish the 24/7 citywide centralized telephone triage program.

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
New York City Health & Hospitals Corporation (HHC)	CMMI Grant, Round 2: ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use	April 2014	March 2017	HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
New York City Health & Hospitals Corporation (HHC)	Medicare Shared Savings Program	June 2012	December 2016	HHC ACO, Inc. (the HHC ACO) was formed by HHC in June 8, 2012, to further the goals of the Medicare Shared Savings Program (MSSP).
AHRC New York City	Developmental Disability Care Coordination Pilot (Part of an 1115 Waiver)	2014	2015	The purpose of this pilot is to provide MLTS without capitation (i.e., primarily care coordination) for people with intellectual and developmental disabilities.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home Care Management entity under subcontract with 4 NYS Health Home providers.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.



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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Riverdale Mental Health Association	CMS Innovation Center Health Care Innovation Awards (HCIA)	2015	2015	As part of the HCIA award, Riverdale Mental Health Association provides the Parachute NYC Bronx Crisis Respite Center.
Visiting Nurse Service of NY (VNSNY)	CMS Innovation Center Health Care Innovation Awards (HCIA)	2014	2017	Mount Sinai School of Medicine received funds to pilot a hospital-at-home model (Mobile Acute Care Team Services). VNSNY is a partner in this project but not the lead.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

Six hospitals in the PPS are participating in a Preventing Avoidable ED/Inpatient Use grant, funded by the Center for Medicare & Medicaid Innovation (CMMI), in Round 2 of available funding. Our PPS intends to implement the same ED Care Management program at the six hospitals that were not part of the CMMI grant (Coney Island, Harlem, Metropolitan, North Central Bronx, Woodhull and UHB), in addition to seven psychiatric EDs and six CPEPs. At the end of the CMMI grant period (DSRIP Year 4), the PPS will enhance the ED Care Management program in the six CMMI-funded hospitals (Bellevue, Elmhurst, Jacobi, Kings County, Queens, Lincoln). Enhancements will include supplementary care management and ambulatory support tools developed under DSRIP.

The HHC ACO focuses on Medicare Fee-for-Service (FFS) beneficiaries linked to participating PCPs. Financial performance and shared savings/losses pertain to services rendered to Medicare beneficiaries only. The HHC ACO is specifically designed to deliver seamless, coordinated, high quality care to Medicare FFS beneficiaries through an organized group of HHC affiliated physicians, 11 hospitals and other healthcare providers who have agreed to work together to treat a defined population of patients across care settings—including primary and specialty care, hospitalizations and long-term care—and become accountable for the quality, cost and overall care delivered. DSRIP builds on HHC’s MSSP experience by extending redesigned care processes for high quality and efficient service delivery to Medicaid patients and the uninsured.

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently



eligible for Health Home services. Similarly, this project will build on work that our partners have begun through the Developmental Disability Care Coordination Pilot and HClA, expanding services to a wider population than is currently served by these programs.

The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. HARP service providers and behavioral health enrollees are likely to participate in this project. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



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