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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.

The health care system in Brooklyn too often fails to deliver culturally sensitive, evidence-based, and coordinated care. Frequently, patients receive fragmented and disparate care from a variety of institutions and in a variety of settings, wherein providers neither communicate well nor fully address the social determinants of health. The Brooklyn CNA, including survey responses from Brooklyn residents, confirms that the health care system falls short of meeting community needs in many ways. The Brooklyn Bridges PPS is committed to addressing these systemic failures through the creation of a truly integrated delivery system (IDS).

The IDS will serve Brooklyn's racially, ethnically, and linguistically diverse population of 2.5 million residents. The CNA identifies key barriers and underlying gaps that drive poor outcomes for these residents, including access to timely outpatient medical and behavioral health care. Respondents describe long wait times for appointments, as well as economic challenges and other stresses related to accessing care, including balancing long work hours with limited provider hours. Approximately 60% of CNA survey respondents report lack of availability of substance abuse services and as many as 50% report access issues related to mental health services. The CNA reflects the need to improve language

services and cultural competency among health care providers: 35% of Brooklyn's population is foreign born and 25% of the population report speaking English less than "very well."
These factors, among others, contribute to preventable use of high-cost services in Brooklyn. Residents overuse EDs, perceiving the ED as a place to access convenient, comprehensive care. Chronic illnesses, including respiratory conditions such as asthma, cardiovascular conditions such as hypertension, and diabetes, represent the highest numbers of potentially preventable admissions (PQI) in Brooklyn.

Numerous social and economic factors confounding optimal use of health care in Brooklyn include poverty, lack of available community resources, safety concerns, and shortages of housing, employment, and healthy food. These issues create competing priorities for residents that impact patient activation and self-management and contribute to the complexity of transforming health care delivery.

The Brooklyn Bridges PPS is committed to transforming health care delivery and envisions an IDS comprised of an organized and collaborative network of primary, specialty, behavioral, post-acute, long- term care, and other community-based health and social service providers. The IDS will improve health for our DSRIP-attributed patients, as well as the underserved Medicaid and uninsured patients cared for by our partners. The IDS will equip providers with IT systems and central services that support Population Health Management (PHM) and communication across health provider and social service organizations. Providers will have access to navigation services for their patients through a Patient Navigation Center (PNC) and data exchange that gives them the full picture of their patients' care. The IDS' integration of social service partners will allow the PNC to assist providers and patients with addressing the social complexities that affect health status and increase the challenge of self- management and access to care. The primary goals of the IDS over the DSRIP project period include reducing avoidable ED and inpatient hospital use by 25% among our attributed patients and achieving sustainability through value-based payment arrangements with Medicaid managed care (MMC) plans and other payers.

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.

The PPS is anchored in community-based primary care and strengthened by: 1) the leadership and commitment of the Lutheran Health System; 2) Lutheran Family Health Centers' (LFHC) successful track record of delivering patient-centered care and managing population health; and 3) Lutheran's strategic and clinical partnership with NYULMC, which will support the PPS in transforming care through its IT infrastructure, financial backing, expansive physician network, and expertise in health care delivery and payment reform innovation.

To achieve this project's goals, the PPS will mobilize the following existing assets:
Population Health Management:
*LFHC's Community Case Management Program provides community-based care coordination, navigation, and health coaching to high-risk patients within one of the nation's largest FQHC networks.

*LFHC's robust network of community resource partnerships includes OASAS and OMH providers, adult day care, transportation, housing, workforce training, adult education, and food programs.
*NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, uses centralized Registered Nurse Clinical Care Coordinators (RN CCCs), working from EMR-based patient registries to conduct outreach and assessments, and to assist high-risk patients in obtaining needed preventive health services.

HIT:
*LFHC uses the Azara software to identify patients who are at risk for readmissions and/or who require active management of chronic conditions. NYULMC performs risk stratification using claims and EMR data.
*NYULMC's enterprise-wide EMR ensures widespread adoption of standard order sets, continuity of care, and care coordination within the same EMR. This same EMR will be implemented at Lutheran.
*NYULMC's HIE ensures information transfer for continuity of care among its NYULMC-affiliated Brooklyn community-based, voluntary providers.

The PPS identifies the following resources to be developed and/or repurposed:
*Culturally-competent and multi-lingual care coordination services through the PNC.
*A workforce training and deployment strategy to ensure that the PPS has providers and staff who are ready to meet the needs of the IDS.
*Strengthened partnerships with MMC plans to access timely population health analytics and to develop value-based payment arrangements that support PPS financial sustainability.
*Investment in resources to help our primary care partners reach PCMH NCQA 2014 Level 3 certification.

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.

The PPS will employ the following approaches to address anticipated project challenges:
PPS-wide IT Readiness:

*The PPS will provide technical assistance to partners to foster the adoption and use of EMRs and establish connectivity to the PPS HIE and the RHIO/SHIN-NY.
*Through the Hospital Medical Home HEAL project, Lutheran has integrated disparate EMRs with its PHM platform, utilizing the RHIO and achieving PCMH NCQA 2011 Level 3 recognition for its health centers. The PPS will continue to leverage and expand the RHIO across its partners.
*The PPS will employ NYULMC's HIE solution which already connects to 26 different EMRs. The PPS will leverage this approach in the short-term for as many partners as possible.

Data Needs:
*Data needs to support the PHM strategy of risk-stratification, utilization monitoring, and quality performance are significant. The PPS will develop data requirements related to PHM activities.
*The PPS will use HIE integrated with EHRs and care management systems to provide access to a complete medical record.
*As a condition of joining the PPS, each partner will sign a data-sharing agreement.
*The PPS will collaborate with our MMC plan partners to access data to support PHM.

Financial Sustainability and Payment Reform:
*The PPS will collaborate with MMC plans to develop value-based payment arrangements that move along the continuum from pay for quality and population health services, to shared savings, to bundled payment and other forms of shared and full risk.
*The PPS will work with partners to address readiness concerns related to assuming financial risk and will assist partners (e.g., FQHCs) in developing the structure and capacity to enter into risk-based contracts.
*The PPS will leverage NYULMC's PHM expertise, which includes Medicare's Bundled Payment for Care Improvement initiative, Medicare Advantage, and commercial ACO contracts; by April 2015, NYUPN will manage 180,000 patients in risk arrangements. This experience can be translated to MMC contracts.

Patient Activation and Engagement:
*The PPS will utilize PNC resources to engage patients in care, to provide assistance with care coordination and educate patients about the optimal use of health care services.
*To actively engage difficult-to-reach patients, the PPS will deploy community health workers and embed care managers in PCMH sites.

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.

The Brooklyn-based PPSs, including Brooklyn Bridges, Collaborative Care of Brooklyn, the New York City Health and Hospitals Corporation, have collaborated to conduct a borough-wide CNA and host a community-wide stakeholder meeting on December 12, 2014 in which 150 stakeholders participated. These three PPSs also have aligned five of their clinical projects and have conducted joint planning that will continue during the implementation phase of DSRIP. Coordination and alignment is critical to this project, in particular, because it ensures that Brooklyn Bridges' efforts to develop an IDS complements, rather than conflicts with, other emerging PPSs.

The IDS structures of each PPS should align with DSRIP goals by allowing for better cross-PPS management of patients. As such, the PPS has committed to work with this coalition of Brooklyn-based PPSs to devise a plan for "rightsizing" Brooklyn's acute care bed capacity to address excess capacity. The PPSs also will work together to develop referral relationships and data-sharing mechanisms to best coordinate care for Brooklyn patients and to ensure universal access to

available treatment options in the county. The PPSs have agreed upon a standard methodology for identifying and quantifying the actively engaged population for each project. The PPSs also agreed to develop a common approach to aligning provider incentives such that providers in overlapping PPSs will be held accountable for consistent performance metrics.

Finally, the PPS PNC will develop data-sharing mechanisms through the RHIO/SHIN-NY with other Brooklyn-based PPSs to ensure universal patient access to all available treatment options in the county and providers' awareness of the totality of care a patient receives.

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.

As part of its IDS vision, the PPS intends to shift financial, clinical, and workforce resources from inpatient, acute care to community-based, ambulatory care, including patient-centered behavioral health, substance abuse, and social support services. System transformation and reallocation of

resources consistent with this vision require a comprehensive strategy and action plan to reduce excess acute care and long-term care bed capacity.

According to the report by the Brooklyn Health Systems Redesign Work Group headed by Stephen Berger, on average in 2011, only 51% of Brooklyn's 6,389 licensed hospital beds were occupied. The Work Group found that Brooklyn could shed approximately 1,000 licensed beds and still be at or below the 85% occupancy standard. A Brooklyn bed reduction strategy requires collaboration across the PPSs serving the borough; a single PPS or facility cannot influence bed reductions absent a coordinated, borough-wide approach. As such, the PPS has committed to work with a coalition of Brooklyn-based PPSs to devise a plan for "rightsizing" Brooklyn's acute care bed capacity.

