Table of Contents

Using this document to submit your DSRIP Project Plan Applications 2

Domain 2 Projects 3

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management 3

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 15

2.b.iii ED Care Triage for At-Risk Populations 23

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions 31

Domain 3 Projects 39

3.a.i Integration of Primary Care and Behavioral Health Services 39

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only) 48

3.c.i Evidence based strategies for disease management in high risk/affected populations. (Adult only) 57

3.d.iii Implementation of Evidence Based Medicine Guidelines for Asthma Management 65

Domain 4 Projects 72

4.b.i Promote tobacco use cessation, especially among low SES populations and those with poor mental health (Focus Area 2; Goal #2.2) 72

4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer) 81

Using this document to submit your DSRIP Project Plan Applications

Please complete all relevant text boxes for the DSRIP Projects that you have selected.

The Scale and Speed of Implementation sections for each of the Domain 2 and 3 projects have been removed from this document (highlighted in yellow) and are provided in a separate Excel document. You must use this separate document to complete these sections for each of your selected projects.

Once you have done this, please upload the completed documents to the relevant section of the MAPP online application portal.

Domain 2 Projects

2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management

Project Objective: Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management.

Project Description: This project will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed population and reduce avoidable hospital activity. For this project, avoidable hospital activity is defined as potentially-preventable admissions and readmissions (PPAs and PPRs) that can be addressed with the right community-based services and interventions. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system – from one that is institutionally-based to one that is community-based. This project will create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services. If successful, this project will eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes.

Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting at the right time, at the appropriate cost. By conducting this project, the PPS will commit to devising and implementing a comprehensive population health management strategy – utilizing the existing systems of participating Health Home (HH) or Accountable Care Organization (ACO) partners, as well as preparing for active engagement in New York State's payment reform efforts.

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. All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.
2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,

including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.

5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.
8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

ACP serves a broad geographic region spanning four boroughs – Bronx, Brooklyn, Manhattan, and Queens. In 2012, the Potentially Preventable Readmissions (PPR) rates per 100 at-risk admissions were comparable to the NY State rate of 6.3. However, the risk-adjusted rate per 100 for Potentially Preventable Visits (PPVs) for Medicaid beneficiaries are generally higher than the state rate of 36.1. The risk-adjusted Prevention Quality Indicators (PQI) "composite" measures per 100,000 for the Bronx (2,344) is 26 percent worse than the city rate (1,859).
PPR Rate:
- Bronx- 7.4,
- Brooklyn-6.0
- Manhattan-7.4
- Queens-5.7
PPV Rate:
- Bronx-38.2,
- Brooklyn-28.8
- Manhattan-42.1
- Queens-30.8
PQI "Composite" Measure:
- Bronx-2,344

- Brooklyn-1,724
- Manhattan-1,716
- Queens-1,482

Some of the notable needs that the CNA identified across the four boroughs were:
- Hospital beds in Queens and Brooklyn
- Nursing home beds in Brooklyn and Manhattan
- Primary care and mental health needs across all four boroughs, especially in low-income neighborhoods

Studies in our regions shows that the majority of potentially avoidable readmissions are for chronic conditions responsive to intervention and management in less costly community-based, ambulatory care or outpatient settings. Hence, there is a significant opportunity for improvement. The information collected also suggested that even where there are resources available, the system of care is very fragmented. Problems with care coordination, management, and navigation are the key system-related issues cited in key informant interviews with providers of physical health, mental health, and social services and in the provider surveys.
All selected projects will improve care management and coordination, reduce barriers to access, and decrease preventable admissions, readmissions, and ED visits. We will collaborate with partners' existing care management programs and develop a centralized care management function to fill gaps in care management across the PPS.
ACP has aimed to address the aforementioned areas of opportunity by creating an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of care and reduces service fragmentation while aligning provider incentives. The IT infrastructure we are developing will assist in improving care coordination, community engagement, and provider-to-provider communication. ACP will connect all partners to local RHIOs to enable data sharing with that larger group of providers across NYC.
As New York's only physician-led PPS, we are in a unique position to truly transform the way physicians' decisions about care delivery impact costs of care as well as engage patients. We will assist physician practices with the transformation to PCMH and team-based models of care. Practices will be held accountable to evidence-based disease-specific care guidelines and protocols, thereby improving quality while simultaneously addressing costs of care. Our hospital partners, with deep expertise in managing the Medicaid population and reducing readmissions, will continue to work with us to make further progress toward this aim. We will also draw on the resources of our community partners to bolster our efforts.
ACP is designed to achieve the triple aim of improved health for the population, enhanced patient experience and reduced costs of care for the community's benefit. While we are using DSRIP funds to build our infrastructure and capabilities, we believe that this will position us for the future of value-based payments and risk-based arrangements to support the ongoing financial sustainability of the IDS. In addition, the infrastructure will be consistent with, and supported by, infrastructure for similar population health strategies among the PPS lead organizations.

b. 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.

Provider Network and PPS Partners

ACP selected our partners with the intent of meeting the DSRIP requirements for

a comprehensive network of care, serving our current community and selecting partners whose expertise in physician leadership, care management, quality improvement, cost reduction and population health could be brought together to create an entity greater than the strength of its individual parts. Ultimately, our selected partners are aligned in our goal of creating an integrated delivery system that achieves DSRIP's Triple Aim of improved quality, improved population health, and lower costs.
ACP has culturally aligned primary care providers located within the same geographical service areas. Our PPS includes every category of healthcare service provider, with more than 800 primary care providers, 1,200 specialty physicians, 16 hospitals and 120 behavioral health/substance abuse providers. We have excellent established relationships between physician practices, hospitals, and other community based providers. Our PPS and partners also maintain strong and active partnerships with local governmental and community-based initiatives and programs, such as NY Quits. We also have over 60 community-based organizations that can help us address health literacy, housing, and other socioeconomic barriers. The depth and breadth of our network will allow us to support each of our project initiatives to the fullest.

Education and Training
ACP will engage approximately 9,000 of the 18,000 employees, physicians and providers in the PPS to implement the DSRIP projects. To the extent additional orientation and training in population health activities is required, such training will be provided. In addition, as gaps in services are identified, ACP will work with its network providers to extend hours or establish new sites to address the gaps.
ACP will retrain and redeploy displaced staff in new roles, such as care coordinators and case managers, depression care managers, and others to provide one-on-one care to our patients. Based on stakeholder survey results, our PPS project implementation plan will engage about 45,000 employees across the PPS network. About 21,000 employees will be directly involved in DSRIP of which around 1,800 represent new hires. Approximately 5,200 staff members will be expected to be hired through retraining and/or redeployment.

Health Information Technology (HIT)
Greater than 90% of ACP's providers currently have EHRs and registries implemented and we will further expand on current EHRs and registries. This includes expanding health information exchange / RHIO connections. Ultimately, ACP will create an integrated technology platform that will be leveraged for the purposes of communication, data sharing and interoperability within this project.

c. 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.

1. Partner Engagement and Communication: ACP has a large number of partners, including over 2,000 physicians, and engaging all of these partners will be challenging. Successful engagement of all partners will require strong leadership from ACP. This challenge will be addressed by building a

strong, centralized project management office. A physician leader, or medical director, will be tasked with engaging physician partners and ensuring continuous feedback regarding performance on managing for value. To address the challenge of communicating and information sharing across this expansive network, we are developing a robust integrated technology platform that will be accessible across the majority of our providers and will go hand-in-hand with an agreed upon communication plan.
2. Increased Demand for Primary Care Services: As our PPS educates patients in the use of lower costs settings, we anticipate the demand for primary care services will increase. We believe our network will be able to meet the demand since we have such a large number of physician partners. However, given the broad geographic region, there will likely be hotspots of need that may require encouraging growth of existing primary care practices or new talent.
3. Patient Engagement: Patient engagement and compliance will be another challenge due to the unique make-up of our population driven by the poly-cultural and poly-lingual nature of our population. We will address this by developing additional culturally sensitive, and language-specific resources to successfully engage and impact our population's health.
4. Support for Patients: ACP will need to assist its patients in overcoming barriers to care as identified in our CNA, including:
- Affordability of co-payments
- A lack of access to transportation
- Patients' lack of understanding about where to access appropriate levels of care
Five percent of DSRIP funds will be allocated to non-reimbursed services that will help address some of these barriers listed here.
5. Performance Monitoring: Monitoring metrics will be a challenge with such a large network of providers who have a variety of EHRs or paper documentation processes. We will be establishing a data warehouse to collect, store, and analyze data across these provider sources, and are planning a concentrated effort to expand EHR use and IT connectivity across all providers.

d. 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.

ACP has overlapping service areas with other PPSs. ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs. PPS collaboration will continue throughout the life of DSRIP.
We plan to coordinate with the hospitals within those PPS's across all DSRIP projects to share resources and data, such as receiving alerts from hospitals when one of our members receives or is planning on receiving care. This project in will be a source of integration for the nine other DSRIP projects. This integration will be achieved through improved IT, RHIO connectivity, centralized communications, educational efforts and governance. With information from interconnected providers, safety net providers, local RHIOs, PCP referrals in particular through the 2biii project, and MCOs, our PPS will facilitate collaboration with other PPSs in the area to share health information about Medicaid beneficiaries that access services in multiple PPS networks. ACP will also share DSRIP best practices (e.g., protocols, outcomes) and communicate with other PPSs' in Queens and Long Island through our partnership with NSLIJ, which is part of several PPSs. MediSys has and will continue to discuss ways to improve care and coordinate efforts with the HHC PPS in Queens. ACP also has relationships with other PPS's and hospitals throughout NYC that

will be emphasized to strengthen ACPs and other PPS's performance. We will collaborate with PPSs interested in sharing best practices or engaging in shared learning/training. We will actively participate in state-wide learning collaboratives for all DSRIP PPSs to learn from other organizations through the state and participate in all DOH educational programs.

2. System Transformation Vision and Governance (Total Possible Points – 20)

a. Please describe the comprehensive strategy and action plan for reducing the number of unnecessary acute care or long-term care beds in parallel with developing community-based healthcare services, such as ambulatory, primary care, behavioral health and long term care (e.g. reduction to hospital beds, recruitment of specialty providers, recruitment of additional primary care physicians, hiring of case managers, etc.). The response must include specific IDS strategy milestones indicating the commitment to achieving an integrated, collaborative, and accountable service delivery structure.

ACP, with our strong complement of physicians, is uniquely positioned to pursue our vision of reducing avoidable services while ensuring that access to primary care is enhanced and quality is improved. Our governance model has outlined a plan for oversight of the IDS through a number of committees in the PAC and project management office. This group will ensure that the project requirements and strategy milestones are met as well as evaluate network adequacy on an ongoing basis.

The ten projects that we have selected have the potential to impact a need for health care resources. ACP plans to work closely with hospital leadership to address challenges that may arise, including but not limited to loss of hospital beds and impact on the healthcare workforce. We will use objective measures in our assessment of how the changes in utilization are impacting the need for specific acute care beds and other facilities. NYS' Bed Need Methodology, considering changes in acute care and long-term care utilization, overall health status of the community and population growth and Medicaid enrollment trends, will serve as one such resource. We will assess these impacts on a regular basis to ensure that we are taking appropriate action to adapt to the changing healthcare landscape. We recognize that some of our partners will be particularly impacted by the success of this initiative with declining revenues. As such, we will help to transition these organizations in our funds flow model.

ACP will employ the following strategies in developing our IDS:

- Our PPS and partners will work with a variety of community based organizations, including housing agencies, meal delivery services, food banks, and faith-based organizations, to address the social determinants of health.
- The PPS is also working will all of its partners, including providers and community-based organizations, to improve patient engagement and strengthen health literacy prior to the start of the DSRIP performance period. Patient navigators will play a key role in educating patients on how to best care for themselves and appropriately access care.
- Our PPS will strive to enhance the primary care network and healthcare workforce, especially related to transitioning all primary care practices to PCMH 2014 Level 3 certification and meaningful use standards by DY3.
- All of our providers will be connected to our centralized IT infrastructure and local RHIOs enabling two-way data sharing and improved provider-to-provider and provider-to-patient communication. The IT infrastructure will help the PPS track cost utilization, clinical quality

metrics, engage patients with appointment reminders and adhering to care plans, and achieve population health metrics. The action plan for this strategy is the purchase and implementation of necessary hardware and software to enable IT connectivity across the PPS by DY3.
- Our PPS and partners will create and implement care guidelines and protocols across all the network specific DSRIP projects including, 2aiii, 2biv, 3ai, 3bi, 3ci, 4bi, and 4bii, prior to the start of the DSRIP performance period. ACP will build on existing patient registries to track and monitor patients with a particular disease as it is relevant to specific DSRIP projects. All staff will be educated on these care protocols to ensure that patients receive standardized care across the PPS by DY1.
- We will expand care management and care coordination functions across the PPS, particularly to outpatient, community-based settings to direct patients to lower cost settings when possible. Care management efforts will focus on high-risk patients with chronic disease and behavioral health issues by DY2.
- We will improve access to behavioral health services, particularly through the implementation of the IMPACT model in project 3ai at PCP practices, which will provide depression screening for patients in the primary care physician's office and refer identified patients with behavioral health needs to necessary follow-up services by DY1.
- We will work with existing MCOs and Medicaid ACOs on a regular basis to transition from a traditional FFS reimbursement system to more value-based payment arrangements, as well as a discussion of utilization trends and performance issues by DY1.
- ACP will continuously leverage the strengths of our hospital, health home, long term care, behavioral health, developmental disabilities, community-based organization, MCO, care management organizations, home care, and physician partners to transform the complete continuum of care for our Medicaid beneficiaries, working toward our PPS achieving the Triple Aim, a better patient experience, improved health outcomes and reduced costs, throughout the DSRIP performance period.

