LeadingAge New York
13 British American Blvd. | Suite 2 | Latham, NY 12110
leadingageny.org

HINMAN STRAUB P.C.
ATTORNEYS AT LAW

What DSRIP Projects Relate to LeadingAge NY Members?

Below are DSRIP Projects that may be of interest to LeadingAge NY members, by service line. Bear in mind that there are many projects, and based on the unique qualities of your organization; you may find that the opportunities are broader than that those listed below. We have tried to highlight those projects that most clearly present an opportunity, but encourage you to review the Toolkit in its entirety.

DSRIP Projects: Domains 2 (System Transformation) and 3 (Clinical Improvement)		
Nursing Homes		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management.	56
2.a.v	Create a medical village/alternative housing using existing nursing home infrastructure	42
2.b.v	Care transitions intervention for skilled nursing facility residents	41
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	41
3.a.v	Behavioral Interventions Paradigm in Nursing Homes	40
3.g.iii	Integration of palliative care into nursing homes	25
Home Care		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management	56
2.a.v	Create a medical village/alternative housing using existing nursing home infrastructure	42
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	43
2.b.vi	Transitional supportive housing services	47
2.b.viii	Hospital-Home Care Collaborative Solutions	45
2.c.i	Development of community based health navigation service to assist patients to access healthcare more efficiently.	37
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	31
3.b.ii	Implementation of evidence based strategies in the community to	26

	address chronic disease-primary and secondary prevention strategies (adult only): Cardiovascular health	
3.c.ii	Implementation of evidenced based strategies in the community to address chronic disease-primary and secondary prevention strategies (adult only): Diabetes Care	26
3.d.ii	Expansion of asthma home-based self-management program	31
Adult Day Health Care		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management	56
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	43
3.a.iii	Implementation of evidence-based medication adherence program (MAP) community based sites for behavioral health medication compliance	29
3.b.i	Cardiovascular Health - Evidence based strategies for disease management in high risk/affected populations	30
3.c.i	Diabetes Care – Evidence based strategies for disease management in high risk/affected populations (adult only)	30
3.c.ii	Diabetes Care – Implementation of evidence based strategies in the community to address chronic disease—primary and secondary prevention strategies. (adult only)	26
3.d.i	Implementation of evidence-based medication adherence programs (MAP) – asthma medication	29
3.e.i	Comprehensive project to decrease HIV/AIDS transmission – development of Center of Excellence management HIV/AIDS	28
Assisted Living		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management	56
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for health homes through access to high quality primary care and support services	46
2.a.v.	Create a medical village/alternative housing using existing nursing home infrastructure	42
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	43
2.b.vi	Transitional supportive housing services	47
Palliative Care		
Project #	**Project Name/Description**	**Score**
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management.	56

3.g.i	IHI "Conversation Ready" model	29
3.g.ii	Integration of palliative care into medical homes	22
3.g.iii	Integration of palliative care into nursing homes	25
Housing		
Project #	**Project Name/Description**	**Score**
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for health homes through access to high quality primary care and support services	46
2.a.v.	Create a medical village/alternative housing using existing nursing home infrastructure	42
2.b.vi	Transitional supportive housing services	47

Note that DOH encourages the inclusion of managed care/managed long term care and health homes in all PPSs. Domain 4 "Population-wide" projects should also be evaluated by providers based on community-specific needs.

Below are additional projects that may be of interest to some member organizations.

Clinics		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management	56
2.a.iv	Create a medical village using existing hospital infrastructure	54
2.b.i	Ambulatory ICUs	36
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scare services	31
3.b.i	Cardiovascular Health - Evidence based strategies for disease management in high risk/affected populations	30
3.b.ii	Implementation of evidence based strategies in the community to address chronic disease—primary and secondary prevention strategies (adult only)	26
3.c.i	Diabetes Care – Evidence based strategies for disease management in high risk/affected populations (adult only)	30
3.c.ii	Diabetes Care – Implementation of evidence based strategies in the community to address chronic disease—primary and secondary prevention strategies. (adult only)	26
3.d.i	Implementation of evidence-based medication adherence programs (MAP) – asthma medication	29
3.d.iii	Implementation of evidence based medicine guidelines for asthma management	31
3.e.i	Comprehensive project to decrease HIV/AIDS transmission – development of Center of Excellence management HIV/AIDS	28
3.f.i	Increase support programs for maternal and child health (including high	32

	risk pregnancies)	
Renal Care		
Project #	**Project Name/Description**	**Score**
3.h.i	Specialized Medical Home for Chronic Renal Failure	29
Mental/Behavioral Health Providers		
Project #	**Project Name/Description**	**Score**
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine/Population Health management.	56
2.a.iii	Health Home At-Risk Intervention Program. Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	46
2.b.i	Ambulatory ICUs	36
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	43
3.a.i	Integration of primary care and behavioral health services	39
3.a.ii	Behavioral health community crisis stabilization services	37
3.a.iii	Implementation of evidence-based medication adherence program (MAP) community based sites for behavioral health medication compliance	29
3.a.iv	Development of Withdrawal Management (ambulatory detoxification) capabilities within communities	36
3.a.v	Behavioral Interventions Paradigm in Nursing Homes	40