Lutheran has identified at least 40 skilled nursing facility beds at Lutheran Augustana Center for Extended Care and Rehabilitation (Lutheran Augustana) that may be reduced if delivery system transformation is effective and patients are able to receive more appropriate long-term care services in their homes and appropriate ambulatory settings, rather than in an institutional setting. Lutheran Augustana intends to phase out these beds over the course of the DSRIP project period, and will submit a more specific timeframe and plan for doing so as part of its implementation plan.

The PPS also has strategically selected partners to ensure the IDS is an organized and collaborative network of primary, specialty, behavioral, post-acute, long-term care, and community-based service providers. The focus on ambulatory care providers will help advance health care delivery transition from the inpatient to the outpatient setting. Specific ambulatory care partners, including our nine FQHC partners, will be instrumental in launching the IDS and caring for complex patients to prevent unnecessary hospitalizations. In fact, what distinguishes the Brooklyn Bridges PPS is its tight-knit and nimble network of ambulatory care partners, many of whom already share common EMR systems, have long-standing close working relationships, and are poised to rapidly transform health care delivery.

Primary care practice transformation is an essential part of the PPS's strategy. The facets of this transformation include: 1) intensive technical assistance and IT capacity building to enable universal achievement of PCMH NCQA 2014 Level 3 certification; 2) the provision of centralized care coordination technology and resources to primary care practice sites; 3) expansion of evidence-based clinical and population health protocols; 4) expanded hours of operation and staffing to increase primary care capacity; and 5) expansion of the scope of services offered within primary care sites to increase their ability to provide "one-stop shopping," including increased point-of-care diagnostic capabilities and onsite access to specialists.

Ambulatory care partners will be supported by a PNC that will enhance patient engagement and improve retention in preventive health services. PNC resources will be linked to providers' patient care teams to foster active ambulatory management of risk factors, including unsafe housing conditions that exacerbate chronic conditions, non-compliance with medications, and untreated mental health conditions. The PNC will support the patient care team by linking patients with needed community resources and other providers to address risk factors before they interfere with care and result in avoidable acute care use. The feedback loop from the PNC to patient care teams will be critical to successful ambulatory management of complex medical and social conditions.

While the PPS develops new services through the PNC and deploys its PHM strategy, it simultaneously will begin developing a sustainable business model through new value-based payment arrangements. Closing hospital beds results in lost revenue for longstanding health care institutions, closures that may impact valuable workforce resources. Recognizing that the best care for patients may not be in an acute care setting, and often is in the patient's home or a clinic setting, the PPS is committed to developing a sustainable model of payment to support this system transformation, including delivery redesign and workforce transitions.

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 PPS governance strategy for its IDS project will support PPS evolution to a fully integrated health care delivery system by including the following key components: 1) implementation of robust central services to support partner integration; 2) provider bonus payments to incent and reward integration; 3) evolution of PPS governance to a structure that supports risk-bearing models and that can assume responsibility for risk-sharing contracts; and 4) transition to value-based payment.

Central Services. The PPS's central services and infrastructure will support partner practice transformation and integration into the PPS delivery system over the five-year DSRIP period. Key among these services are: information technology and integration services; PCMH certification technical assistance; clinical quality and care innovation supervision; population management services and technology; analytics and performance monitoring; network adequacy and compliance with agreed protocols; and workforce training. Specific milestones that the PPS will work to achieve in evolving to an integrated system include: 1) clinically interoperable systems among all of provider partners in place by the first half of DY 2; 2) partner EHR connectivity to the RHIO and SHIN-NY by the second half of DY 3; 3) all partners achieving federal Meaningful Use Level 1/2 standards by the second half of DY 3; and 4) all partners achieving PCMH Level 3 (2014) standards by the second half of DY 3.

Provider Bonus Payments. The PPS will allocate a portion of DSRIP funds to support provider bonus payments distributed to partners who demonstrate meaningful achievement of DSRIP goals. These payments are an essential tool in integrating our partners through investment in and incentives for activities that promote integration. These funds support the transition to value-based payment arrangements in which the PPS will ultimately participate during the DSRIP project period.

Evolutionary Governance. As described in Section 1 of this Application, the PPS has an inclusive and transparent governance structure that will guide the PPS's evolution to an integrated healthcare delivery system. The Executive Committee will provide strategic leadership, establish methodologies for the distribution of DSRIP funds, evaluate partner performance, and oversee clinical project implementation. Three standing sub-committees will also have a significant role in PPS development as an entity able to assume clinical and financial responsibility for managing and

delivering care for our attributed lives:
1) the Finance Sub-Committee will develop and oversee the methodology for distributing DSRIP funds and will develop the PPS's value-based contracting strategy;
2) the IT Sub-Committee will develop strategy and policies to optimize health information's critical role in redesigning care delivery; and
3) the Clinical Sub-Committee will oversee the implementation of the PPS clinical projects.
Beginning late in DY 2 and into DY 3, the PPS will develop a structure that assumes responsibility for risk-based managed care contracting on behalf of the PPS partners. Migration from current program governance to one that supports risk bearing will be essential for further integration and long-term PPS sustainability.

Transition to Value Based Payment Arrangements. As noted in Section 9, the PPS has defined three milestones in the transition to value-based payments: 1) milestone 1, beginning in DY 1, will involve direct payment from plans to partners for care management services; 2) milestone 2 will comprise of the development of shared savings arrangements for the specific clinical conditions being addressed through our DSRIP projects (e.g., asthma and diabetes, among others); and 3) milestone 3 will involve the initiation of shared savings arrangements transitioning to risk-based arrangements in DY 5 and beyond. We project that 80% of our attributed lives will be in some model of value-based payment agreements by the end of DY 5.

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.

The PPS will require capital funds to develop a shared IT infrastructure to support PPS-wide PHM efforts, including: 1) development and dissemination of a care management platform and patient registries; 2) enhancement of Brooklyn RHIO capabilities and EMR systems for partner organizations; and 3) development of analytics and reporting processes and network management. Taken together, this strategy will support communication across PPS partners and help achieve a coordinated and accountable service delivery structure, both of which are critical to this project's success.

The PPS also will require capital funds to expand the capacity and scope of services available in primary care centers. Capital funding will support the design and implementation of new construction, repairs, renovation of fixed assets, equipment costs, and other asset acquisitions.

The PPS will use capital funds to deploy a centralized PNC that will provide navigation services, including telephonic triage and appointment scheduling, to improve care coordination and PHM. Specifically, capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support PNC centralized care coordination activities.

These improvements will develop the services needed to meet DSRIP project objectives, improve care coordination, and facilitate population health management.

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
Harlem United/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Bowery Residents' Committee (BRC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HeartShare Wellness	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Concern for Independent Living, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
SCO Family of Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Lutheran Family Health Centers	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
VNSNY	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2016	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Public Health Solutions	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2017	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
New York Therapeutic Communities, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cerebral Palsy Associations of New York State	Medicare Shared Savings Program (MSSP)	2014	2016	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Cerebral Palsy Associations of New York State is a participating provider in an MSSP project.
Dominican Sisters Family Health Service	Community-based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
JNS Counseling Services INC.	Community-based Care Transitions Program	2014	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities.

The Health Home program, particularly the experience and capacity of participating Health Homes and downstream care management agencies, is a strong foundation for many of the PPS's DSRIP projects. This project will build on this experience, but will provide a broader set of interventions and serve a larger group of Medicaid patients, including those who are not eligible for Health Home services.

The MSSP program targets Medicare patients served through ACOs. The PPS will build on the experience of these partners to establish its care management and coordination model. The IDS project will improve care for Medicaid patients through a broader set of interventions.

The Community-based Care Transitions program targets Medicare patients. The Brooklyn Bridges PPS will build on the experience of these partners to establish PPS-customized care transitions protocols at Lutheran Medical Center, extending the model to a broader population of Medicaid patients.

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.

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 applications.

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.

Although 82% of CNA survey respondents reported having a primary care provider or personal doctor, nearly one in four reported that there was a time in the last 12 months when they needed health care or service but did not access it. Wait times to access primary care in Brooklyn were reported by survey respondents to be three to four months long, discouraging the optimal use of existing primary care services. Accordingly, there were approximately 347,000 potentially preventable ED visits (PPV) in Brooklyn in 2013, accounting for 75% of all ED visits in the borough.

Commonly reported reasons for ED utilization include the inability to get a timely appointment with a primary care provider, limited clinic hours, or the need for multiple visits. Community members strongly perceive the ED as a place to access convenient, comprehensive care at any time.

In 2013, more than 30,000 Medicaid patients visited Lutheran's ED. Of these, 94% had 1-2 ED visits, 5% had 3-5 ED visits, and 1% had 6 or more ED visits. Alcohol abuse was the most common principal diagnosis among the "frequent fliers," accounting for 30% of ED visits. Acute upper respiratory tract infections, viral infections, asthma, chest pain, and gastroenteritis were among the other leading diagnoses for these visits.

Interventions that address CNA identified opportunities and gaps include:

*INCREASE PRIMARY CARE/PCMH CAPACITY by up to 10% by DY 5, including additional staffing of primary care physicians, nurse practitioners and physician assistants, expanded hours of operation, open-access scheduling, and increased scope of onsite services, such as point-of-care testing and specialty services that will offer convenient access for patients in a lower-cost setting.