All of these core pillars of our approach will be further delineated in our March 1, 2015 implementation plan.

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

The Board will monitor the effectiveness of the evolving partner network into an integrated delivery system. As the DSRIP projects are implemented, the Board will evaluate the achievement of DSRIP goals, potential changes related to decision-making, project implementation, integration, compliance, incentive payment distribution methodologies, and communication. As demonstrated in the ACP organizational chart in the governance section, the Project Management Office and a set of committees will ensure successful project implementation under ACP's Delegated Governance Model.

The Project Management Office, the PAC Leadership Committee, the Finance Committee, the IT Committee, the Steering Committee, and the Clinical Committee will all monitor the partners' performance in all of the DSRIP projects, which by definition includes the formation of an

integrated delivery system over the five-year DSRIP period. The IT and Finance Committees will work together to establish the IDS platform that will enable information sharing and support the shift to value-based payments. The Finance committee will also monitor the funds flow and incentive distribution in collaboration with NSLIJ, the fiduciary to the PPS. The Project Management Office, Clinical Committee, and county-specific Care Teams specific to each project will monitor the clinical aspects of the IDS formation including the implementation of standardized care protocols across the PPS and centralized care management initiatives. These committees will meet on a quarterly basis. The PAC leadership committee will receive feedback from patients, partnering organizations, and providers and will bring that feedback to the relevant ACP committees to improve the IDS and facilitate further integration of providers.

ACP believes that successful outcomes can be obtained by providing clear protocols and delineated processes to which PPS providers will adhere. ACP will provide each provider with written protocols and a procedure manual, with milestones and metrics for implementation and minimum performance goals. ACP specific reporting metrics will be developed which may include PQRS codes, flow charts, meaningful use (MU) data pull, clinical decision support system (CDSS) alert fulfillment, registries and others. This monitoring process will ensure that all PPS partners achieve the IDS project requirements.

The Board, with support from relevant Committees, will be held accountable for meeting key milestones related to this project including:

- Achieving PCMH 2014 Level 3 status at all PPS primary care practices by DY3;
- Implementing an integrated technology infrastructure to support data sharing and monitoring efforts related to DSRIP performance metrics, real-time data sharing between patients and providers, and population health management analytics;
- Engaging all PPS partners in the IDS formation;
- Assessing network adequacy, specifically addressing areas with an oversupply of hospital beds as needed; and
- Engaging in value based payment contracts with MCOs over time.

Through the Board's continuous monitoring and adaption, the PPS will achieve its goal of evolving into a fully integrated delivery system. To ultimately achieve the objectives of the DSRIP program, ACP will employ a continuous improvement process by which results and feedback from each year will dictate necessary changes to be made. The metrics generated from project implementation during Year 1 will serve as an opportunity for the Board to review the governance structure and assess whether elements of the structure can be improved. Subsequent reviews will occur annually upon assessment of project metrics and disbursement of funds. This will include refreshing committee participation and project-specific workgroups annually. As a PPS with a large physician network and with a number of hospitals, other healthcare providers, and community based organization partners, ACP is well-equipped to recognize areas of improvement and create plans to better meet the goals of DSRIP as well as evolve into an integrated delivery system during the DSRIP performance period to improve the overall health outcomes of the Medicaid population. ACP will also benefit from having a large base of physicians to support the development of an IDS, as physicians, especially primary care physicians, become the main party responsible for a patient's care in an IDS that is working on effectively managing the health of a population.

Lastly, contractual arrangements, particularly as they relate to incentive distributions, may need to be adjusted as the IDS evolves. Arrangements that are being set up during the DSRIP baseline year may not sufficiently address all legal and regulatory issues as the current,

fragmented network achieves integration.

3. Scale of Implementation (Total Possible Points - 20):

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.

4. 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.

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

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Our PPS will be requesting capital funding to provide necessary resources that would aid our IDS in achieving the Triple Aim of a better patient experience, improved health outcomes, and reduced costs.
Our PPS plans to use capital funds to finance the development of an IT infrastructure that would connect all providers across the PPS. This would include implementing an EMR at all partnering provider locations, connecting local hospitals, physicians and other partners to facilitate data sharing and communication, and joining local RHIOs to contribute to and benefit from the data available on those networks.
We are also considering the development of new facilities and/or renovating and repurposing existing facilities that would likely be funded by capital and would provide improved access to care

and facilitate project implementation. Some facilities under consideration are centers that could provide urgent care, primary care, behavioral health, and other social services to patients. These facilities would be located in areas demonstrating a significant need for services (hotspots) and/or areas with an inadequate supply of healthcare providers. Our Medicaid population would benefit from these facilities, as many patients currently have limited access to care.

b. 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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

a. 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.

6. 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 the implementation of the IDS strategy and action plan, governance, 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.

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

Project Objective: This project will expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of higher risk patients. These patients do not qualify for care management services from Health Homes under current NYS HH standards (i.e., patients with a single chronic condition but are at risk for developing another), but on a trajectory of decreasing health and increasing need that will likely make them HH eligible in the near future.

Project Description: There is a population of Medicaid members who do not meet criteria for Health Homes but who are on a trajectory that will result in them becoming Health Home super-utilizers. This project represents the level of service delivery and integration for the complex super-utilizer population who fall in between the patient-centered medical home and the Health Home general population. Some risk stratification systems refer to these patients as "the movers." Early intervention through this project shall result in stabilization reduction in health risk and avoidable service utilization.

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. Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH PCPs in care coordination within the program.
2. Ensure all participating primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH or Advanced Primary Care accreditation by Demonstration Year (DY) 3.
3. Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.
4. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.
5. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
6. Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.
7. Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.
8. Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local

government units (such as SPOAs and public health departments).

9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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.

ACP's Community Needs Assessment (CNA) identified health home at-risk intervention as a major opportunity. The goal of ACP in this project is to identify those patients at risk for deteriorating health conditions and to implement a comprehensive care management model to increase the quality, adequacy and frequency of care that they receive to improve their health, thus avoiding the progression into Health Homes. There is a high prevalence of patients with one or more chronic conditions in our PPS' service area. Additionally, Jamaica has one of the highest rates of potentially avoidable emergency room visits (PPV) in Queens (33.8%) after making adjustments for case mix and area demographics.

The majority of Prevention Quality Indicator ("PQI") admissions in Queens are for chronic conditions that can be addressed in less costly settings. ACP will reduce PQI admissions through this project. Queens has one of the lowest follow-up visit rates after hospitalizations for mental health patients (46.8%), lower than the Queens rate of 50%, substantially lower than the NYS rate of 55%. East New York (50.5%), Jamaica (46.8%), LIC/Astoria (50%), Ridgewood Forest Hills (49.5%) and Southeast Queens (30.6%) are the neighborhoods in the service area that are in line or below state rate.

Many frequent ED users are not receiving the appropriate upstream care necessary to prevent readmissions to the hospital or ED. Without the appropriate guidance and follow-ups, these patients often end up back in the ED as the true source of their condition has been left untreated. Poor housing and nutrition, limited access to transportation, low levels of health literacy, and other factors can limit access to lower-cost care.

The CNA data listed above indicates an opportunity for ACP to work with beneficiaries to manage care. The PQI indicator suggests an access or connectivity challenge between beneficiaries and ambulatory and community care. Another challenge is beneficiary engagement to keep conditions under control. The four boroughs are unable to respond to these challenges due to the minimal incentives to coordinate care across settings, a lack of standardized protocols and evidence-based strategies across providers, and limited integration. This project and associated DSRIP funds will provide the financial incentive for providers to transform the delivery system to ultimately improve beneficiary outcomes.

ACP is strongly positioned to respond to these challenges. ACP is engaging physicians, nurses and other provider types through its network. This includes providers in the designated hotspots. Self-management is taught through patient education and care coordination models. Evidence-

based guidelines have been created to standardize optimal care and identify and manage health home at-risk interventions and their risk factors.
In achieving the goals of this project, ACP with its network of more than 2000 physicians will rely on its Support Center that will include a robust care management model. The PPS will utilize care managers, trained to manage the care of patients "at-risk" of qualifying for health home services. They will institute aggressive coordination, care planning, follow-ups, and education for the patients. The care team will emphasize community-based care alternatives and introduce patients to community-based resources. In addition, social workers will act as a link between the care team and the patients and will connect the patients to appropriate resources such as housing partners, nutrition counseling etc.
The PPS will expand the use of current IT infrastructure to flag and identify patients who fit the "at-risk" criteria as defined for this project. This process will allow the PPS to filter patients into the appropriate level of care management as well as create a means for tracking patients. In addition, we will ensure that all participating safety net providers are actively sharing EMR systems and notification alerts.

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.

Our target population is defined by geography, demographics and disease type. Data will be gathered to include patients within the four counties served by ACP: Bronx, Brooklyn, Manhattan, and Queens. The demographics of the patients will include all Medicaid patients with the following disease types:
- Diabetes
- Hypertension
- Angina
- COPD
- Heart Failure
- Asthma
- Behavioral Health
- Long term care needs

Claims data grouped by ICD 9 codes will be used to identify targets. ACP will assign ICD 9 codes for each targeted disease type. The PPS will also use registries within the providers' EHR data to obtain patient information and supplement the data filters as described above.
This project will target all patients in the PPS' service area who do not qualify for a health home at the moment, but due to their condition/health status/comorbidity are considered "at-risk" of qualifying. Patients satisfying one or more of the "at-risk" criteria listed above will be flagged for evaluation by a care manager.

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.

Cultural Competency
ACP has culturally aligned primary care provider offices located within the same geographical areas as the targeted population. These providers are of ethnic and racial minority groups reflecting the populations served and have patient relationships. This network is culturally sensitive and linguistically aligned with the patients in the geography.
Evidence-based Protocols
ACP has developed evidence-based protocols for the project that include :
- Lifestyle modifications including diet
- Identification of patient needs beyond taking medication
- Screenings to identify tobacco and alcohol use, depression, mental health co-morbidities
- Assessment of ability to perform activities of daily living, living conditions, socioeconomic needs and engagement of partner organizations (i.e., social services)
- Additional disease specific evidence-based protocols for other DSRIP projects
Provider Network and PPS Partners
The ACP network includes over 2,500 providers, and currently has strong Health Home capabilities from which to draw resources and experience, and apply this to the new "at-risk population." These Health Homes have had success in care management of the frail and chronically sick patients that they serve increasing the quality of life and reducing hospital utilization as well as better disease management.
Community based providers are reflected in specialty and social services providers, and community stakeholders, housing, dieticians. All providers will participate in the care and compliance of the patients to reach successful outcomes.
Care Coordination
ACP will leverage its Support Center which includes the following components:
- Specialist care
- Home care services
- Monitor patient compliance (i.e., medication adherence refills, blood pressure readings)
- Medication and meal delivery services
- Transportation for specialist appointments
- Social support/housing services
ACP has active partnerships with governmental and community-based initiatives (i.e., NY Quits). ACP's current network of PCMH clinics will be leveraged to bring the other primary care providers of ACP to successful PCHM level 3 certification.
Education and Training
ACP will provide training to office staff, including back and front office, to ensure patients have timely blood pressure measurements and guidance. ACP is also implementing specific community outreach and education, using the Stanford model, designed for each community in a language and format that can reach the target population.
Health Information Technology (HIT)
Greater than 90% of ACP's providers currently have EHRs and registries implemented and we will further expand on health information exchange / RHIO connections. Ultimately, ACP will create an IDS platform in the development of project 2.a.i that will be leveraged for the purposes of

communication, data share and interoperability within this project.

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.

ACP expects to encounter these challenges:
1. Customs and Culture: Changing traditional eating patterns will represent a challenge. To meet this challenge the PPS will leverage its cultural diversity and culturally aligned physicians, staff and programs to reach the patient in an acceptable language and tone, and families and caregivers, who are often responsible for the patient. The PPS will also provide one-on-one, handout, and population-wide education at the Primary Care level on disease, and disease prevention and management.
2. Changing Primary Care Office Mechanics: These offices will have to incorporate patient education with no additional reimbursement. The PPS plans to meet this challenge by providing support and training to front and back office staff to allow staff to respond to needs. ACP will also create educational materials, patient incentives and negotiate with MCOs to cover additional services.
3. PCMH Level 3 Certification: It will be difficult to ensure all network providers receive certification. The PPS will meet this challenge via a strong Support Center comprised of IT support staff and EHR and PCMH experts who will guide the practices step by step in achieving this requirement and monitor metrics closely.

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.

ACP has already collaborated successfully with all PPSs in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs.
ACP will engage in several population-wide educational efforts. Working with other PPSs in ACPs geographical area on patient education materials, especially those regarding lifestyle modification, will be created and broadcast along a wide range of media. ACP will also work with other PPSs in procuring patient compliance incentives.
ACP has negotiated collaboration with North Shore Long Island Jewish (NSLIJ)PPS for providing care to Nassau patients requiring services within Queens, Bronx, Manhattan or Brooklyn and for NSLIJ providing services to ACP patients requiring services in Nassau county, both PPSs will willfully exchange information and support each other's efforts.
ACP will collaborate with many health organizations regardless of the PPS that they are participating in to best ensure patient reach and patient compliance. The services rendered to ACP's patients will come from nearly all of the hospitals in the same geographical area that ACP engages in and the PPS will therefore have collaborative agreements for prompt and efficient care as well as data interchange and care coordination.

1. **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.

2. **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.

3. **Project Resource Needs and Other Initiatives (Not Scored)**

   a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be required for the development of a wellness center.

   b. 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
☐	☒

   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

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.

4. **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.

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.

ACP's CNA identified overutilization of ED as a significant opportunity. Potentially Preventable Emergency Room Visits (PPV) for Medicaid only population were especially high in Manhattan (42.1%) and the Bronx (38.2%). Queens and Brooklyn experienced 30.8% and 28.8%, respectively. This is likely due to the lack of members choosing to use primary care.

The CNA data also pointed to a gap in the physician/patient relationship. More than 21% of the Bronx population reported having no personal doctor. In Brooklyn, Manhattan, and Queens, those rates were slightly lower at 18.6%, 17.6%, and 18%, respectively. Additionally, the greatest proportion of residents that reported not having had a routine check-up in one to two years was in Brooklyn (10.8% across the borough; highest: 15.1% in Downtown Brooklyn) and Manhattan (11.9% across the borough; highest: 17.7% in East Harlem). In Queens and the Bronx, rates were slightly lower at 8.7% and 7.1%, respectively.

Our CNA also identified an inconvenience for patients to use primary care over the ED. Throughout our communities, appointment wait times of 4+ days are not uncommon. This PCP-supply issue exists across all of our geographies, This project and associated DSRIP funds will enable our vast network of providers to transform the delivery system and expand primary care capacity in specific areas of need.

To address the above challenges, ACP's vison for this project is to establish an effective ED Triage program focused on reducing preventable emergency department utilization by engaging in efforts that will improve PCP connectivity and educate patients on how and when to access ED care. As patients transition to care outside the ED, ACP will also ensure that the patient has adequate resources available in order to receive timely, high quality care in a primary care setting and has linkages to any needed community based organizations.

ACP will be establishing an ED triage process in emergency rooms that will include a robust team of ED Patient Navigators available to every patient to perform ED triage and connect the patient with their existing PCP, to link those without a PCP to an ACP primary care provider and to schedule a timely appointment with the PCP before leaving the ED using ACP's integrated platform or the PCP's EHR portal. The ED patient navigators will also serve to educate patients about alternative sites of care for non-ED sensitive conditions.

Care managers who will provide more aggressive coordination, care planning, follow up and educational resources to higher risk patients and connect those with Health Homes where they can receive high quality integrated care.

In addition to programs within the PPS Hospital settings, ACP will engage its broad population by through is vast network of primary care providers. ACP will achieve this by integrating all of its providers via development of a technology platform as part of project 2.a.i which will provide real time scheduling and data exchange for ER discharge information, presenting symptoms etc. The

platform will also serve to alert EDs by identifying over-utilizers so that more robust intervention can be provided with greater outreach and narrower bonds. All PCPs, Health homes and FQHCs will implement protocols for receiving, engaging and following closely those patients being referred from the ED. Same or following day appointments will be made available to each patient referred from the ED.
The project will have impact on future ED visits and success will be measured based on patient reutilization since at initial ED visit the ED triage plan will ensure connectivity with PCP.

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.

Our target population is defined by geography, demographics and disease type. Our target population for reducing preventable ED utilization will be all Medicaid at risk patients utilizing care within the Emergency Departments of the four Hospitals in the PPS.

ACP recognizes that it is in the interest of the patient's well-being that each patient have an active relationship with a primary care provider, therefore the PPS will implement an ED triage plan for all patients regardless of disease type, age or sex. The patients who will need the greatest attention and intervention are those that are identified as high-utilizers and/or part of an at-risk population, as defined socioeconomic/living conditions, and disease types including and with special attention to substance abuse and mental illness. For instance, patients with chronic diseases (cardiovascular disease, diabetes) and mental illness are high ED utilizers who have the potential to reduce ED visits if overseen through proper care management and PCP support.

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.

PPS Network and Partners
Currently ACP has over 2,500 providers in its network that includes PCPs, PCMH and Health Homes, close to 90%of whom have the capacity to integrate via their EHRs across our PPS and to other PPSs in the region. ACP will leverage this capability to receive referrals from the EDs, both within the PPS and from outside. Additionally, ACP will build capacity to handle non-ED conditions through our Urgent Care Centers, where patients may receive services, maintain their connection with their PCP and incur lower costs.
ACP will leverage the resources of its partners, such as trained and knowledgeable ED staff and care coordinators that are experienced in directing patients towards primary care; a current hospital based EMR system, EPIC, that tracks high utilizers; contains direct messaging tools that provides a secure platform for physicians to follow-up with patients and communicate care plans and appointments. ACP also has and will leverage established call centers that can direct patients to health resources and schedule appointments.
Care Coordination
ACP's care coordination model has been successful in coordinating services and caring for patient

needs. The PPS plans to expand on this model to create and implement a robust triage process between EDs and PCP offices. The ED patient navigators and care coordination teams at the ED will make arrangements to ensure that the patient is connected with the PCP/Health Home and leaves the ED with an appointment in hand to see the primary care provider. Additionally, they will create connection to community based services, transportation, and social services as needed. Currently, we have several health home partners which serve the four counties served by ACP. These include Heritage Health Home, North Shore-Long Island Health System Health Home, Visiting Nurse Service of New York Community Care Management Partners (VNS), Mount Sinai Health Home, and NYC Health and Hospital Corporation (NYCHHC). As we work with our target population on this and on project 2.a.iii Health Home At-Risk Intervention Program, we will definitely collaborate with additional Health Homes to serve broader needs of our target population.

With respect to workforce strategy, as the job tasks are similar to care managers and coordinators for preventing avoidable hospitalizations and Health Home at-risk intervention, we may include ED triage in their jobs initially. We will monitor the volume and types of service needs and separate out the jobs when indicated.

Health Information Technology (HIT)

Greater than 90% of ACP's providers currently have EHRs and registries implemented and we will further expand on health information exchange / RHIO connections. Ultimately, ACP will create an IDS platform to include robust technologies in the development of project 2.a.i. The platform will be leveraged to create a portal through which appointments will be made in real-time for follow up care of every patient seen in the ED. The integration platform will also provide the ability to exchange data creating more accurate treatment plans and reducing error rates. We will extend our IT/data sharing capabilities to other PPSs to successfully integrate and create capacity for receiving patients.

Open Access Scheduling

Through open access scheduling, our patients and ED patient navigators will be able to easily obtain appointments within the outpatient setting and our PPS will be able to work alongside our large network of providers to reduce the barriers to receiving care. We will expand the use of open access scheduling throughout the PPSs vast number of providers to decrease non availability of appointments.

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.

ACP expects to encounter challenges in three areas:

1. Customs and Culture: Many cultures within our geographies are biased towards going to the ED for all care, as they see it as convenient and immediately responsive. These populations have lacked sufficient community outreach and education regarding ED use and alternative sites of care. Our PPS plans to provide population wide education and awareness campaigns to better educate patients on proper care and the importance of remaining connected to a Primary Care provider. ACP will work closely with our physicians to build trusting relationships with populations so they will want to use their PCPs for care. Additionally, we will work alongside our community

organization partners to expand outreach and education into the many ethnic groups represented in the patient population.
2. Capacity of PCPs/Alternative Sites of Care: Promoting that patients should see their PCP more often and use the ED less often represents a challenge for success since our PPS is serves an underserved area with low capacity for new appointments. Success will require PCPs to create greater capacity and possibly extend their work hours. ACP plans to address this challenge by providing support and training to the PCPs and staff to help make their practices more efficient and patient care more satisfying. ACP will also make available Care Managers that may be able to lighten the load for the PCP through participation in patient care. Additionally, this project may create the need for additional alternative sites of care such as urgent care which ACP will be building out and staffing.
3. Technology: Given the unique structure of our PPS that spans more than 2,000 physicians and community based providers, communication and information sharing could pose a potential challenge. We will address this through a robust, integrated technology platform that will be accessible across all of our providers. Additionally, this initiative will rely heavily on our capability to communicate with other PPS' in our area that are also participating in the initiative. We are currently building capabilities alongside our IT vendor, eCW, and will also leverage the SHIN-NY and RHIO platforms to assist in this task.

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.

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs. ACP has over 2,500 physicians spanning four boroughs: Bronx, Brooklyn, Manhattan, and Queens. PCP's patients will seek and receive care at several hospitals associated with other PPSs. ACP will integrate and allow access to their EHRs to these other PPSs in an effort to facilitate appointment scheduling's and coordinate care. ACP has robust relationships with all the other PPSs across the four boroughs including Mount Sinai and Bronx Lebanon and will be working closely with them on this integration project. When a patient assigned to an ACP primary care physician presents from a collaborating PPS Hospital, ACP will facilitate primary care follow up appointment scheduling. Additionally, ACP will establish a protocol with collaborating PPSs to receive ADT notification feeds to monitor the emergency department use by its attributed population.
Lastly, ACP's goal is to ensure system wide coordination and integration for care delivery across the entire geographic area that it serves thereby encompassing all of the overlapping PPSs.

2. <u>Scale of Implementation</u> (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 proje

Yes	No
☒	☐

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

Capital funding will be requested for costs associated with construction to reconfigure participating emergency departments to meet the objectives of the project. Additionally, we are requesting capital funds for the building of a Support Center to hold care coordination and case management teams. Capital Funding will also be required for building the integration platform including hardware, also subscription to mobile care communication and care coordination software.

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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

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.

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

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. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. 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.

The CNA identified opportunities to reduce readmission rates. In addition, the CNA surveys and interviews identified lack of integration as a top contributing factor to readmission.
The CNA identified the following Potentially Preventable Readmission (PPR) Rate:
- Bronx –7.41
- Brooklyn –6.04
- Manhattan –7.45
- Queens –5.44

ACP identified target hospital collaborators within each borough (defined by excess readmission ratio values greater than 1):
- Bronx: Lincoln, Montefiore
- Brooklyn: Maimonides, Brooklyn Hospital, University Hospital
- Manhattan: Lenox Hill, Metropolitan, Bellevue
- Queens: Flushing, Forest Hill, New York Hospital of Queens

A gap driving 30 day hospital readmissions is fragmentation of care. Providers and beneficiaries alike cited lack of care coordination as a top health care delivery system issue.
ACP identified borough challenges from the data above:
- Limited Protocols
- Adequate Care Coordination Training

Implementing this project through DSRIP will provide funding to adequately distribute protocols and train appropriately.
ACP has many strengths that will be enhanced through this project. Support teams will ensure that the lines of communication and connectivity are maintained. Evaluation guidelines and protocols will be expanded to all providers and settings.
The goal of ACP is to create a Care Transitions program by which includes:
1. Simple and customized discharge plan for all patients
2. Post discharge follow up is planned
3.Communication requirements

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.

Our target population is defined by geography, demographics and utilization trends and/or conditions. ACP will target all of its attributed patients with a hospital admission to any hospital within Bronx, Brooklyn, Manhattan and Queens with a chronic disease both physical and mental, substance abuse, and those with symptoms consistent with Cardiac or Gastroenterological Disease but who have had negative workups during their hospitalization. ACP will also target those patients' frequent admissions of any cause. The target population will include patients of all ages. There are certain high-risk groups who will likely fall into the higher intensity, shorter term

services and higher intensity longer, term service subgroups as they represent medically complex patients that are frequent utilizers of hospital services. These groups include:
- The chronically ill and developmentally disabled;
- Those with mental health problems
- Those with behavioral health and substance abuse issues;
- Patients with multiple co-morbid conditions

To estimate the target population for this project, we will use the 2013 total admissions.