*IMPLEMENT EVIDENCE-BASED TRIAGE PROTOCOLS for the identification and redirection of non- emergent patients through a team-based care model to ensure patients can access and receive the appropriate level of care. The PPS will increase its staffing and training of ED care managers at both Lutheran and NYU Langone-Cobble Hill (Cobble Hill), formerly Long Island College Hospital, ED sites to ensure adherence to the ED triage protocols.

*UNIVERSAL CARE COORDINATION to facilitate patient activation to ensure treatment adherence/continuation, including facilitated referral by the Patient Navigation Center (PNC) to community-based resources, education/health coaching, and transition planning.

*ELECTRONIC TRANSFER OF INFORMATION to connect providers across the levels of care and ensure continuity of care for patients. The PPS will leverage Lutheran's existing EMR and open-access scheduling and NYULMC's HIE to enable information sharing across partners.

*PATIENT EDUCATION both at the point of care and in the community to provide culturally competent education about when and where to seek emergency care, the increased capacity of primary care clinics, and how to communicate with PCMH providers. ED care managers at Lutheran and Cobble Hill will educate patients on post-ED visit care plans and medication management.

*TELEMEDICINE PILOT to ensure appropriate transfer of facility-based patients to the ED, such as patients in developmental disability residences or day programs, nursing homes, or shelters. Through the implementation of two or three pilots, the PPS will evaluate the ability of ED telemedicine consults to reduce potentially avoidable ED visits among facility-based patients in the PPS.

*FACILITATED REFERRAL TO SUBSTANCE ABUSE SERVICES provided by OASAS-licensed PPS partners in order to promote patient enrollment in ongoing treatment and to drive down ED usage by patients with alcohol and substance use related conditions.

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.

The PPS expects to actively engage a diverse cohort of Medicaid beneficiaries aged 18 or older and the families/caregivers of Medicaid beneficiaries under the age of 18 who access the Lutheran or Cobble Hill EDs for non-emergent care. Non-emergent conditions and symptoms may include alcohol-related conditions, shortness of breath (i.e., asthma, chronic obstructive pulmonary disease, congestive heart failure, pneumonia), acute respiratory track conditions, viral infections, abdominal pain, and chest pain. The PPS will ensure that patients and families/caregivers without an identified primary care provider are connected to a PCMH primary care provider in the PPS. The PPS will also ensure coordination with community providers outside of the PPS through the RHIO/SHIN-NY.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:
Unique Experience:
*As a result of Super Storm Sandy, Lutheran's ED was overwhelmed with patients who had been diverted from closed EDs at nearby hospitals. During this period of time, Lutheran nimbly deployed an ED triage process to decant the ED of non-emergent cases. This

experience shows readiness and ability to implement an ED triage project at the Lutheran and Cobble Hill EDs in coordination with FQHC and local community-based primary care providers.

Care Coordination:
*Lutheran's existing care coordination resources for Health Home-eligible and non-eligible patients, including an ED care manager and embedded PCMH care managers, can be expanded to manage additional populations.
*NYULMC's care coordination and Population Health Management (PHM) resources have had a demonstrated impact on reducing avoidable hospitalizations and ED visits.

HIT:
*Lutheran and LFHC maintain open-access scheduling and an EMR, providing a starting point for the PPS to expand the scheduling system and EMR capabilities to all participating primary care sites.
*NYULMC's enterprise-wide EMR ensures widespread adoption of standard order sets and continuity of care for patients.
*NYULMC's HIE ensures information transfer for continuity of care throughout NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, including its Brooklyn-based providers.

Clinical Guidelines:
*Lutheran and NYULMC both utilize evidence-based clinical guidelines for point-of-care patient education and medication reconciliation.

PCMH:
*The majority of our nine partnering FQHCs, including all LFHC sites, are designated PCMH NCQA 2011 Level 3 . This existing asset facilitates rapid achievement of PCMH NCQA 2014 Level 3 certification by DY 3.

The PPS identifies the following resources to be developed and/or repurposed:
Expand PCMH:
*Provide technical assistance to ensure that independent physicians and non-LFHC FQHCs are supported to reach PCMH NCQA 2014 Level 3 certification by the end of DY 3. The PPS will establish an internal project management office that will identify, coordinate, and deploy resources to practices across the PPS to assist with PCMH certification.
*Leverage existing NYU technical resources for these activities and engage with local and national organizations (e.g., Primary Care Information Project, Primary Care Development Corporation, etc.) and vendors for assistance with implementation.

Establish Patient Navigation Center:
*Coordinate primary care provider scheduling and appointment reminders.
*Connect PPS patients with appropriate community resources for social, behavioral, and physical support services.
*Provide culturally competent, multi-language patient education and outreach materials to promote the value of primary care and community access to the PNC.
*Educate patients, families, and caregivers on the appropriate use of ED.

Launch Telemedicine Pilot:
*Pilot telemedicine capabilities to limit after-hours use of ED among specific PPS providers such as developmental disability group residences and nursing home providers. Up to three PPS facility sites would be selected for the telemedicine pilot, targeting a launch in DY 2 or 3.

Enhance Care Coordination:
*Explore potential opportunities to collaborate with New York Mobile Integrated Health Association to improve technological integration between hospital EDs, PCMHs, and emergency medical services (EMS). This would allow for field recognition of patient's PCMH affiliations or at-risk status empowering EMS to coordinate care from the field or at least expedite clinical care.

Expand HIT Connectivity:
*Develop HIE capabilities to allow sharing of appropriate patient health information among PPS partners.

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.

The PPS will employ the following potential solutions to address anticipated project challenges:

*To impact patients' perceptions and use of the ED for convenient comprehensive care, the PPS will develop culturally-competent patient education materials promoting the benefits of primary care provider engagement and the downside of unnecessary testing.
*To offer patients convenient access to non-urgent care needs, PCMH sites within the PPS will offer extended hours and increased capacity to provide comprehensive services onsite, including certain point-of-care testing and specialty services. PCMH sites will also utilize open-access scheduling to help patients get same day and next day appointments.
*To address alcohol-related ED use, the PPS will oversee the development of enhanced clinical pathways in collaboration with OASAS partners.
*To combat high rates of uninsured, the PPS's PNC will connect patients to certified application counselors in the community to promote insurance enrollment.

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.

The Brooklyn-based PPSs, including Brooklyn Bridges, Collaborative Care of Brooklyn, and the New York City Health and Hospitals Corporation, have collaborated to select the ED Care Triage project and align key interventions related to its implementation. During the January-

March 2015 implementation planning period, the PPS intends to collaborate further with Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

Additionally, the PPS will develop referral relationships and data-sharing mechanisms with OASAS- licensed PPS partners in order to ensure universal patient access to all available treatment options in the county.

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 proj

Yes	No
☒	☐

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

The PPS will require capital funds to support expansion of Lutheran's ED capabilities. Specifically, capital funding will be needed for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions at this site. These capital improvements are needed to successfully curb preventable ED utilization among frequent, low-severity utilizers, especially those in the behavioral health population.

The PPS will use capital funds to build an Observation Unit adjacent to the Lutheran ED.

Constructing an Observation Unit will enable Lutheran's ED providers to transfer patients presenting to the ED without a clear need for inpatient services to the Observation Unit for monitoring, stabilization, and treatment, with the goal of reducing avoidable inpatient admissions.

The PPS will require capital funds to develop and pilot ED telemedicine consultation capabilities with developmental disability residences or day programs, nursing homes, and shelters. Specifically, capital funds will be needed to support videoconferencing capabilities and IT terminals and equipment in both the Lutheran ED and three of these facilities for the pilot. This will reduce potentially avoidable ED use by these facilities with otherwise limited options for assessing their patients' health care needs. If successful, additional capital may be required to expand the ED telemedicine consult capabilities across selected PPS sites.

The PPS will use capital funds to deploy a centralized PNC that will provide patient navigation services, including telephonic triage and appointment scheduling, to improve care coordination and PHM. Specifically, capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support PNC centralized care coordination activities.

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
Harlem United/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Bowery Residents' Committee (BRC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare Wellness	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Concern for Independent Living, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
SCO Family of Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Lutheran Family Health Centers	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
VNSNY	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2016	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Public Health Solutions	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2017	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York Therapeutic Communities, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Cerebral Palsy Associations of New York State	Medicare Shared Savings Program (MSSP)	2014	2016	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Cerebral Palsy Associations of New York State is a participating provider in an MSSP project.
Dominican Sisters Family Health Service	Community-based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
JNS Counseling Services INC.	Community-based Care Transitions Program	2014	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
God's Love We Deliver	FIDA-Fully Integrated Duals Advantage	2015	2018	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Amber Court Assisted Living Communities	FIDA-Fully Integrated Duals Advantage	2015	2018	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities.

The Health Home program, particularly the experience and capacity of participating Health Homes and downstream care management agencies, is a strong foundation for many of the PPS's DSRIP projects. The ED Care Triage project will build on this experience, but will provide a broader set of interventions and serve a larger group of Medicaid patients, including those who are not eligible for Health Home services.