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.

Discharge Planning

ACP has a several arrangements to support this project:
- New York Hospital of Queens: Real-time, 24/7 admit-discharge-transfer (ADT) notifications and discharge summaries
- Flushing Hospital and Lutheran Medical Center send a daily Excel file of ADT notifications and discharge summaries. This has the disadvantage of having a 1-day lag in notification.
- EmblemHealth, Amerigroup, HealthFirst, UnitedHealthcare, and Wellcare send a daily Excel file of admissions. The MCO files have the advantage of listing all cause all hospitals admissions to allow us to target patients upon admission and provide pre-discharge planning. However, the information lacks a discharge summary available.

An ACP analyst tracks, monitors, and provides summary presentations on discharge planning opportunities and gaps.

Care Coordination

Two main programs already in place:
- Home Visiting Practice: Providers conduct transitional care visits in the home providing comprehensive evaluation and management including performing comprehensive medication reconciliation, fall risk assessments, pain management, etc. Patient diagnostic services and assistance in the home are provided through affiliations with diagnostic, home care, pharmacy, meal delivery partners, among others.
- Care Coordination Teams: These are multi-disciplinary provider teams to manage successful care transitions. The team will prioritize at-risk patients. In-person visits are prioritized at the point of care for physician continuity linkage and patient trust. The team also works to achieve cultural competency, health literacy, and improve patient activation and engagement. There is continuous feedback among all parties involved. In the future, multiple care coordination teams will work off of a shared platform, standardized protocols (currently built) and will be part of a centralized support center being built out.

In addition, ACP's Support Center will include IT, Outreach staff, Care Coordinators and Case Managers to address and monitor fulfillment of referrals and compliance with treatment plans and provide outreach. Staff displaced from other areas within the PPS partners may be used to fill these positions.

Evidence-based Protocols

ACP has already written standardized protocols for this purpose. Process and procedure manuals that contain the following will be drafted or expanded upon:
• Identification of all patient needs including housing, home care, meal delivery, etc.

• Establish triggers and methods for referrals and intervention

Provider Network and PPS Partners

ACP will leverage its large provider network of over 2,500 providers, including cross-setting partners. For implementation of this DSRIP project, we will have collaborative discussions with all hospitals in ACP's geographical area to expand a framework to ensure success of this project. This includes not only linking with ACP's platform and data interchange but also gaining access to care managers and pre-discharge planning. This will allow comprehensive review of discharge instructions, follow up appointment scheduling and education.

Health Information Technology (HIT)

While preparing full integration with RHIO/SHINY, agreements will be negotiated with all hospitals in the PPS area to use Cureatr or ShiFox solutions for real-time 24/7 ADT notification. The ShiFox solution seems to have a cost advantage, especially for many of our community-based providers and partners. A full-function care coordination software, like Acupera, will support the tracking and reporting tasks.

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.

ACP anticipates three main challenges:

1. Patient Engagement: Traditionally, patient engagement in all boroughs is lacking due to lack of cultural competency, low education and health literacy rates. Enhanced emphasis on patient engagement is critical to ensuring positive and sustainable behavioral change. Without a significant change in behavior, DSRIP gains will not be sustainable over the long-term. The PPS will address this challenge with expansion of current culturally sensitive educational efforts and ongoing monitoring.

2. Changing Provider Office Mechanics: This change will be especially challenging because institutions which have been accustomed to working within a closed network will have to collaborate with other PPS' case managers. This includes access to patients while still in the inpatient setting for pre-discharge planning. ACP realizes that full service/clinical integration by all PPS' in one geography is key to the success. ACP understands that the benefits of population health management can only be tapped to the degree that providers are fully integrated. To address these challenges, we will initiate conversations and negotiations with all hospitals regardless of PPS affiliation and implement an IT platform that facilitates provider-to-provider communication.

3. Network Integration: ACP spans more than 2,500 physicians and community based providers; communication and information sharing could pose a potential challenge. We are preparing to address that through a robust, integrated technology platform that meets the requirements of project 2.a.i. In the development of project 2.a.i, we have incorporated necessary items that will enhance our Care Transitions project and help achieve success. This IDS will be accessible across all of our providers. Additionally, the ACP Support Center, included in all projects, will monitor metrics across providers who have a variety of EHRs or paper documentation processes. We will establish a data warehouse to collect, store, and analyze data and expand EHR use across all providers.

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.

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs. ACP leadership has demonstrated a strong commitment to collaboration as evidenced in the on-going negotiations with several hospital led PPSs. ACP expects that these negotiations will fruition into lasting agreements in areas of overlapping geography. We plan to coordinate with the hospitals within those PPSs across all DSRIP projects to share resources and data, such as receiving alerts from hospitals when one of our members receives or needs care from them.

ACP expects to participate in the creation of work groups across various PPSs. ACP patients engage and receive services from a wide range of providers, some who use other PPSs' resources like housing providers, Home Care providers, etc. ACP will work closely with the other PPSs to provide efficient care without duplication of services. ACP will facilitate communication between other PPSs in Bronx, Brooklyn, Manhattan, and Queens. Community based organizations familiar to ACP can help provide population wide services, for example Meal delivery services, medication delivery services, etc. ACP will work closely and collaboratively with all hospitals in our geographic area regardless of the PPS that they represent to ensure that ACP has case managers on site for efficient pre-discharge planning at the bedside.

Collaboration and data sharing with the other PPSs in our area will facilitate patient engagement, care coordination and management, IT, and training and repurposing of displaced workers working in conjunction with labor unions.

We will replicate our successful ADT notification program with New York Hospital of Queens and Flushing Hospital to all other partner hospitals.

Lastly, ACP's goal is to ensure system wide coordination and integration for care delivery across the entire geographic area that it serves thereby encompassing all of the overlapping PPS's.

2. <u>Scale of Implementation</u> (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. <u>Speed of Implementation/Patient Engagement</u> (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 project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be required for building of a Support Center to hold care coordination team and case management team. Capital Funding will also be required for building the integration platform including hardware, also subscription to mobile care communication and care coordination software.

b. 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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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.

5. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

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.

Domain 3 Projects

3.a.i Integration of Primary Care and Behavioral Health Services

Project Objective: Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

Project Description: Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

The project goal can be achieved by 1) integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then in model 3) behavioral health specialists can be incorporated into primary care coordination teams (see project IMPACT described below).

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

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.
Any PPS undertaking one of these projects is recommended to review the resources available at http://www.integration.samhsa.gov/integrated-care-models.

A. *PCMH Service Site:*
   1. Co-locate behavioral health services at primary care practice sites. All participating primary care providers must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by Demonstration Year (DY) 3.
   2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
   3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
   4. Use EHRs or other technical platforms to track all patients engaged in this project.

B. Behavioral Health Service Site:

1. Co-locate primary care services at behavioral health sites.
2. Develop collaborative evidence-based standards of care including medication management and care engagement process.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

C. IMPACT: This is an integration project based on the Improving Mood - Providing Access to Collaborative Treatment (IMPACT) model. IMPACT Model requirements include:

1. Implement IMPACT Model at Primary Care Sites.
2. Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
3. Employ a trained Depression Care Manager meeting requirements of the IMPACT model.
4. Designate a Psychiatrist meeting requirements of the IMPACT Model.
5. Measure outcomes as required in the IMPACT Model.
6. Provide "stepped care" as required by the IMPACT Model.
7. Use EHRs or other technical platforms to track all patients engaged in this project.

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

2. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

According to ACP's CNA, fifty-three percent of all NYS Medicaid beneficiaries diagnosed with a mental health condition live in NYC, with Brooklyn and the Bronx having the highest prevalence. The top neighborhoods across the four boroughs for serious psychological distress are as follows:
- Coney Island (12%);
- Bay Ridge/Bensonhurst (9.8%);
- Williamsburg/Bushwick (9.6%);
- Pelham Bay/Throgs Neck (8.6%);
- South Bronx (8.1%).

Depression, chronic stress and anxiety and schizophrenia are the three most common mental health diagnoses in NYC. A combination of complex socioeconomic factors (poverty, job insecurity, immigrant-related issues, limited language ability, etc.) place an overwhelming amount of stress on lower income residents that contribute to high levels of depression. There is an opportunity to improve the availability of culturally competent behavioral health, which is needed in the diverse populations of all four boroughs.

Additionally, each of the following neighborhoods have greater than 25% of beneficiaries with Mental Health Conditions and are considered project hot spots: Kingsbridge and Riverdale, Northwest Brooklyn, Southern Brooklyn, Chelsea and Clinton, East Harlem, Gramercy Park and Murray Hill, Lower Manhattan, Upper East Side, Upper West Side, and Rockaways.

Medicaid beneficiaries with a behavioral health condition face many barriers to receiving appropriate care for their complex needs such as inadequate access, difficulty in navigating the system and lack of integration between PCPs and behavioral health providers. As a result, we see high potentially preventable visit (PPV) rates amongst these patients. Additionally, our CNA indicated that Medicaid beneficiaries with either a mental health or substance abuse health condition, or both, in New York City had much higher rates than "all other" health conditions. In our CNA's key informants' survey, the supply of behavioral health services was perceived as the biggest gap in available health care, behavioral health, and social services. This project and associated DSRIP funds will provide the financial incentive for providers to transform the delivery system towards greater integration and ultimately improve beneficiary outcomes.

ACP will address this gap in available resources and coordination of care with a special focus on those suffering from depressive disorders by implementing the IMPACT Collaborate Care model in both current PCMH practices and practices that are not PCMH yet. Emphasis will be placed on early intervention, onsite PCP coordination, medication management, non-stigmatizing practices, culturally and linguistically competent care engagement, and moving from episodic care to whole health care. Under this model, the PCP provides enhanced screenings for depression and alcohol and substance abuse; achieves universal EHR connectivity with interoperability; recruits, trains and deploys Depression Care Managers and Patient Advocates to conduct outreach, engage and educate patients; and potentially establishes a Crisis Intervention Center. The project will be implemented in all primary care practices within the four boroughs serviced by our PPS.

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.

Our target population is defined by geography, demographics, and disease type, and will consist of all patients receiving care at the PPS' primary care physician practice. Those patients will be screened using the PHQ9 tool as a base, and may also receive screening via Audit C, GAD, SBIRT, and DAST tools for identification of several Mental and Behavioral Health conditions.

Per evidence-based clinical guidelines, all patients will receive the appropriate screenings, especially in the above identified hot spot service areas. Appropriate treatment and follow-up services will also be provided accordingly. Our target will encompass all attributed lives including those with disparities such as foreign-born, low socioeconomic status, and those with chronic illness conditions, which may also contribute to mental health issues. Based on the results of the CNA, we have identified a number of primary care and Behavioral and Mental Health providers in

our service areas. We will continue to seek out additional resources and establish and strengthen linkages to ensure integration of primary care and behavioral health services within our PPS.

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.

Provider Network and PPS Partners
ACP is comprised of a broad, highly organized network of over 2,500 providers that include culturally competent PCPs located in every community within Bronx, Brooklyn, Manhattan and Queens. Most of the PCPs are of a minority descent and fully reflective of the ethnicity and racial composition of the target population and attuned to the cultural factors that may contribute to stigma associated with mental/behavioral health interventions. These providers will be supplemented by behavioral health professionals and trained care managers to improve patient engagement. Additionally, ACP has a vast network of community-based behavioral and mental health providers that include OMH Article 31 and OASAS certified providers located throughout the 4 boroughs that it serves.

Collaborative Care/IMPACT
Collaborative care is the cornerstone of the IMPACT model. In consultation with a psychiatrist, the primary care provider and the Depression Care Manager develop and implement an appropriate treatment plan. The Depression Care Manager (DCM) will work directly with the patient. DCM provides education, supports prescribed anti-depression medication regiments, and coaches patients in behavior activation. DCM also provides “stepped care” support, measures, monitors treatment responses, and prepares a relapse prevention plan with each patient.

Development of Support Center
Depression Care Managers, Care Coordinators and Outreach staff will be part of ACP’s Support Center. They will provide “warm” handoffs to specialist services. Other resources within ACP is Flushing Hospital Medical Center’s integrated primary care and behavioral health services at two locations. It was awarded one of ten state DOH integrated care licenses. FHMC has re-labeled behavioral health as “Life Style Medicine” to reduce the stigma associated with behavioral health and emphasize health promotion. Additionally, two of our federally qualified health centers (FQHCs), Charles B. Wang Community Health Center and Heritage Health, also offer integrated primary care and behavioral health services.
ACP will re-purpose and re-train displaced staff in the development and achievement of this project’s goals through employment of Depression Care Managers, Care Coordinators, Outreach staff. Our support center will include a 24/call center for immediate response to our patients needs.

Health Information Technology (HIT)
Greater than 90% of ACP’s providers currently have EHRs and registries implemented and we will further expand on health information exchange / RHIO connections. Ultimately, ACP will create an integrated delivery system platform in the development of project 2.a.i that will be leveraged for the purposes of communication, data share and interoperability within this project.

Education and Training
ACP will contribute to the repurposing and retraining of displaced staff in the development and achievement of this project's goals through the following:
- Employment of Depression Care Managers and coordinators
- IT, Metrics, communications staff to prepare and deliver Community Education and Outreach training and deployment of Patient Advocates
- Outreach staff, who will staff a 24 hour call center for immediate response to patient calls and for making and confirming appointments with PCPs and specialists

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.

ACP expects to encounter challenges in two areas:
1. Perception of Mental Health: There is a big taboo around mental health in most of the cultures that ACP serves. Mental illness is seen as a weakness and not as a true illness. Fear of being perceived as "crazy" if under the care of a mental health professional keeps patients away from receiving much needed care and thus leads to the progression of the mental illness and the noncompliance of treatments for other physical illnesses and the aggravation of symptoms. This lack of acceptance of mental illness creates higher hospital utilization as somatic manifestations arise such as palpitations, headache, shortness of breath, etc. ACP will address this challenge engaging the cultural makeup of its PCPs to address the patient's sensitivities and draw on their established rapport with patients and their families to promote the use of mental health professionals and educate the patient.

2. Substance Abuse: Another challenge is the acceptance of certain substance abuse behaviors in certain cultures. The PPS will address this by providing education and educational materials at the PCP's office, with details on how these behaviors impact overall health as well as progression of physical disease. This is also addressed with the institution of "warm handoffs" by which the PCP himself or PCP staff shall personally introduce the patient to a mental or behavioral health provider.

3. Primary Care Culture: Primary care providers already feel overworked partly due to the need to provide excessive documentation. The ACP protocols call for the continuous use of several screening tools which the providers may not currently be using to the fullest extent but that they will have to implement and adhere to. The PPS plans to address this by providing all of its providers with an extensive support staff, incentives and on-going training both of themselves and of their staff.

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

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs. In addition, the ACP leadership has demonstrated a strong commitment to collaboration as evidenced in the on-going collaborations with several hospital led PPS's, including North Shore LIJ. ACP expects that these collaborations will develop into lasting agreements in areas of overlapping geography. We plan to coordinate with the hospitals within those PPS's across all DSRIP projects to share resources and data, such as receiving alerts from hospitals when one of our members receives or needs care from them.

ACP will collaborate and work closely with all area hospitals, including those involved in other PPSs on data exchange and integration so as to have bidirectional access to data and care in which the hospitals will accept direct admits and refer avoidable admissions to PCPs, and those patients seeking care with psychosomatic symptoms diagnosed via negative findings. ACP covers the same geographical area as several other PPSs and will collaborate with these in promoting patient education regarding behavioral health, substance abuse, and others.

ACP will collaborate with many Mental and Behavioral health organizations regardless of the PPS that they are participating in to best ensure patient reach and patient compliance. The services rendered to ACP's patients will be rendered by several providers including hospitals that are members of other PPSs but with whom ACP will have a collaborative arrangement for prompt and efficient care and care coordination. ACP may collaborate with other PPS' also in patient education initiatives and outreach.

Lastly, coordination and integration are large components of two of our other projects (2.a.i. and 2.b.iv.) which will require ACP to create an integrated delivery system.

3. <u>Scale of Implementation</u> (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. <u>Speed of Implementation/Patient Engagement</u> (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 project require Capital Budget funding? *(Please mark the appropriate box below)*

Yes	No
☒	☐

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

Capital funds will be pursued in support of the following structures:
- IT capacity expansion
- Call Center, in support of discreet case management functions
- Construction of State of the Art Training facility in support of all/on-going Human Resources needs
- Urgent Care Centers-as an alternative to ER BH episodic visits

b. 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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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.

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.

c. **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.

d. **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.

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Project Objective: To support implementation of evidence-based best practices for disease management in medical practice for adults with cardiovascular conditions. (Adults Only).

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of cardiovascular disease. These strategies are focused on improving practitioner population management, adherence to evidence-based clinical treatment guidelines, and the adoption of activities that will increase patient self-efficacy and confidence in self-management. Strategies from the Million Hearts Campaign (http://millionhearts.hhs.gov) are strongly recommended.

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

1. Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.
2. Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
3. Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
4. Use EHRs or other technical platforms to track all patients engaged in this project.
5. Use the EHR or other technical platform to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).
6. Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.
7. Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.
8. Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.
9. Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.
10. Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

Improve Medication Adherence:

11. Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

Actions to Optimize Patient Reminders and Supports:

12. Document patient driven self-management goals in the medical record and review with patients at each visit.
13. Follow up with referrals to community based programs to document participation and behavioral and health status changes
14. Develop and implement protocols for home blood pressure monitoring with follow up support.
15. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.
16. Facilitate referrals to NYS Smoker's Quitline.
17. Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.
18. Adopt strategies from the Million Lives Campaign.
19. Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
20. Engage a majority (at least 80%) of primary care providers in this project.

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

ACP's Community Needs Assessment (CNA) identified cardiac care as a major opportunity. In 2012, the risk adjusted rate per 100,000 of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions (PQI S02 Circulatory Composite) were:
- Bronx – 547.7
- Brooklyn – 426
- Manhattan – 378.5
- Queens – 372.2

The Bronx accounts for nearly one in five (20.1 %) of all such admissions in the State. ACP will reduce this PQI by 25% through this project. Preventable hospital admissions include those for cardiac symptoms due to uncontrolled hypertension and coronary artery disease (CAD). The PPS has the following prevalence rates:
CAD:
- City-wide – 48.2%
- Bronx – 48.6%

- Brooklyn – 57.9%
- Manhattan – 33.4%
- Queens – 48.1%

Hypertension:

- City-wide – 27.8%
- Bronx – 32.9%
- Brooklyn – 29.1%
- Manhattan – 23.1%
- Queens – 27.3%

CAD is the most common type of heart disease. One in every three U.S. adults (67 million) has hypertension, and about half of these indi¬viduals have their condition under control. Hypertension is the most common condition seen in primary care and can lead to other conditions, including death, if not detected early and treated appropriately. Heart disease was the number one leading cause of death in New York City (2010-2012).

ACP identified hotspots (neighborhoods with greater than 30% prevalence) related to the following:

- High blood pressure: Northeast Bronx, Rockaways, South Bronx, Southeast Queens, Bedford Stuyvesant/Crown Heights, Flatbush
- High cholesterol: Pelham/Throgs Neck, Coney Island, Northeast Bronx, Chelsea/Greenwich Village, Greenpoint, Southwest Queens

The CNA data listed above indicates an opportunity for ACP to work with beneficiaries to manage cardiovascular care. The PQI indicator suggests an access or connectivity challenge between beneficiaries and ambulatory and community care. Another challenge is beneficiary engagement to keep conditions under control. The four boroughs are unable to respond to these challenges due to the minimal incentives to coordinate care across settings, a lack of standardized protocols and evidence-based strategies across providers, and limited integration. This project and associated DSRIP funds will provide the financial incentive for providers to transform the delivery system to ultimately improve beneficiary outcomes.

ACP is strongly positioned to respond to these challenges. As described in 1.d, ACP is engaging physicians, nurses and other provider types through its network especially in the identified hotspot service areas. Self-management is taught through patient education and care coordination models, like Million Hearts Campaign. To standardize optimal care, evidence-based guidelines to identify and manage cardiovascular diseases and their risk factors have been created.

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.

Our target population is defined by geography, demographics and disease type. Data will be gathered to include patients within the four counties served by ACP: Bronx, Brooklyn, Manhattan, and Queens. The demographics of the patients will include all Medicaid patients over the age of 18. The disease types to be targeted will be Hypertension, Coronary Artery Disease,

Hyperlipidemia, and Congestive Heart Failure. Claims data grouped by ICD 9 codes will be used to identify targets. ACP will assign ICD 9 codes for each targeted disease type. The PPS will also use registries within the providers' EHR data to obtain patient information and supplement the data filters as described above.
Based on the results of the CNA, we have identified and confirmed that ACP has providers in all hotspots (Northeast Bronx, South Bronx, Southeast Queens, Southwest Queens, Bedford Stuyvesant/Crown Heights, Flatbush, Greenpoint, and Chelsea/Greenwich Village) where Cardiovascular Disease is most prevalent across the four boroughs.

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.

Cultural Competency
ACP has culturally aligned primary care provider offices located within the same geographical areas as the targeted population. These providers are of ethnic and racial minority groups reflecting the populations served and have patient relationships. This network is culturally sensitive and linguistically aligned with the patients in the geography.
Evidence-based Protocols
ACP has developed evidence-based protocols for the project that include :
- Implementation of Million Hearts campaign.
- Lifestyle modifications including diet (Cardiovascular Disease)
- Identification of patient needs beyond taking medication
- Screenings to identify tobacco and alcohol use, depression, mental health co-morbidities
- Assessment of ability to perform activities of daily living, living conditions, socioeconomic needs and engagement of partner organizations (i.e., social services)

Provider Network and PPS Partners
The ACP network includes over 2,500 providers. This includes Broadway Internal Medicine, which has been designated a Million Hearts Champions by the Centers for Medicare and Medicaid (CMS). Their expertise will be shared across all partners as Million Hearts is implemented in the PPS.
Community based providers are reflected in specialty and social services providers, and community stakeholders, housing, dieticians. All providers will participate in the care and compliance of the patients to reach successful outcomes.
Care Coordination
ACP will leverage its Support Center which includes the following components:
- Coordinate adherence to referrals
- Arrange relevant transportation
- Referrals to life-style educators
- Monitor patient compliance (i.e., medication adherence refills, blood pressure readings)
- Call center (inbound / outbound) to provide and confirm appointments
ACP has active partnerships with governmental and community-based initiatives (i.e., NY Quits). ACP's current network of PCMH clinics will be leveraged to bring the other primary care providers of ACP to successful PCHM level 3 certification.

Education and Training
ACP will provide training to office staff, including back and front office, to ensure patients have timely blood pressure measurements and guidance. As part of Million Hearts, ACP will create patient incentives for lifestyle modification, medication adherence and compliance; patient friendly mechanisms to record blood pressure values; and print and website educational literature. ACP is also implementing specific community outreach and education, using the Stanford model, designed for each community in a language and format that can reach the target population.
Health Information Technology (HIT)
Greater than 90% of ACP's providers currently have EHRs and registries implemented and we will further expand on health information exchange / RHIO connections. Ultimately, ACP will create an IDS platform in the development of project 2.a.i that will be leveraged for the purposes of communication, data share, patient tracking and interoperability within this project. We will ensure safety net provider EHR systems meet Meaningful Use and PCMH Level 3 by the end of Demonstration Year 3.

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.

ACP expects to encounter these challenges:
1. Customs and Culture: Changing traditional eating patterns will represent a challenge. To meet this challenge the PPS will leverage its cultural diversity and culturally aligned physicians, staff and programs to reach the patient in an acceptable language and tone, and families and caregivers, who are often responsible for the patient. The PPS will also provide one-on-one, handout, and population-wide education at the Primary Care level on disease, and disease prevention and management.
2. Changing Primary Care Office Mechanics: These offices will have to incorporate patient education and blood pressure checks with no additional reimbursement. The PPS plans to meet this challenge by providing support and training to front and back office staff to allow staff to respond to needs. ACP will also create educational materials, patient incentives and negotiate with MCOs to cover additional services.
3. PCMH Level 3 Certification: It will be difficult to ensure all network providers receive certification. The PPS will meet this challenge via a strong Support Center comprised of IT support staff and EHR and PCMH experts who will guide the practices step by step in achieving this requirement and monitor metrics closely.

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

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs. ACP will engage in several population wide educational efforts. Working with other PPS' in ACPs geographical area on patient education materials, especially those regarding lifestyle modifications will be created and broadcast along a wide range of media. ACP will also work with other PPS' in procuring patient compliance incentives. ACP has negotiated collaboration with North Shore Long Island Jewish (NSLIJ)PPS for providing care to Nassau patients requiring services within Queens, Bronx, Manhattan or Brooklyn and for NSLIJ providing services to ACP patients requiring services in Nassau county, both PPS' will willfully exchange information and support each other's efforts. ACP will collaborate with many health organizations regardless of the PPS that they are participating in to best ensure patient reach and patient compliance. The services rendered to ACP's patients will come from nearly all of the hospitals in the same geographical area that ACP engages in and the PPS will therefore have collaborative agreements for prompt and efficient care as well as data interchange and care coordination.

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 project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Potential capital funding will be required for the development of a wellness center.

b. 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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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.

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 scale of project implementation, completion of project requirements 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.

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

Project Objective: Support implementation of evidence-based best practices for disease management in medical practice related to diabetes.

Project Description: The goal of this project is to ensure clinical practices in the community and ambulatory care setting use evidence based strategies to improve management of diabetes. Specifically, this includes improving practitioner population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence based guidelines.