The MSSP program targets Medicare patients served through ACOs. The PPS will build on the experience of these partners to establish its care management and coordination model. The ED Care Triage project will improve care for Medicaid patients through a broader set of interventions.

The Community-based Care Transitions program targets Medicare patients. The Brooklyn Bridges PPS will build on the experience of these partners to establish PPS-customized care transitions protocols at Lutheran Medical Center, extending the model to a broader population of Medicaid patients.

FIDA enrollees are likely to participate in this project given that this project targets high-need populations. This DSRIP project, however, is being implemented at the partner/provider, not plan level, and is distinct from and will supplement services provided under FIDA plans. In addition, this project will extend to all of the PPS's actively engaged population, not just those enrolled in FIDA, as well as a broader set of interventions.

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.

2.b.ix Implementation of Observational Programs in Hospitals

Project Objective: This project will reduce inpatient admissions vis-à-vis the creation of dedicated observation (OBS) units for patients presenting to emergency departments (EDs) whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.

Project Description: While observation beds are not new to hospitals, the goal of this project is to bring care coordination services to the unit in order to ensure continuity of care with community services. Short stay hospitalizations are often related to ambulatory-sensitive diagnoses. These admissions can be avoided with improved access to primary care and behavioral health services, as well as with compliance to evidence-based clinical guidelines by the practitioner and patient. Health literacy, community values, and language may be barriers to connectivity of the patient with necessary health care services. Appropriate communication may assist with removing these barriers.

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 appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.
2. Create clinical and financial model to support the need for the unit.
3. Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.
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. Use EHRs and other technical platforms to track all patients engaged in the 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.

In 2012, there were roughly 14,000 Medicaid potentially preventable hospitalizations (PQI 90) in Brooklyn. The borough had a much higher rate of preventable hospitalizations than New York State overall; the age adjusted PQI rate for Medicaid beneficiaries aged 18 and older in New York State was 135.6/10,000 whereas Brooklyn's age-adjusted PQI rate was 172/10,000. Additionally, racial disparities among Black non-Hispanics, Hispanics, and White non-Hispanics were persistent in the age-adjusted PQI rates for Medicaid beneficiaries aged 18 years and older.

The greatest proportion of PQIs was for chronic conditions, specifically respiratory conditions (asthma, chronic obstructive pulmonary disease), cardiovascular conditions (heart failure, hypertension), and diabetes. Management of these conditions represents the greatest opportunity for reducing preventable admissions.

In 2013, 2,773 Medicaid admissions to Lutheran Medical Center, excluding deliveries and normal births, were one- and two-day stays. Many of Lutheran's short stay top diagnoses are conditions that the American College of Emergency Physicians identifies as appropriate for observation status, including dehydration, chest pain, abdominal pain, syncope, infections (i.e., pneumonia and cellulitis), asthma, and alcohol-related conditions.

The PPS aims to reduce the PQI rate through the use of a 10-bed Observation Unit (OU) adjacent to the Lutheran ED, with full implementation of the OU by the second quarter of DY 3.

Interventions that address CNA-identified opportunities and gaps include:

*BUILD OBSERVATION UNIT ADJACENT TO THE LUTHERAN ED for effective oversight and management by emergency medicine physicians and to ensure efficient, patient-centric operations. Implementation of a 10-bed OU adjacent to the ED will better facilitate the transfer of medically appropriate patients from the ED to the OU, thereby reducing potentially preventable admissions.

*IMPLEMENT EVIDENCE-BASED OBSERVATION PROTOCOLS for the identification of observation eligible patients through a team-based care model to ensure patients are receiving the appropriate level of care. Observation protocols will be applied when: 1) determining if the ED patient qualifies for observation status; 2) determining if the patient is appropriate for admission at any time during his/her stay at the OU; and, 3) determining when the patient is ready to be discharged from the OU and back into the community. The PPS will document comprehensive patient assessments in the EMR and explore expansion to pediatric patients as need arises.

*STAFF OBSERVATION UNIT to ensure efficient operations for timely discharge and coordination with post-discharge support services such as home care or primary care/specialty physician office visits via the Patient Navigation Center (PNC).

*UNIVERSAL CARE COORDINATION to facilitate: patient activation, treatment adherence, and continuity of health care; referrals to community-based resources; education and health coaching; and, transition planning. The PNC will conduct patient outreach post-discharge from the OU and assist in scheduling follow-up appointments with PCMH and Health Home providers.

*ELECTRONIC TRANSFER OF INFORMATION to connect providers across the levels of care and ensure continuity of care for patients.

*FACILITATED REFERRAL TO SUBSTANCE ABUSE SERVICES provided by OASAS-licensed PPS partners in order to promote patient enrollment in ongoing treatment and to reduce ED usage by patients with alcohol and substance use related conditions.

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.

The PPS expects to actively engage a diverse cohort of its PPS beneficiaries aged 18 or older who are admitted to the Lutheran OU. In addition to serving its own PPS beneficiaries, the PPS anticipates admitting Medicaid patients from other Brooklyn PPSs to its new OU. The targeted population are those who present with the following observation-eligible conditions and symptoms: abdominal pain; alcohol withdrawal; allergic reaction; asthma; back pain; cellulitis; chest pain; dehydration; headache; shortness of breath; and syncope. The PPS will ensure that patients without an identified primary care provider are connected to a PCMH primary care provider in the PPS. The PPS will also ensure coordination with community providers outside of the PPS through the PPS HIE and the RHIO/SHIN-NY.

Additionally, the project will tailor post-discharge care coordination services based on the patient's risk of readmission or return to ED. The scope of targeted conditions may be expanded for the adult population, and the pediatric population may be included within the five year DSRIP timeframe, upon implementation of the permanent OU at Lutheran.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:
Two Midnight Rule Experience:

As a result of Medicare payment reform known as the Two Midnight Rule, Lutheran has configured its EMR with decision support tools for ED clinicians to ensure appropriate inpatient admissions for Medicare patients. Lutheran utilizes clinical guidelines to admit Medicare patients to observation status. This experience demonstrates readiness to rapidly implement an interim Medicaid OU at Lutheran in coordination with NYULMC. NYULMC has extensive experience with operating an existing OU at Tisch Hospital. This experience and expertise will be invaluable as Lutheran begins to operate a discrete OU in DY 3.

Care Coordination:

*Lutheran's existing care coordination resources for Health Home-eligible and non-eligible patients, including an ED care manager and embedded PCMH care managers, can be expanded to manage additional populations.
*NYULMC's care coordination and Population Health Management (PHM) resources have had a demonstrated impact on reducing avoidable hospitalizations and ED visits.

HIT:
*LFHC maintains open-access scheduling and an EMR, providing a starting point for the PPS to expand the scheduling system and EMR capabilities to all participating primary care sites.
*NYULMC's enterprise-wide EMR ensures widespread adoption of standard order sets and continuity of care for patients.
*NYULMC's HIE ensures information transfer for continuity of care throughout NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, including its Brooklyn-based providers.

Clinical Guidelines:

*NYULMC utilizes evidence-based clinical guidelines in its existing OU. These clinical guidelines will be tailored for and adopted at Lutheran.

PCMH:
*The majority of our nine partnering FQHCs, including all LFHC sites, are designated PCMH NCQA 2011 Level 3. This existing asset facilitates rapid achievement of PCMH NCQA 2014 Level 3 certification by DY 3.

Risk Stratification:
*NYULMC risk stratifies patients using a variety of data sources including claims and clinical data. Risk stratification is a critical element to tailoring interventions and deploying resources to the highest risk patients.
The PPS identifies the following resources to be developed and/or repurposed:

Expand PCMH:
*Provide technical assistance to ensure independent physicians and non-LFHC FQHCs are supported to reach PCMH NCQA 2014 Level 3 certification by the end of DY 3. The PPS will establish an internal project management office that will identify, coordinate, and deploy resources to practices across the PPS to assist with PCMH certification.
*The PPS will leverage existing NYU technical resources for these activities as well as engage with local and national organizations (e.g., Primary Care Information Project, Primary Care Development Corporation, etc.) and vendors for assistance with implementation.

Strengthen Access to Community-Based Resources:
*Establish the PNC to coordinate primary care provider scheduling and appointment reminders as outlined in the patient's post-OU care plan.

*Connect PPS patients who are discharged from the OU with appropriate community resources for social, behavioral, and physical support services via the PNC.
*Collaborate with our OASAS partners to develop enhanced clinical pathways and resources that target alcohol-related ED use.
*Provide culturally competent, multi-language patient education and outreach materials to promote the value of primary care and community access to the PNC.

Expand IT Connectivity:
*Develop HIE capabilities to allow sharing of appropriate patient health information among PPS partners.

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.

The PPS will employ the following approaches to addressing anticipated project challenges:
Lutheran and NYULMC have developed a plan and budget to build the dedicated OU adjacent to Lutheran's ED with implementation scheduled for the second quarter of DY 3. In the interim, Lutheran will explore designation of observation satellite beds.

*To address the need for dedicated OU staff, the PPS will conduct a workforce analysis to identify opportunities to train and redeploy Lutheran staff to the interim observation beds and to the permanent OU. This redeployment and retraining strategy, discussed in greater detail in Section 5, will include a shared Medical Director with the ED.