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

1. Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.
2. Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.
3. Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
4. Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.
5. Ensure coordination with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other technical platforms to track all patients engaged in this project.
7. Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3 for EHR systems used by participating safety net providers.

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

Diabetes was the single most frequently mentioned health issue in key informant interviews, was among the most prominent issues raised by the majority of Medicaid member focus groups, and ranked as the highest-priority health issue on surveys. These findings are confirmed by the percentage of Medicaid Beneficiaries with diabetes:
Diabetes Prevalence in Medicaid Beneficiaries:
- Bronx –11.0%
- Brooklyn –11.2%
- Manhattan –12.1%
- Queens – 11.1%

Diabetes Long-term Complications (per 100,000):
- Bronx –256.8
- Brooklyn –205.1
- Manhattan –189.8
- Queens – 164.4

Diabetes Short-term Complications (per 100,000):
- Bronx –131.2
- Brooklyn –101.4
- Manhattan –144.8
- Queens – 83.8

Diabetes was among the top five leading causes of death in the Bronx, Brooklyn, and New York City overall, with age-adjusted death rate of 21 per 100,000 people in 2012. It was among the top three to five leading causes of premature death in all the counties that we serve. For New York City, the 2012 age-adjusted premature death rate was 11 per 100,000. Diabetes was also among the top three leading causes of death for non-Hispanic Blacks since 2005. Blacks and Hispanics were disproportionately burdened with diabetes mortality and hospitalization (primary diagnosis) rates. Both groups had the highest rates among racial/ethnic groups in every borough, except that Hispanics in Queens had the lowest rate among racial/ethnic groups. Blacks had the highest diabetes mortality and hospitalization rates in all four boroughs.

Based on the results of the CNA, we have identified areas that are considered hotspots and confirmed that we have providers in those areas that will be participating in this project.

The short and long-term complications identified in the PQIs above illustrate an opportunity to better manage care and reduce long and short-term impact and downstream cost. Across all boroughs, there is limited care coordination and primary care utilization. Limited integration makes it difficult to identify high-risk patients and address complications before they develop. ACP's goal is to improve the quality of life and well-being of its patients, thereby reducing progression of disease and lower hospital utilization rates. In accomplishing this, ACP will:
- Develop multidisciplinary care teams around the PCP, including endocrinologists, cardiologists, nurses, dietitians, social workers, pharmacists, meal delivery services, diabetic educators, and

others to fill noted gaps in patient care and compliance.
- Implement evidence-based protocols with guidelines on the diagnosis and management of diabetes across the PPS.
Develop educational programs to improve the community's knowledge of diabetic risk factors and diabetes management with strong focus on obesity prevention, lifestyle modification, and self-management per evidence-based clinical guidelines such as using the Stanford Model of Chronic Disease Self-Management.

2. 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.

Our target population is defined by geography, demographics and disease type. Data will be gathered to include patients within the four counties served by ACP: Manhattan, Bronx, Brooklyn, and Queens. The demographics of the patients will include all Medicaid patients over age 18. The disease type to be targeted will be diabetes and those with obesity for which we will use data based on ICD 9 codes assigned for these disease types. The PPS will use registries within the providers' EHR, and/or claims data to obtain patient target information using filters as described above. Based on the results of the CNA, we have identified and confirmed that ACP has providers in all areas where Diabetes is most prevalent across the four boroughs, including Northeast Bronx, South Bronx, Southeast Queens, Southwest Queens, Bedford Stuyvesant/Crown Heights, Flatbush, Greenpoint, and Chelsea/Greenwich Village.

3. 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.

Provider Network and PPS Partners
ACP has culturally aligned primary care provider offices located within the same geographical areas as the targeted population, most of whom already have an established relationship with the target population. The majority of the PPSs primary care providers are of ethnic and racial minority groups and serve populations of their same ethnic makeup, thus creating a network of providers that are culturally sensitive and linguistically aligned with the patients that they serve.
ACP has partnerships with local governmental and community-based initiatives and programs. These include community stakeholders, housing, dieticians and others including MCOs. ACP has home visiting providers for those patients that have difficulty getting to their PCP due to frailty factor or homebound status or living condition.
The CAIPA Social Day Care Center runs education programs for pre-diabetics that will assist in disease prevention and control. The day care center's model is in accordance with the Stanford Model for Disease Prevention, and the same model will also be implemented at various community centers throughout the PPS' geographical catchment area.
Evidence-based Protocols
ACP has reviewed and adopted evidence-based protocol for the management of diabetes. The

protocols which shall be implemented across the PPS include:
Performing assessments:
- PHQ-9
- Tobacco
- Alcohol use
- Comprehensive history and exam to identify need for referrals
Emphasis on lifestyle modification, nutritional counseling, and self-management techniques
Assessing control using proven markers of HgbA1C levels and frequency of testing
Introduction of Diabetic educators and Medical nutritional counselors

Care Coordination
ACP will also leverage its Support Center which includes a strong care coordination model to coordinate adherence to referrals, arrange relevant transportation, life-style modification educators, care managers who will monitor patient compliance via medication adherence refills, and blood pressure readings, and a call center with outreach staff who will provide and confirm appointments. Additionally, ACP will leverage the network of a partner's (MediSys) PCMH clinics to bring all of ACP's primary care providers to PCHM level 3 certification.

Education and Training
The PPS will provide further training to all staff in areas specific to the goals of the project. Additional existing resources that will be leveraged include existing biannual magazine articles with diabetes nutrition plans by Dr. George Liu (Endocrinologist). ACP plans to expand upon an existing Diabetes Center that co-locates all specialists in one physical location.

Health Information Technology
ACP will create an integrated delivery system platform in the development of project 2.a.i that will be leveraged for the purposes of communication, data share and interoperability within this project.

4. 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.

ACP expects to encounter challenges in two areas:
1. An anticipated challenge is that based on customs and culture. The ACP PPS providers serve ethnic populations that are accustomed to high carbohydrate diets, and have low education and health literacy rates. Changing eating patterns that are passed from generation to generation will represent a great challenge for the PPS. To meet this challenge the PPS plans to leverage its cultural diversity and the integration of its culturally aligned providers to reach not only the patient in a language and tone that they can understand and accept, but also to reach the families and caregivers of these patients who are many times responsible for providing for the needs of the patient. The PPS will also provide education at the Primary Care level with regard to disease, disease prevention and disease management, directly one on one, and through educational

materials/handouts and via the website and population wide campaigns.
2. Another challenge will be changing the mechanics of a primary care office which is already stressed and overworked and will now have to incorporate more teaching time. The PPS plans to meet this challenge by providing strong support and training to all staff so that there is not just one or two people available, but rather any available staff member may provide the needed service. ACP will create the educational materials and have a communications and outreach team put together patient incentives. The PPS will also negotiate with MCOs to cover the full cost of blood pressure for all patients with hypertension.

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

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs.
ACP will engage in several population-wide educational efforts. Working with other PPS' in ACPs geographical area patient education materials, especially those regarding lifestyle modifications will be created and broadcast along a wide range of media. ACP will also work with other PPS' in procuring patient compliance incentives.
ACP has negotiated collaboration with NSLIJ PPS for providing care to Nassau patients requiring services within Queens, Bronx, Manhattan or Brooklyn and for NSLIJ providing services to ACP patients requiring services in Nassau county, both PPS' will exchange information and support each other's efforts.
ACP will collaborate with many health organizations regardless of the PPS that they are participating in to best ensure patient reach and patient compliance. The services rendered to ACP's patients will come from nearly all of the hospitals in the same geographical area that ACP engages in and the PPS will therefore collaborative agreements for prompt and efficient care as well as data interchange and care coordination.
ACP plans to carry out Obesity and better nutrition campaigns at several places including hospital venues within hospitals partners of other PPS' and working together with non-physician partners who are partners of other PPSs.

6. <u>Scale of Implementation</u> (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.

7. 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.

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

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be needed for the creation and expansion of Care Coordination Model Department/Care Management Department, Call Center, and Urgent Care Centers within the counties that we serve; IT infrastructure, Stanford Model publications and outreach, as well as patient resources.

b. 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
☐	☒

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

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.

9. 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.

3.d.iii Implementation of Evidence Based Medicine Guidelines for Asthma Management

Project Objective: Implement evidence based medicine guidelines for asthma management to ensure consistent care.

Project Description: The goal of this project is to implement asthma management practice guidelines, develop asthma action plans, and increase access to pulmonary and allergy specialists in areas of New York State.

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

1. Implement evidence based asthma management guidelines between primary care practitioners, specialists, and community based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population-based approach to asthma management.
2. Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.
3. Deliver educational activities addressing asthma management to participating primary care providers.
4. Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.
5. Use EHRs or other technical platforms to track all patients engaged in this project.

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

ACP's Community Needs Assessment (CNA) identified asthma as a major opportunity. The Bronx, Brooklyn, and Manhattan all had rates of hospitalization for asthma overall and for youth up to age 17 worse than the state. Rates in the Bronx were approximately three times the state averages. Asthma hospitalization rates among youth were highest in every borough for Blacks and Hispanics. ACP will reduce this PQI by 25% through this project. Hospital emergency department visit rates for asthma were higher in all four boroughs than the NYS PA 2017 target, and higher in the Bronx, Brooklyn, and Manhattan than for New York State. The Bronx exhibited rates more than three times the state averages, for all ages and for those ages 0-4 years.

Chronic Lower Respiratory Disease (CLRD) was in the top five leading causes of death in both Manhattan and Queens, and among the top five leading causes of premature death in the Bronx and in Manhattan.
Asthma was raised as a high priority health issue as frequently as diabetes and cardiovascular diseases in key informant interviews. Half of interview participants who mentioned asthma made a point of focusing on childhood asthma. Asthma also was mentioned as a top issue in the majority of the Medicaid member focus groups, including those covering Washington Heights/Inwood, Bronx, and East and Central Harlem.
ACP is strongly positioned to respond to the project challenges. In order to improve the health of Asthma patients within our communities, ACP providers will evaluate patients and create personalized action plans, provide coaching and information to patients to improve medication compliance and ensure safe environment for patients. Overall goals of this project will be to promote wellbeing and quality of life, prevent triggers of asthma, limit exacerbations and prevent patients from being readmitted. During the course of this project, providers will be measured on process measures such as action plans completed, number of patients receiving counseling from social workers and asthma educators etc.

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.

Our target population is all ages defined by geography, demographics, and disease type. The target population will be all Medicaid patients within Manhattan, Bronx, Brooklyn and Queens with a diagnosis of Asthma. Claims data grouped by ICD 9 codes will be used to identify targets, and ACP will assign ICD 9 codes for each targeted disease type. The PPS will also use registries within the providers' EHR data to obtain patient information and supplement the data filters as described above. This project will include both children and adult Medicaid patients with a diagnosis of asthma. Although the PPS will focus on reaching asthmatic patients within all four boroughs, of particular interest will be those patients located in the Bronx, Brooklyn, and Manhattan which had higher rates of hospitalization for asthma overall and for youth up to age 17 which were worse than the state rates.

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.

ACP has culturally aligned primary care provider offices located within the same geographical areas as the targeted population. These providers are of ethnic and racial minority groups reflecting the populations served and have patient relationships. Included in ACP's network are a number of specialists such as pulmonologists, allergists, and others that can provide specialized, effective care to our asthmatic population.
Evidence-based Protocols
ACP has developed evidence-based protocols for the project that include:

- Implementation of School asthma action plan working in collaboration with schools
- Implementation of a home action to be implemented for both children and adults with the involvement of family/caregiver
- Several assessments that shall be performed to identify triggers both home and environmental with referral for social and home care services as needed to include collaboration with the Department of Health on environmental factors such as infestations
- Screening for at risk behaviors such as tobacco screening and referral to NY Quits
- Asthma self-management education
- Medication management consistent with National standards both pediatric and adult
- Evaluation and referral to specialists, such as allergist for allergy testing, pulmonologists, etc.

Providers in all populations will serve to identify at home triggers, living conditions, provide education for high risk behaviors encountered and implement action plans more successfully.

Provider Network and PPS Partners

The ACP network consists of over 2,000 providers. These providers include community based providers, specialty and social services providers, community stakeholders, housing, and dieticians.

Care Coordination

ACP will leverage its Support Center which includes the following components:

- Coordinate adherence to referrals
- Arrange relevant transportation
- Referrals to life-style educators
- Monitor patient compliance (i.e., medication adherence refills, blood pressure readings)
- Call center to provide and confirm appointments

ACP has active partnerships with governmental and community-based initiatives which can assist with containment/modification/improvement of environmental factors such as infestations that are known triggers for asthma exacerbation.

Education and Training

ACP will provide training to office staff, including back and front office, to ensure patients have timely measurements and guidance. ACP will create patient incentives for lifestyle modification, medication adherence and compliance, patient friendly mechanisms and print and website educational literature. ACP is also implementing specific community outreach and education, using the Stanford model, designed for each community in a language and format that can reach the target population.