*Lutheran will designate and train an ED physician champion for the OU and create pocket cards for ED physicians identifying OU-appropriate conditions and protocols. Physicians, ED care managers, and staff at the NYU Langone-Cobble Hill ED will be trained to identify OU-appropriate conditions and protocols.

*The PPS will implement a HIE platform to enable patient data-sharing and facilitate transitions of care.

*PCMH sites within the PPS will offer extended hours and increased capacity to provide comprehensive services, including expanded point-of-care testing and specialty services. PCMH sites will also utilize open-access scheduling to help patients get same day and next day appointments.

*To address alcohol-related ED use, the PPS will oversee the development of enhanced clinical pathways and community resources in collaboration with OASAS partners. As noted previously, alcohol- related conditions are among the top diagnoses for short stay admissions at Lutheran, suggesting a strong opportunity to reduce unnecessary admissions for beneficiaries with these conditions.

*To combat high rates of uninsured, the PNC will connect uninsured patients to certified application counselors in the community to promote enrollment in health coverage. The PPS will work collaboratively with Medicaid managed care (MMC) plans to develop value-based payment arrangements that support a financially sustainable business model.

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.

While the PPS is the sole PPS pursuing this project in Brooklyn, there are opportunities to collaborate with the other Brooklyn-based PPSs, particularly as we anticipate that the Lutheran OU will serve a significant number of patients attributed to other Brooklyn PPSs. Collaboration will occur around information sharing and protocols to ensure that other Brooklyn PPS patients have a smooth hand-off from the Lutheran OU to the patient's PPS provider. During the January-March 2015 implementation planning period, we intend to collaborate and share clinical protocols and lessons learned with other PPSs implementing this project throughout New York State. Additionally, the PPS will develop referral relationships and data-sharing mechanisms with OASAS- licensed PPS partners in order to ensure universal patient access to all available treatment options in the county.

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.

The PPS will require capital funds to renovate space adjacent to the Lutheran ED to accommodate a new OU.

Constructing an OU will enable Lutheran's ED providers to transfer patients presenting to the ED without a clear need for inpatient services to the OU for monitoring, stabilization, and treatment, with the goal of reducing avoidable inpatient admissions.

Capital funding will be needed for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions related to the development of an OU. These capital improvements are needed to successfully curb avoidable and costly inpatient admissions for PPS patients.

The PPS also will use capital funds to deploy a centralized PNC that will provide patient navigation services, including telephonic triage and appointment scheduling, to improve care coordination and

PHM. Capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support PNC centralized care coordination activities.

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
Dominican Sisters Family Health Service	Community-based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
JNS Counseling Services INC	Community-based Care Transitions Program	2014	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cerebral Palsy Associations of New York State	Medicare Shared Savings Program (MSSP)	2014	2016	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Cerebral Palsy Associations of New York State is a participating provider in an MSSP project.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities. The Community-based Care Transitions program targets Medicare patients. The Brooklyn Bridges PPS will build on the experience of these partners to establish PPS-customized care transitions protocols at Lutheran Medical Center, extending the model to a broader population of Medicaid patients. The MSSP program targets Medicare patients served through ACOs. The PPS will build on the experience of these partners to establish its care management and coordination model. The OU project will improve care for Medicaid patients through a broader set of interventions.

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 <u>completion of project requirements</u>, <u>scale of project implementation,</u> and <u>patient engagement progress</u> 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.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently

Project Objective: This project will develop community-based health navigation services to assist patients in accessing healthcare services efficiently.

Project Description: Health literacy, community values, language barriers, and lack of engagement with community health care services can result in avoidable use of hospital services. People who do not understand how to access and use the healthcare system cannot be expected to use it effectively. This project is focused on persons utilizing the system but doing so ineffectively or inappropriately. The intended navigation services will provide bridge support until the patient has the confidence to self-manage his/her health. These community resources will not necessarily be licensed health care providers, but persons trained to understand and access the community care system. For example, navigators will assist patients with scheduling appointments and obtaining community services. Navigators will be resourced in-person, telephonically, or online; they will also have access to language services and low literacy educational materials.

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. Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.
2. Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.
3. Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.
4. Resource appropriately for the community navigators, evaluating placement and service type.
5. Provide community navigators with access to non-clinical resources, such as transportation and housing services.
6. Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.
7. Market the availability of community-based navigation services.
8. Use EHRs and other technical platforms to track all patients engaged in the 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.

The number of potentially preventable admissions (PQI) for chronic conditions in Brooklyn is nearly three times that for acute conditions, indicating that improved management of chronic conditions presents a significant opportunity to reduce preventable inpatient stays. Throughout Brooklyn, 65-80% of ED visits are estimated to be potentially preventable.

The CNA data provides evidence of several types of barriers and underlying gaps that are driving poor health outcomes among Brooklyn residents, including barriers to accessing timely outpatient care.
Respondents describe long wait times for appointments, economic challenges, and challenges balancing long work hours with limited provider hours. These factors contribute to overuse of the ED as community members strongly perceive the ED as a place to access convenient, comprehensive care at any time.

CNA respondents additionally report the need to improve language and cultural competency among providers and support resources to address the health and social service needs of patients with diverse backgrounds. 35% of the borough's population is foreign-born, with 25% of the population reporting speaking English less than "very well."
Some Brooklyn neighborhoods are characterized by high levels of poverty, lack of community resources, safety concerns, and shortages of housing, employment, and access to healthy food. In addition to high rates of chronic disease, these conditions create competing priorities that pose challenges to patient activation and self-management.

The PPS intends to reduce avoidable ED visits and improve connections to health and social services for our attributed patients through implementation of a Patient Navigation Center (PNC) beginning in DY 1 with 100% actively engaged patient participation by DY 4.

Project interventions that address CNA identified opportunities and gaps include:

*CULTURALLY-COMPETENT AND MULTI-LINGUAL NAVIGATION/CARE COORDINATION SERVICES delivered telephonically and in-person to ensure:

1) Effective and efficient access of healthcare services, including PCMH enrollment, by PPS members;
2) Patient activation to ensure treatment adherence and continuity of care, including facilitated referrals to community-based resources;

3) Patient education and health coaching to improve patient self-management; and
4) Effective transition planning, including post-discharge.

*ELECTRONIC TRANSFER OF INFORMATION to connect providers across the levels of care and ensure continuity of care for patients.

*DEVELOPMENT OF A COMMUNITY RESOURCE GUIDE to connect patients to needed health care and social services, including transportation, housing, psychosocial support, and food access.

*INTEGRATION OF CENTRALLY-TRAINED CARE MANAGERS INTO PCMH CARE TEAMS to ensure longitudinal access for chronically high-risk patients and to facilitate care team integration.

*IMPLEMENTATION OF HOME- AND COMMUNITY-BASED COMMUNITY HEALTH WORKER (CHW) SERVICES to ensure effective provision of home-based trigger reduction assessment, disease self-management assistance, and field-based patient activation for those not effectively accessing PCMH care.

*INCREASE PRIMARY CARE/PCMH CAPACITY by up to 10% by DY 5, including additional staffing, expanded hours of operation, and increased scope of onsite services, such as point-of-care testing and specialty services.

*STRONG PARTNERSHIPS WITH MEDICAID MANAGED CARE (MMC) PLANS to develop value-based payment arrangements that support a sustainable financial model and access to timely population health analytics, including risk stratification data.

*INBOUND AND OUTBOUND CALL CAPACITY to schedule appointments, follow-up on health care treatment and medication adherence, and assist in connecting patients to the most appropriate site of care.

*USE OF INNOVATIVE PATIENT OUTREACH leveraging smart phone technology, secure messaging to patients, alerts, and health tracking.

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. .

Referral criteria to the PNC may include:

*Post-discharge care transitions (e.g., change in level of care, inpatient to outpatient, ED, and Observation Unit discharges);

*Initiation of disease-specific care intervention protocols (e.g., Asthma Home-Based Self-Management Program and Diabetes Management Program);

*Initiation of longitudinal care management for patients identified or stratified as high-risk; and

*Referrals for individual patients or caregivers seeking to schedule appointments or gain access to community-based services.

More structured and high-intensity navigation services—including community-based navigation—will be targeted towards the subset of these patients who:

*Are identified as high-risk in the context of a care transition, a physician referral, or via risk stratification of claims or clinical data; and

*Do not have a good understanding of the local health care system and cannot be expected to access it or use it effectively absent intensive 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.

To achieve this project's goals, the PPS will mobilize the following existing assets:

Care Coordination:

*LFHC's Community Case Management Program provides community-based care coordination, patient navigation, and health coaching to high-risk patients; LFHC is one of the largest FQHC networks in the country and an affiliated member of the Brooklyn Health Home.

*Existing LFHC community resource guide includes OASAS and OMH providers, adult day care, transportation, housing, workforce training, adult education, and food programs, and an established network of community-based providers.

*Standardized care coordination protocols and training curriculum, provided by 1199SEIU.

*Registered Nurse Clinical Care Coordinators (RN CCCs) through NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, assist diabetic patients in obtaining preventive health services. Through claims data, the RN CCCs work from EMR-based patient registries to conduct outreach and assessment.

*NYU School of Medicine has demonstrated success with CHW interventions including two National Institutes of Health funded projects and one Centers for Disease Control and Prevention funded project. These initiatives improved health outcomes for Filipinos, Bangladeshis, and other South Asian populations with hypertension and diabetes. This public health expertise and published learnings will help the PPS develop a successful CHW program.

HIT:

*LFHC uses Azara, a clinical software suite, to identify patients at risk for readmissions and in high need of management of chronic conditions; the PNC will leverage Azara for risk stratification to enroll patients into care management services of appropriate intensity.

*LFHC maintains open-access scheduling and an EMR, providing a starting point for the PPS to expand the scheduling system and EMR capabilities to all participating primary care sites.

*NYULMC's enterprise-wide EMR ensures widespread adoption of standard order sets and continuity of care for patients. Care coordination documentation, scheduling, and clinical care is done in the same EMR, which will be implemented at Lutheran.

*NYULMC's HIE ensures information transfer for continuity of care throughout NYUPN, including its Brooklyn-based providers.

*By January 2015, NYULMC Faculty Group Practice physicians will have online scheduling for direct patient access to appointments. Additionally, NYULMC's Digital Transformation Initiative redesigned the Find A Doc feature of the website for 2,000 NYUPN physicians. These tools can be rapidly expanded to the PPS partners.

*NYULMC has developed the ability to risk stratify patients using a variety of data sources including claims and clinical data. Risk stratification is a critical element in tailoring interventions and deploying resources to the highest risk patients.

The PPS identifies the following resources to be developed and/or repurposed:

Community Resource Guide:

*The PPS Clinical Sub-Committee, with broad representation across the PPS, will be convened to review and update the existing community resource guide. The PPS will develop a searchable database of community resources to be made available to the PNC contact center and CHWs.

Expanding PCMH:

*Provide technical assistance to ensure independent physicians and non-LFHC FQHCs are supported to reach PCMH NCQA 2014 Level 3 certification by the end of DY 3.

Integrated Delivery System:

*The PPS IDS will require investment in additional infrastructure. This will include a care coordination technology platform with a robust workflow and rules engine, risk stratification analytics, HIE connectivity, and the ability to collect and report on key patient engagement and activation metrics.

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.

The PPS will employ the following approaches to addressing anticipated project challenges:

*To address the challenge of ensuring convenient access, PCMH sites within the PPS will offer extended hours and increased capacity to provide comprehensive services onsite, including certain point-of-care testing and specialty services. PCMH sites will also utilize open-access scheduling to help patients get same day and next day appointments.

*To actively engage difficult to reach patients, the PPS will deploy CHWs and embed care managers in PCMH sites.

*To rapidly scale PNC resources, the PPS will leverage partners' existing care management resources.

*The PPS will coordinate with MMC plans and partners who have existing care management resources to avoid duplication of services and to optimize the role of each care management entity.

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.

While Brooklyn Bridges is the sole PPS pursuing this project in Brooklyn, there are opportunities to collaborate with the other Brooklyn-based PPSs. The other Brooklyn-based PPSs, including Collaborative Care of Brooklyn and the New York City Health and Hospitals Corporation PPS, will undertake DSRIP Project 2.a.i. to develop an IDS with the provider partners in their PPS networks. Brooklyn Bridges will assess the level of interest and need for PNC services among these emerging PPSs during the January- March 2015 implementation planning period. The PPS intends to scale PNC services to be offered borough-wide.

Regardless, the PNC will develop data-sharing mechanisms with other Brooklyn-based PPSs in order to ensure universal patient access to all available treatment options in the county.

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 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.

The PPS will use capital funds to deploy a centralized PNC that will provide patient navigation services, including telephonic triage and appointment scheduling, to improve care coordination and Population Health Management (PHM). Capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support the PNC's centralized care coordination activities.

The PPS also will require capital funds to develop a shared health IT infrastructure to support PPS-wide PHM efforts. Efforts will include 1) development and dissemination of a care management platform and patient registries; 2) enhancement of Brooklyn RHIO capabilities and EMR system licenses for partner organizations; and, 3) development of analytic and reporting processes and network management capacity.

This capital funding will support communication among PPS partner organizations and help achieve a coordinated and patient-centered experience for PPS patients.

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
Dominican Sisters Family Health Service	Community-based Care Transitions Program	2012	2016	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
JNS Counseling Services INC	Community-based Care Transitions Program	2014	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
God's Love We Deliver	FIDA-Fully Integrated Duals Advantage	2015	2018	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Amber Court Assisted Living Communities	FIDA-Fully Integrated Duals Advantage	2015	2018	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Cerebral Palsy Associations of New York State	Medicare Shared Savings Program (MSSP)	2014	2016	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Cerebral Palsy Associations of New York State is a participating provider in an MSSP project.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities.

The Community-based Care Transitions program targets Medicare patients. The Brooklyn Bridges PPS will build on the experience of these partners to establish PPS-customized care transitions protocols at Lutheran Medical Center, extending the model to a broader population of Medicaid patients.

FIDA enrollees are likely to participate in this project given that this project targets high-need populations. This DSRIP project, however, is being implemented at the partner/provider, not plan level, and is distinct from and will supplement services provided under FIDA plans. In addition, this project will extend to all of the PPS's actively engaged population, not just those enrolled in FIDA, as well as a broader set of interventions.

The MSSP program targets Medicare patients served through ACOs. The PPS will build on the experience of these partners to establish its care management and coordination model. The navigation services project will improve care for Medicaid patients through a broader set of interventions.

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.

Between 50-60% of Brooklyn CNA respondents report that substance abuse and mental health services, collectively, behavioral health (BH) services, are lacking in their communities, likely contributing to a high prevalence of BH disorders. The CNA describes myriad stressors on lower income Brooklyn residents, resulting in high levels of depression. Depression and anxiety are common self-reported health issues, affecting 22% of Brooklyn residents surveyed for the CNA. Drug and alcohol use are top health concerns for 44% of those surveyed.

Stigma impedes some from seeking services from BH providers, suggesting that embedding BH services into primary care will increase access. However, almost half of Brooklyn CNA survey respondents report that they could not access non-emergency health care services, and one in four report that primary care was difficult or impossible to access. Nearly one-third report that pediatric/adolescent BH services were difficult or impossible to access.

Reducing barriers to access will not fully address untreated BH diagnoses. Nearly half (47%) of

New York State Medicaid managed care (MMC) enrollees who were prescribed antidepressant medications did not use them for the 12-week acute treatment phase, and only 37% remained on the medication for at least six months. In New York State, only 57% of children enrolled in MMC who were prescribed medication for attention deficit hyperactivity disorder completed a follow-up visit within 30 days of starting medication. Only 65% of MMC adults hospitalized for a mental illness received follow-up within seven days of discharge and only 79% within 30 days. Untreated BH disorders are linked to poor health outcomes; the CNA reports that over 50% of Brooklyn adults using BH services have co-morbid chronic medical disorders, and one in ten children with BH service use had pulmonary disorders.

Brooklyn Bridges proposes to develop two Integrated Care models to address BH related community need identified in the CNA. Where feasible, the PPS will support co-location of BH services at partner primary care sites, and where co-location is not feasible, the PPS will support implementation of the IMPACT model.

Interventions that address CNA identified opportunities and gaps include:

*INCREASING PRIMARY CARE CAPACITY by up to 10% by DY 5, including additional staffing, expanded operating hours and increased scope of onsite services (e.g., point-of-care testing and specialty services).

*INTEGRATION OF BEHAVIORAL HEALTH SERVICES INTO UP TO NINE PPS FQHCs, seven Article 28 diagnostic and treatment centers (DTC), and 29 private Brooklyn primary care practice sites per the PCMH and IMPACT Models, increasing the availability of BH services in underserved communities and reducing care fragmentation.

*UNIVERSAL CARE COORDINATION & TREATMENT SUPPORT to facilitate patient activation, treatment adherence and health care continuity through facilitated referrals to community resources, education/health coaching and transition planning.

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.

The PPS expects to actively engage through this project a diverse cohort of Medicaid beneficiaries ages five years and older who currently receive primary care at committed partner sites. In the ED Care Triage, Observation Unit and Patient Navigation Center (PNC) projects, the PPS will identify and engage individuals who access the PPS emergency and inpatient services, but who are not engaged in primary care and/or have untreated BH conditions, and link them to Integrated Care partner sites. Partner sites will have demonstrated clinical competencies and population management tools to address diverse patient needs.

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.

Below is a description of PPS PCMH-integrated and IMPACT initiatives, including the PPS resources for implementation and additional resources to be developed. The PPS will provide partners with planning, workforce training, capacity building, and implementation support for these initiatives.

Primary Care:
*The primary care-centered PPS brings to this project a strong network of nine FQHCs, seven DTCs and 29 private Brooklyn primary care practice sites located in high need communities. A significant number of our large FQHC and DTC partners (at least six) are designated PCMH NCQA 2011 Level 3. This existing asset facilitates rapid achievement of PCMH NCQA 2014 Level 3 by DY 3.