Health Information Technology (HIT)

Greater than 90% of ACP's providers currently have EHRs and registries implemented and we will further expand on health information exchange/RHIO connections. Ultimately, ACP will create an IDS platform in the development of project 2.a.i that will be leveraged for the purposes of communication, data share and interoperability within this project.

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.

ACP expects to encounter these challenges:
1. Customs and Culture: Changing traditional cultural habits will represent a challenge. For example, many Asians, due to their religious beliefs, have incense burning continuously throughout the home which is a source of asthma exacerbation, especially for the children. To meet this challenge the PPS will leverage its cultural diversity and culturally aligned physicians, staff and programs to reach the patient in an acceptable language and tone, and families and caregivers, who are often responsible for the patient. The PPS will also provide one-on-one, handout, and population-wide education at the Primary Care level on disease, and asthma self-management.
2. Changing Primary Care Office Mechanics: These offices will have to incorporate patient education, including patient teaching, such as the proper use of inhalers and nebulizers. The PPS plans to meet this challenge by having certified asthma educators to support the primary care offices in direct teaching and in training the offices' clinical staff. ACP will also create educational materials, patient incentives and negotiate with MCOs to cover additional services.
3. PCMH Level 3 Certification: It will be difficult to ensure all network providers receive certification. The PPS will meet this challenge via a strong Support Center comprised of IT support staff and EHR and PCMH experts who will guide the practices step by step in achieving this requirement and monitor metrics closely.

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

ACP has already collaborated successfully with all PPS's in the Bronx and Brooklyn to guide the Community Needs Assessment of these two boroughs.
ACP will engage in several population wide educational efforts, especially those regarding culturally sensitive lifestyle modification. Working with other PPS' in ACPs geographical area on patient education materials, especially those involving asthma self-management will be created and broadcast along a wide range of media. ACP will also work with other PPS' in procuring patient compliance incentives.
ACP will collaborate with many health organizations regardless of the PPS that they are participating in to best ensure patient reach and patient compliance. The services rendered to ACP's patients will come from nearly all of the hospitals in the same geographical area that ACP engages in and the PPS will therefore have collaborative agreements for prompt and efficient care as well as data interchange and care coordination. We will also work closely with the schools to coordinate and improve pediatric asthma management.

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 project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be required in order to implement urgent care centers.

b. 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
☐	☒

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

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.

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.

Domain 4 Projects

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

Project Objective: This project will promote tobacco use cessation, especially among low SES populations and those with poor mental health.

Project Description: Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS). Cigarette use alone results in an estimated 25,000 deaths in NYS. There are estimated to be 570,000 New Yorkers afflicted with serious disease directly attributable to their smoking. The list of illnesses caused by tobacco use is long and contains many of the most common causes of death. These include many forms of cancer (including lung and oral); heart disease; stroke; chronic obstructive pulmonary disease and other lung diseases.

The economic costs of tobacco use in NYS are staggering. Smoking-attributable healthcare costs are $8.2 billion annually, including $3.3 billion in annual Medicaid expenditures. In addition, smoking-related illnesses result in $6 billion in lost productivity. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Although there have been substantial reductions in adult smoking in NYS, some tobacco use disparities have become more pronounced over the past decade. Smoking rates did not decline among low-socioeconomic status adults and adults with poor mental health. This project is targets decreasing the prevalence of cigarette smoking by adults 18 and older by increasing the use of tobacco cessation services, including NYS Smokers' Quitline and nicotine replacement products.

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. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Adopt tobacco-free outdoor policies.
2. Implement the US Public Health Services Guidelines for Treating Tobacco Use.
3. Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).
4. Facilitate referrals to the NYS Smokers' Quitline.
5. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.
6. Promote smoking cessation benefits among Medicaid providers.

7. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.
8. Promote cessation counseling among all smokers, including people with disabilities.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
New York City Department of Health (DOH)

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 100)

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. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

According to the city data, the adult smoking rate rose to 16.1% in New York City in 2013, the third straight year that tobacco use has crept up after hitting a low of 14% in 2010.
According to our CNA, the Percentage of Adults who Smoke is as follows:
- Bronx –15.8%
- Brooklyn –16.0%
- Manhattan –15.3%
- Queens –14.9%

City-wide Prevalence:
- White –17.6%
- Black –14.2%
- Hispanic –15.9%
- Asian –12%

A significantly higher percentage of men (19.7%) than women (11.7%) reported being a current smoker. Bronx had the lowest proportion of people who reported being heavy smokers (2.9%), and Manhattan had the highest (4.5%).

Hot spots were identified in neighborhoods where more than 20 percent of survey respondents reported being a current smoker:
- Pelham/Throgs Neck (Bronx)
- Coney Island (Brooklyn)
- Union Square/Lower Manhattan (Manhattan)
- The Rockaways (Queens)

It is challenging to quit smoking due to the influence of cultural norms including smoking indicating maturity and offering cigarettes as a common courtesy. Lack of reimbursement and awareness of smoking cessation tools is also a challenge. This DSRIP project is needed to address population-wide smoking cessation efforts by providing incentives and cohesive messaging across PPSs.

ACP's goal for this project is to increase the number of smokers participating in cessation programs and thus reducing the number of smokers within the four boroughs that it serves, and in turn the risk of chronic disease development. ACP will increase patient engagement with tobacco cessation resources, increase physician engagement in performing tobacco screenings in outpatient settings, and decrease smoking prevalence in the communities that the PPS serves. ACP will continue to utilize the neighborhood as an organizing principle for the implementation of this project. Through this project, ACP will:

1. Adopt tobacco-free indoor policies:
- The DOHMH's NYC Tobacco-Free Hospitals Campaign will be adapted for ACP to assist in evaluating and upgrading tobacco use policies for employees and patients.
- ACP will adopt tobacco free workplace throughout the PPS facilities.
2. Implement the US Public Health Services Clinical Practice Guidelines for Treating Tobacco:
- ACP will Use electronic medical records to prompt providers to complete 5As method of brief intervention: 1) Ask about tobacco use, 2) Advise user to quit, 3) Assess willingness to make a quit attempt, 4) Assist move towards a successful quit attempt, and 5) Arrange a follow-up contact.
- ACP will work with the DOHMH to provide strategic planning, technical assistance and quality improvement.
- ACP will adopt evidence based tobacco cessation protocols
3. Promote cessation counseling among all smokers, including people with disabilities:
- ACP will launch population wide media campaigns to reach those difficult to reach patients.
- ACP will in conjunction with the DOHMH, will provide practices with coordinated pieces for providers and patients that recognize cultural norms and practices.
4. Facilitate referrals to the NYS Smokers' Quitline:
- ACP will provide patients with NYS Smokers' Quitline hotline verbally and in writing.
5. Promote smoking cessation benefit among the community:
- ACP will launch population-wide media and community outreach campaigns.
6. Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications:
- ACP will work with DOHMH to convene PPSs to discuss ways to coordinate activities.
7. Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications:
- ACP will work with MCO partners.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

ACP looks at this project as a population wide project promoting tobacco use education at all levels both to increase rates of cessation success and to prevent smoking addiction. Our target

population is defined by geography, demographics and disease type. This project will target all Medicaid beneficiaries in the four counties served by the PPS: Bronx, Brooklyn, Manhattan, and Queens. Focus will be on those identified as smokers and ACP anticipates that 15% of overall attributed population will benefit from this project.

A greater emphasis and targeting will be placed on discrete populations identified through the CNA as having with a high prevalence of smoking. The CNA shows very high prevalence of smoking within the Asian and Arab population across counties and hence, they will be a significant part of the target Medicaid population group. Additionally, the assessment hints at an inverse correlation between the socioeconomic status and probability of smoking – the lower the socioeconomic status the higher the chance of smoking. Our smoking cessation project will therefore, focus significantly on Medicaid patients with lower socioeconomic status.

Patients in high-risk groups diagnosed with COPD, bronchial asthma, and cardio-vascular disease will be targeted more aggressively as these comorbidities lead to higher mortality rates and higher utilization due to tobacco related complications.

Finally, this project will specially target the neighborhoods and neighborhood clusters with the highest incidence of tobacco use. These neighborhoods include:

Bronx	Pelhan Bay/Throgs Neck	21.2%
	South Bronx	18.2%
Brooklyn	Coney Island	23%
	Williamsburg/Bushwick	18.9%
Manhattan	East Harlem	18.9%
	Central Harlem	17.1%
Queens	Flushing/Clearview	17.7%
	Ridgewood/Forest Hills	17.7%

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.

Tobacco Free Hospitals
Some partners in ACP PPS, North Shore-Long Island Jewish and MediSys have received recognition from the NYCDOH for high performance in the Tobacco-Free Hospitals Campaign. The PPS plans to utilize the experience and best practices of these organizations, in screening and treating the inpatient population, in order to provide effective outreach to the outpatient population. The best practices will be applied to physician and clinic sites.

Provider Network and PPS Partners
ACP has a broad network of over 2,500 physicians and specialists who are of the same ethnic background, culture, and are in the same community as the target population. This will greatly increase the chances of successful counseling and outreach since the physician will speak the same language as the patient and will better relate to any and all cultural sensitivities. ACP has hundreds of community based organization (CBO) sites throughout the target area which include

several hundred behavioral health providers in NYC with proven success in treating addiction. ACP consists of several ethnically aligned IPAs, these IPAs have established relationships with several ethnic media outlets, electronic and print. These relationships will be leveraged to increase the reach of smoking cessation campaigns. ACP will engage in educational campaigns regarding the effects of smoking and tobacco use, including its role in development of disease and its role in complication of current conditions together with its extensive community based organization partners. We will also collaborate and coordinate with the smoking cessation campaign led by the NYC Department of Health and Mental Hygiene (NYCDOHMH)

Evidence-based Protocols
ACP will leverage the experience of its partners in providing tobacco screening and cessation counseling. This experience will be useful as the PPS engages other partnering organizations and physicians. ACP use this experience to adopt written evidence based protocol for treatment of Tobacco addiction which includes any or all of the following; medication management, counseling, or mental and behavioral health.

Care Coordination
In order to enhance ACP's capability to reach and engage the target population ACP will recruit, train and deploy Patient Advocates from the impacted community. Patient Advocates will conduct outreach, provide information, make referrals to the "NYS Smokers' Quit Line," organize events and educate individuals and the community at large about smoking. ACP will leverage the partnership with the NYCDOH to execute and achieve the tobacco use cessation project. Patients will be referred to the NYS Smokers' Quitline, educated through brochures and encouraged to be part of the DOH's counselling sessions for smokers. In discussions with the DOH, they are willing to set up educational kiosks for patients at each of the physician facilities of the PPS.

Health Information Technology (HIT)
85% of ACP physicians have EHRs and the majority have already achieved success in tobacco screening measures, including the Joint Commission's Tobacco Treatment Measures.

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.

Success with tobacco cessation has not been great historically as suggested by the CNA data showing a growth in the adult smoking rate in NYC in 2013. ACP anticipates that achieving success in this project will be difficult. ACP recognizes that addictions many times have multifactorial causes including:

1. Culture: Smoking is perceived as "cool" in many cultures and considered acceptable as a recreational tool. Therefore, patients are resistant to quitting for fear of alienation from peers. ACP will overcome this challenge by being able to explain to the patients the serious consequences of smoking in a language and culturally relevant manner that the patient can understand and relate to. This will be overcome since ACP has over 2,500 physicians who

themselves are of the same minority as the patient.

2. Patient Adherence: Patient's acceptance and adherence to treatment plans and follow through will be a challenge. ACP will face this challenge by providing "warm" handoffs of the patient to one of our partners or to an employed counselor. The PPS will address this with increased, culturally sensitive educational efforts, ongoing monitoring and consistent implementation of the tobacco use cessation protocol across providers.

3. Cost: Currently, cessation programs may be expensive and the patient will not follow through for lack of sufficient income. ACP plans to address this challenge by negotiating with relevant MCOs to provide coverage for services and supplies needed in the treatment of tobacco addiction.

4. Monitoring: Another key challenge will be monitoring the metrics with such a large network of providers who have a variety of EHRs or paper documentation processes. We will establish a data warehouse to collect, store, and analyze data across these provider sources, and are planning a concentrated effort to expand EHR use across all providers.

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.

On December 4, 2014 ACP met with the NYC DOHMH and representatives from 3 PPSs that include NY Presbyterian Hospital, NS-LIJ and MediSys to discuss collaboration on this project. The group committed to a common agenda and work plan and to reach out to more partners including community partners and issue-focused groups across the four boroughs to work on this project.

ACP will work collaboratively with other PPSs. We will be sharing data via RHIO/SHINY especially since our patients receive services at hospitals participating in or leading other PPS'. This is addressed in project 2.a.i and 2.b.iv. ACP has already collaborated successfully with all PPS in the Bronx and Brooklyn to guide the CNA.