Behavioral Health Care:
*LFHC has significant experience implementing the IMPACT model for depression as well as the PHQ 9 and will provide technical assistance to partners.
*LFHC is New York City's largest Article 31 provider serving 3,500 patients with over 78,000 visits in 2013. Patients who need specialty care will be seen at the 11 Article 31 mental health and 22 OASAS-licensed substance abuse (SA) treatment program partners in the PPS. Brooklyn Bridges will also work with Coordinated Behavioral Care, an IPA with 50 BH specialty providers (many in Brooklyn) to add capacity as needed.
*Lutheran's inpatient services include a 35-bed, acute care psychiatric unit providing psychiatric evaluation and treatment. The Lutheran ED also provides BH services to the community at all times and a psychiatrist is always on duty for emergency evaluation and care.

Care Coordination:
*Lutheran is a founder and co-owner of the Brooklyn Health Home. It coordinates care for 400 people, with CAMBA (a PPS partner), working with 250 Lutheran referrals.
*LFHC embeds care coordinators in its primary care sites to engage patients, assist the care team with pre-visit planning, and link patients to community-based resources.

The PPS identifies the following resources to be developed and/or repurposed:
Adding Primary Care Capacity:
*By expanding operating hours and PCPs at project sites, overall primary care capacity will grow by up to 10% by DY 5.

Expanding BH Care:

*To facilitate primary care-based BH integration, the PPS will expand its BH clinician workforce.

Increasing Care Coordination:
*The Brooklyn Health Home infrastructure and expertise will be the foundation for patient activation/engagement and care navigation for this project. Individuals who are not Health Home eligible, but need care navigation, will be offered services from the PPS PNC that will serve PPS patients in this and other projects.

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.

The PPS will employ the following approaches to addressing anticipated project challenges:

*To address Brooklyn's shortage of psychiatrists, the PPS will explore centralized staffing models, including the use of tele-psychiatry.

*To address regulatory challenges, including New York State's limitations on the provision of BH services in Article-28 licensed sites, the PPS may require Article 31 licensure at sites serving sizable populations with serious mental illness.

*To increase providers' experience with BH disorders, the PPS will develop training for all primary care providers at partner sites as well as an Implementation Toolkit to facilitate the culturally competent, stigma-conscious use of PHQ 9 and SBIRT (and age appropriate screening for ages 5-11). Currently, most partner sites and many primary care providers lack experience in assessing and treating people with BH disorders.

*To track patient engagement and outcomes, the PPS will develop electronic documentation of clinical assessments and the tracking of patient engagement, project implementation and outcome improvement through EMR and HIE tools.

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.

The Brooklyn-based PPSs , including Brooklyn Bridges, Collaborative Care of Brooklyn, and the New York City Health and Hospitals Corporation, have collaborated to select Project 3.a.i. and

align key interventions related to its implementation. During the January-March 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, uniform patient consent, and selection of culturally competent patient education resources to support this project.

Additionally, the PPS will develop referral relationships and data-sharing mechanisms with OASAS-licensed PPS partners in order to ensure universal patient access to all available treatment options in the county.

Finally, the Brooklyn Bridges PPS is participating in a New York City Department of Health and Mental Hygiene collaboration on DSRIP projects related to BH, including 3.a.i. Integrated Care.

3. 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.

The PPS will require capital funds for investment in new equipment for clinical services. Capital funding will be needed for development and expansion of shared IT, telemedicine capabilities to expand the borough's capacity for psychiatric consultation and evaluation, and medical monitoring to support virtual co-location, increase care coordination among providers, facilitate Population Health Management (PHM), and via telemedicine, increase patient-provider contacts without sacrificing productivity.

The PPS also will require capital funds to expand the capacity and scope of services available in partner primary care sites. Capital funding will support the design and implementation of new construction, repairs, renovation of fixed assets, equipment costs, and other asset acquisitions.

The PPS also will use capital funds to deploy a centralized PNC that will provide patient navigation services, including telephonic triage and appointment scheduling, to improve care coordination and PHM. Specifically, capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support the PNC's centralized care coordination activities.

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
Little Flower Children and Family Services of New York	Bridges to Health NYS Medicaid Waiver Program	2010	2015	The State Bridges to Health program supports home services for foster children who have emotional problems, developmental disabilities or are medically fragile.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
God's Love We Deliver	HARP	2015	2015	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Harlem United/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Bowery Residents' Committee (BRC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare Wellness	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Concern for Independent Living, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
SCO Family of Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Lutheran Family Health Centers	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
VNSNY	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2016	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Public Health Solutions	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2017	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2014	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York Therapeutic Communities, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and soon children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Lutheran Family Health Centers	HRSA Behavioral Health Integration	2014	2016	HRSA Behavioral Health Integration funding seeks to improve and expand the delivery of behavioral health services through the establishment and/or enhancement of an integrated primary care behavioral health model. Specifically, this funding opportunity will 1) increase access to behavioral health services, and 2) increase the number of health centers with integrated primary care and behavioral health models of care.
Lutheran Family Health Centers	SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Program	2014	2018	The SAMHSA PBHCI Program supports communities to coordinate and integrate primary care services into publicly funded, community-based health settings to improve access to primary care services; improve prevention, early identification and intervention to reduce serious physical illnesses; increase the availability of holistic care for physical and behavioral disorders; and improve overall health status.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities.

Bridges to Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization and other out-of-home care. Brooklyn Bridges' BH integration project will provide services to all pediatric populations, as applicable. This DSRIP project will supplement and expand the home services this funding provides to foster children. The PPS can learn from and leverage this partner's experience in improving care for this specialty population.

HARP service providers in the PPS and are likely to participate in this project. This DSRIP project, however, is being implemented at the partner, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of the PPS's actively engaged population, not just those enrolled in HARP plans, and a broader set of interventions.

The Health Home program, particularly the experience and capacity of participating Health Homes and downstream care management agencies, is a strong foundation for many of the PPS's DSRIP projects. The BH integration project will build on this experience, but will provide a broader set of interventions and serve a larger group of Medicaid patients, including those who are not eligible for Health Home services.

LFHC received HRSA Behavioral Health Integration funding to bring behavioral health services into two LFHC primary care sites via the hiring of onsite social workers as well as community health workers (CHWs). This project will significantly expand BH services across all nine LFHC sites, as well as to other primary care partners. The DSRIP project will benefit from the experience gained by the two sites during its participation in the HRSA program.

LFHC received SAMHSA funding to create care integration in an existing dually licensed site (OMH and DOH) via the hiring of a nurse practitioner care manager as well as other program staff to create a safety net for people with severe mental illness (SMI) to stay in care and achieve medication adherence and effective disease stabilization and management. This project will build on the experience of this program in treating people with SMI, but will serve a larger group of Medicaid patients through the integration of primary care and behavioral health care.

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.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.

The greatest proportion of potentially preventable hospitalizations (PQI) in Brooklyn is for chronic conditions, including diabetes, providing a significant opportunity for reducing preventable inpatient stays. In Brooklyn, there were 3,072 Medicaid PQI All Diabetes Composite hospitalizations. Across New York State, only 51% of Medicaid managed care (MMC) beneficiaries with diabetes received all recommended preventive care services in the last year, and 33% of MMC beneficiaries with diabetes have poorly controlled HbA1c (>9%).

Communities served by Brooklyn Bridges PPS partners have among the highest combined service utilization of diabetes services in Brooklyn by Medicaid beneficiaries. CNA survey responses indicate concerns about obesity and diabetes, as well as barriers to healthy eating and physical activity. Lack of time, budget constraints, and lack of health insurance, reported to be more common among the Latino community than other groups, are barriers to healthy lifestyles and patient self-management.

Lack of access to primary care is reported as well; almost half of Brooklyn CNA survey respondents report they could not access non-emergency healthcare services at a primary care provider, and one in four report that primary care was difficult or impossible to access. Wait times to access primary care in Brooklyn are reported by survey respondents to be three to four months long, discouraging optimal use of existing primary care services. This project will directly address these gaps to reduce diabetes-related preventable hospitalizations in Brooklyn.

Interventions that address CNA identified opportunities and gaps include:

INCREASE PRIMARY CARE/PCMH CAPACITY by up to 10% by DY 5, including additional staffing, expanded hours of operation, and increased scope of onsite services, such as point-of-care testing and specialty services.

*IMPLEMENT EVIDENCE-BASED PRACTICE CLINICAL GUIDELINES for diabetes management, including aspirin and statin protocols for all diabetic patients, by at least 80% of the PPS's primary care physicians participating in this project.

*DEVELOP CARE COORDINATION TEAMS at each site, including primary care physicians, vision, podiatry, and nephrology specialists, alongside Certified Diabetic Educators, nutritionists, nursing staff, behavioral health clinicians, and care managers.

*ENGAGE COMMUNITY PHARMACISTS in medication adherence counseling, including symptom management consultation.

*TRACK POPULATION OUTCOMES via a diabetes registry with risk stratification/predictive modeling, and use report cards to incentivize provider behavior. The diabetes registry will also allow the PPS to identify specific community "hot spots" within its service area that show the greatest opportunity for targeted and culturally-competent diabetes management improvements.