ACP will collaborate with many health organizations regardless of PPS participation to ensure patient reach and compliance. The services rendered to ACP's patients will come from several providers including hospitals that are members of other PPSs but with whom ACP will have a collaborative arrangement for prompt and efficient care and care coordination.

Our PPS has already begun to engage other PPSs, and will continue to bring together organizations to share best practices and to address how to tackle a wide range of issues that include, but are not limited to: patient engagement, case coordination and management, IT infrastructure, and staff training.

ACP will collaborate with other PPSs on patient education initiatives and reach. Working together with other PPSs we will provide population wide educational campaigns on the effects of tobacco use. Campaigns will be run on print and electronic media. , etc. Collaboration could also inform the use of community stakeholders and venues to hold activities like health fairs and promotion of tobacco free workplaces.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

Here is a preliminary outline which will be refined for the implementation plan for March 1, 2015's submission:

1. Educational campaign for ACP providers: Q1 2015
2. Seek out and establish a network of community-based support resources: Q1 2015
3. Population wide screening and treatment of patients: Q1 2015
4. Tobacco cessation protocol implementation: Q1 2015
5. Cessation counseling: Q1 2015 and ongoing
6. Referrals to the NYS Smokers' Quitline: Q1 2015 and ongoing
7. Tobacco reimbursement and benefit negotiations: Q1 2015 and ongoing
8. Culturally specific educational campaign for patients: Q2 2015
9. EMR implementation at provider offices with tobacco use assessment: Q3 2015
10. Media campaign: Q3 2015
11. "Talk to your Doctor about Tobacco" neighborhood-based media campaign: Q4 2015

2. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be needed to create a support center for central care coordination resources (computers, space, etc.). Capital funding will also be needed for the creation of culturally aligned educational materials and a platform for distribution.

b. Are any of the providers within the PPS and included in the Project Plan PPS 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
☐	☒

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

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.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. 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 populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by 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.

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.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. 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.

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

Project Objective: This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

Project Description: The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

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. The implementation must address a specific need identified in the community assessment and address the full service area population.

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

Partnering with Entities Outside of the PPS for this Project
Please provide the name of any partners included for this project outside of the PPS providers. This may include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name
-

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 100)

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. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

ACP's goals for this project are chronic disease prevention, early detection of chronic disease and early intervention. ACP has the following protocol targets:
- Colon Cancer: colonoscopy for both sexes at and after 50, every 5 years if negative, and yearly if positive findings are encountered
- Breast Cancer: Mammogram in women at and after 40, every 5 years if negative and yearly if positive findings
- Prostate Cancer: Rectal prostate exam at and after 50 yearly
- Uterine Cancer: Pap Smears yearly
- Lung Cancer: CT scan yearly for smokers
- Hepatitis B and C: Safe Sex education and vaccination
- HPV: Vaccination promotion for females ages 11 to 26 and males 11-21

Cancer is the second leading cause of death for both males and females in every borough. Cancer is the number one leading cause of premature death for both males and females in Brooklyn, Manhattan, and Queens. In Bronx, it is the number one leading cause of premature death for females.
All Cancer Incidence per 100,000:
- Bronx –456.8
- Brooklyn –457.3
- Manhattan –478.6
- Queens –446.2
- All Cancer Mortality per 100,000
- Bronx –164.7
- Brooklyn –148.8
- Manhattan –152.1
- Queens –137.4

The percent of women 18+ who have had a pap smear in the past 3 years was lower than the state rate (82.7%) for both the Bronx (81.2%) and Queens (79.4%). The percent of women 40+ with mammography screening in the past 2 years was lower than the state rate (79.7%) for Manhattan (78.2%), Brooklyn (78.4%), and Queens (74.8%).

Identifying neighborhoods with the greatest burden of co-occurring disease can help target resources and design neighborhood-level interventions, including preventative care, education of residents, medical providers, and organizations that serve these geographic areas. Of 181 NYC zip

codes, 33% (60) are in the top quintile for multiple diseases. Compared with other boroughs, Bronx has the greatest percentage of zip codes in the top quintile for multiple diseases (68%). The percentage of zip codes in the top quintile for other boroughs is 45% in Manhattan, 25% in Queens, and 22% in Brooklyn. HIV/AIDS and hepatitis C are in the top quintile in 23 zip codes, also primarily in South Bronx, North-Central Brooklyn and Northern Manhattan, as well as the Manhattan neighborhoods of Chelsea-Clinton and the Rockaways in Queens. Based on this data, ACP has identified several hotspots/neighborhoods to target through this project.

The CNA data indicates an opportunity for optimal cancer management, preventative care and screening protocols. Preventive services are limited across boroughs due to the low literacy rates and a lack of clarity for patients to know where to go or how to receive care. The four boroughs are unable to respond to these challenges due to the minimal incentives to coordinate care across settings, a lack of standardized protocols and evidence-based strategies across providers, and limited integration. This project and associated DSRIP funds will provide the financial incentive for providers to transform the delivery system to ultimately improve beneficiary outcomes.

ACP will expand current programs and leverage strengths to respond to these challenges and to meet the project requirements. ACP created a funds model to provide PPS partners with funding to implement high-quality protocols to address gaps in screening and disease management. ACP will use the broad network of providers to provide more education and assist the patient to gain access to preventive services available within their community. This will include collaboration with community based organizations (CBOs) such as CAIPA Social Day Care Center etc. to identify locations and resources to best meet the needs of patients. MCO discussions will be broadened to include identification of additional reimbursement models for disease management. In addition, connection to the RHIO and IDS system will give providers access to data and information to to better manage patients.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population *must be specific and could be based on geography, disease type, demographics, social need or other criteria.*

Our target population is defined by geography, demographics, disease type and socio-economic status (SES). As per the CAN results, there is a high incidence of cancer related deaths across the four boroughs, while there is a big gap in the receipt of preventive services such as pap smears and mammograms. Additionally, there is high prevalence of risky behaviors such as smoking and high rates of STDs in hot spots such as the Bronx and especially among low SES populations that the PPS serves. The project will focus on Medicaid patients of both sexes greater than or equal to 10 years of age in the boroughs of Bronx, Brooklyn, Manhattan and Queens. Patients will also be identified with exhibiting high-risk behavior, such as smoking and unsafe sex patterns. This project will target members that are disengaged from the healthcare system (e.g., low utilizers, etc.), and those that are underserved and culturally sensitive.

The PPS will identify the patients through EMR registries in the primary care office and will reach out to them to connect them to preventive service providers for early detection, intervention, or both of cancer with mammograms, colonoscopies, pap smears, prostate exams and yearly CT scans for smokers. The project will also focus on prevention, early detection and early intervention

of hepatitis B and C, and Human Papilloma Virus (HPV) through safe sex education and vaccination.

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.

Provider Network and PPS Partners
The ACP network includes over 2,000 providers. These include primary care provider offices located in underserved areas throughout Bronx, Brooklyn, Manhattan and Queens. The majority of providers is of a minority ethnic group and speaks the same language as the population that they serve. This is particularly important for patient education for a population with low health literacy rates. ACP providers will be working collaboratively with patients observing all of the cultural sensitivities and customs, while also exerting change through the rapport and credibility that has already been built.

ACP partners can provide state of the art diagnostics to patients through several of its diagnostic facility partners who have screening expertise and locations throughout the four boroughs that it serves including mobile diagnostics. ACP's partners include several early intervention facilities and specialists that can readily provide care at early stages of disease. Several Medicaid MCOs are a part of ACP' PAC Leadership Council and can carry out negotiations to assist in covering screening services. ACP has relationships and will work with American Cancer Society, NYC DOH, American Academy of Pediatrics, Community Stakeholders, and Pharmacology Companies on enhancing care and providing population wide educational campaigns on chronic disease prevention.

Evidence-based Protocols
ACP providers will follow written protocols for how, when and on whom to perform screening exams as well as whom to provide with preventive care and education. ACP will establish clinical decision support system (CDSS) alerts, run registry reports to send reminders, to provide providers with the tools that they need to engage patients.

Care Coordination
ACP resources include a strong care patient centered coordination model with Care Teams that provide holistic services to patients. The Support Center is comprised of Care Coordinators, Care Managers, IT and PCMH support teams, and life-style modification educators. ACP will coordinate care across the expansive integrated network of specialty, social services providers, and community stakeholders to ensure all stakeholders participate in the care and compliance of the patients. ACP will also leverage MediSys' experienced network of PCMH clinics and expand that model to other areas of the PPS.

Education and Training
The PPS will provide further training to all staff in areas specific to the goals of the project, as well as employ new staff, such as care coordinators and case managers to provide one-on-one monitoring/care to the patient. ACP's Support Center will employ, repurpose, and retrain displaced staff. Resources will also be needed for educational and behavioral modification driven incentives for patients. ACP may work with pharmaceutical companies such as the makers of

Gardasil to assist in mass education efforts on chronic disease prevention.

Health Information Technology (HIT)
ACP will implement HIT so all existing providers can coordinate and implement programs at all levels. ACP will incorporate CDSS alerts to identify of at-risk patients. Lastly, ACP will utilize several screening tools, such as tobacco use screening, sexual behavior, audit-C, and may develop other PPS-specific screening tools to identify high-risk behaviors, provide education, counseling and treatment.

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.

ACP anticipates the following challenges relevant to this project:

1. Health Literacy: Many PPS patients are of low socio-economic status (SES) and have English as a second language. This leads to gaps in care, since they may not be familiar prevention strategies and lack the economic stability to cover costs. ACP is ready to overcome this challenge in its educational plan to hold population wide campaigns on disease prevention and early detection. Besides the population wide initiatives, ACP providers will follow written protocols for how, when and on whom to perform screening exams as well as whom to provide with preventive care and education. ACP will establish CDSS alerts, run registry reports to send reminders, to provide providers with the tools that they need to engage patients effectively and timely.

2. Provider Culture: Changing the provider internal workflow and culture will be a challenge since new workflows may require more work and more documentation. ACP is prepared to address this using the Support Center to provide on-going training and guidance. Care coordinators and care managers will be available to help facilitate communication and connection between the patient and the providers.

3. Pediatric Patient Engagement: Engaging the parents and educating them in the benefits of vaccination and children about safe sex will be challenging in cultures where there is much taboo around these topics. ACP is prepared to face this challenge by providing education to parents through media, print and engaging the assistance of pharmaceutical companies' expertise in mass education campaigns.

4. Reimbursement: ACP anticipates challenges in patient compliance due to cost. The PPS serves a low income population that cannot absorb the cost of preventive services. ACP will negotiate with MCOs to provide coverage for all preventive services at no cost to the patient as well as with its partners to provide more timely lower cost services. ACP will also establish compliance based incentives for patients such as pink ribbon items, etc.

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.

ACP has already collaborated with PPSs to conduct the CNA. ACP will reach out to and collaborate with many health and community based organizations some that may be part of a different PPS. This collaboration will ensure patients reach compliance goals as the services rendered by them will come from several providers including hospitals that are members of other PPSs. Additionally, ACP will be able to reach its milestones, such as collaboration with health plans and hospitals outside of the PPS to achieve its goal of providing low or no cost preventive services. Therefore, ACP will have a collaborative arrangement for prompt and efficient care and care coordination.

ACP will collaborate with all of the PPSs in Bronx, Brooklyn, Manhattan and Queens in mass educational campaigns, via print and media. ACP will also collaborate with other PPSs such as Mount Sinai, Bronx Lebanon, to provide necessary preventive services to the patients. Patients in need of certain preventive exams may be referred to providers within those PPSs. Many of the physicians in the ACP PPS actively work in facilities in other PPSs and those ties will remain in place and will serve to enhance the work that ACP does with the project.

Lastly, ACP will develop an Integrated Delivery System as per project 2.a.i which will include integration with other PPS', SHINNY and RHIOs.

f. Please identify and describe the important project milestones relative to the implementation of this project. In describing each of the project milestones relative to implementation, please also provide the anticipated timeline for achieving the milestone.

1. Establish or enhance chronic disease prevention reimbursement and incentive models (Q3/4 DY 1)

2. Offer recommended clinical preventive services and connect patients to community-based preventive resources (Q3/4 DY 1)

3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans (Q3/4 DY 1)

4. Adopt and use certified electronic health records (Q 3/4 DY 1)

5. Adopt medical home or team-based care models (Q 2 DY 1)

6. Create linkages with community preventive resources (Q3/4 DY 1)

7. Provide benchmark feedback to clinicians and incentivize quality improvement efforts (Q 2/DY 2)

8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services (Q3/4 DY 2)

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

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

Capital funding will be needed to create a support center for central care coordination resources (computers, space, etc.). Capital funding will also be needed for the creation of culturally aligned educational materials and a platform for distribution.

b. Are any of the providers within the PPS and included in the Project Plan PPS 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
☐	☒

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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.

3. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project. 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 populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due by 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.

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.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. 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.