*DEVELOP SUPPORT PROGRAMS CONSISTENT WITH THE STANFORD MODEL FOR CHRONIC DISEASE MANAGEMENT in partnership with community-based organizations to focus on peer

engagement and patient self-management.

*COORDINATE CARE via the Patient Navigation Center (PNC) to schedule appointments at specific intervals and facilitate post-discharge care.

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.

Based on Brooklyn Bridges' understanding of the community need, this project will target adult PPS patients diagnosed with Type 1 or Type 2 diabetes. Communities likely to be targeted as "hot spots" for culturally-competent interventions include Flatbush and Williamsburg-Bushwick. These neighborhoods have the highest age-adjusted diabetes mortality rates in Brooklyn at 34.0/100,000 and 33.9/100,0000, respectively, as compared to 25.3/100,000 in Brooklyn overall.

The methodology to identify our actively engaged population will be those unique attributed adult (age 19+) patients with diabetes based on 3M diabetes Major Diagnostic Categories. In particular, the target population will focus on those with poorly controlled diabetes, particularly those for whom health literacy, language barriers, access to diabetes, and diabetes-related care and other factors may impede medication management.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:

LFHC:

*Currently 30% of LFHC's diabetic patients have an A1c > 9%. While lower than NYS's MMC rate, there is opportunity for improvement.

*LFHC successfully piloted a foot examination project to increase the percentage of diabetics undertaking exams; the intervention will be adopted PPS-wide.

*LFHC has two onsite Special Supplemental Nutrition Programs for Women, Infants, and Children (WIC) and relationships with community-based food access programs.

*LHFC monitors and incentivizes providers via report cards; the PPS will expand this program.

*LFHC uses clinical software, Azara, to identify patients at risk for readmissions; the PPS will leverage Azara for risk stratification.

PPS Partner Assets:

*PPS exclusive FQHC partner, Ezra Medical Center, employs a successful diabetes care model that co- locates primary care providers, vision care, podiatrists, and nephrologists to provide "one-stop shopping;" this model will be replicated within the PPS.

*Several PPS PCMH sites maintain open-access scheduling and have patient information sharing capabilities, providing a foundation for PPS-wide collaboration.

*The PPS will also leverage existing community-based organizations' expertise in training and deploying peer health workers to implement aspects of the Stanford Model.

NYU Population Health Management (PHM):

*Registered Nurse Clinical Care Coordinators (RN CCCs) through NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, assist diabetic patients in obtaining preventive health services. Through a combination of claims and clinical data, the RN CCCs work from EMR-based patient registries to conduct outreach and assessment.

*NYULMC PHM expertise includes risk- and value-based contracts. By April 2015, NYUPN will manage 180,000 patients in risk arrangements with CMS and commercial payers.

*NYU School of Medicine has demonstrated success with CHW interventions including two NIH funded projects and one CDC funded project. These initiatives improved health outcomes for South Asian populations with hypertension and diabetes. This expertise will help the PPS develop a successful CHW program.

The PPS identifies the following resources to be developed and/or repurposed:
PNC:

*Coordinate primary care provider scheduling/appointment reminders.

*Connect patients with community resources to provide culturally competent, multi-language education and support to promote diabetes self-management.

HIT:
*Develop a diabetes registry to enable patient tracking and management across the PPS.

*Maximize HIE capabilities to enable PPS-wide care coordination.

Training:
*Train clinicians on diabetes evidence-based clinical guidelines.

Data and Analytics:
*Partner with MMC plans to develop a roadmap for value-based contracting and ensure data needs are met to successfully perform PHM.

Mobile Health:
*Explore opportunities to collaborate with New York Mobile Integrated Health Association to pilot Community Paramedic targeting services in "hot spot" neighborhoods or proactive home visits to provide patient education and support.

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.

The Brooklyn Bridges PPS will employ the following approaches to address anticipated project challenges:

*To increase patients' capacity for healthy eating in an environment that does not readily support such eating habits, PCMH nutritionists/dieticians will provide culturally competent education about healthier food choices.

*To coordinate patients' care, the PPS will implement an HIE platform to enable data-sharing among PPS partners and Brooklyn PPSs, and with health plans.

*To increase patients' knowledge about the long term, negative consequences of diabetes, the PPS will provide multiple, accessible points of culturally competent diabetes education through PCMHs and community-based organizations.

*To minimize the physical constraints that some PCMH sites may experience with co-locating necessary vision, podiatry, and nephrology services to address diabetes' common comorbidities, the PPS will employ telemedicine and rotating specialists across PCMH locations to minimize the physical capacity burden and maximize PPS resources effectively.

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.

The Brooklyn Bridges PPS is the sole PPS pursuing this project in Brooklyn. There will likely be opportunities to collaborate with the other Brooklyn-based PPSs. During the January-March 2015 implementation planning period, the PPS intends to collaborate on sharing best practices and lessons learned around chronic disease management with other Brooklyn PPSs. Additionally, the PPS will develop referral relationships and data-sharing mechanisms with OASAS-licensed PPS partners in order to ensure universal patient access to all available treatment options in the county.

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.

The PPS will require capital funds for investments in new equipment for clinical services. Specifically, capital funding will be needed for development and expansion of shared IT, telemedicine capabilities such as videoconferencing for remote consults, and medical monitoring to support virtual co-location, increase care coordination among providers, facilitate PHM, and via telemedicine, increase patient- provider contacts without sacrificing productivity.

The PPS also will require capital funds to expand the capacity and scope of services available in primary care centers. Capital funding will support the design and implementation of new construction, repairs, renovation of fixed assets, equipment costs, and other asset acquisitions.

The PPS also will use capital funds to deploy a centralized PNC that will provide patient navigation services, including telephonic triage and appointment scheduling, to improve care coordination and PHM. Specifically, capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support the PNC's centralized care coordination activities.

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
God's Love We Deliver	Balancing Incentives Program Grant	2014	2015	The Balancing Incentive Program (BIP) is a Medicaid program to increase access to non-institutional long-term services and supports (LTSS) creating a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities.

Specifically, the BIP provides funding to support service enhancements such as remote patient monitoring to improve non-institutional long-term services and supports (LTSS). This diabetes

project will not duplicate activities provided by BIP funding as BIP does not specifically target this type of chronic disease management. This DSRIP project can learn from and leverage this partner's experience in improving care for this specialty Medicaid population.

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.

3.d.ii Expansion of Asthma Home-Based Self-Management Program

Project Objective: Implement an asthma self-management program including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up to reduce avoidable ED and hospital care.

Project Description: Despite best efforts of practitioners to implement evidence based practices, patients continue to have difficulty controlling their symptoms. The goal of this project is to develop home-based services to address asthma exacerbation factors. Special focus will be emphasized on children, where asthma is a major driver of avoidable hospital use.

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. Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.
2. Establish procedures to provide, coordinate, or link the client to resources for evidence based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.
3. Develop and implement evidence based asthma management guidelines.
4. Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.
5. Ensure coordinated care for asthma patients includes social services and support.
6. Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.
7. Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.
8. 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.

In Brooklyn, the greatest proportion of potentially preventable admissions (PQI) is for chronic illnesses, including respiratory conditions, representing significant opportunity for reducing preventable hospitalizations. Neighborhood-specific rates of asthma-related service utilization range from 3% to 10%, with the highest rates clustered in several communities served by the Brooklyn Bridges PPS: Red Hook, Sunset Park, and Williamsburg-Bushwick. Brooklyn's asthma ED visit rate in 2012 was higher than for New York City (NYC) and New York State (NYS) overall at 143.9/10,000 compared to 139.6/10,000 and 88.6/10,000, respectively.

Among pediatric Medicaid beneficiaries in Brooklyn, the asthma rate is higher than in NYS, 310.87/100,000 versus 210.39/100,000, respectively. The asthma ED visit rate of 297.3/10,000 for Brooklyn children is also higher than the NYS rate of 225.1/10,000.

ED visit rates for asthma may be related to primary care access issues; almost half of Brooklyn CNA respondents report they could not access non-emergency healthcare services at a primary care provider, and one in four report that primary care was difficult or impossible to access. Nearly one-third reported that pediatric/adolescent services were difficult or impossible to access.

Smoking as well as exposure to second-hand smoke is another contributing factor to asthma. Smoking rates within Brooklyn vary widely by neighborhood; high rates (16-19%) are found in Williamsburg/Bushwick, Greenpoint, Bay Ridge/Bensonhurst, and East New York/New Lots. Despite the comparable smoking rates across Brooklyn and NYC, rates of medical assistance with smoking cessation are lower in Brooklyn than in NYC at 5.1% vs. 5.8%, respectively.

Specific project interventions to address CNA gaps and opportunities to mitigate and decrease rates of asthma include:
INCREASE PRIMARY CARE/PCMH CAPACITY by up to 10% by DY 5, including additional staffing, expanded hours of operation, and increased scope of onsite services, such as point-of-care testing and specialty services.

*IMPLEMENT EVIDENCE-BASED PRACTICE CLINICAL GUIDELINES for asthma management at each PCMH site.

*DEVELOP HOME-BASED ASSESSMENT AND SELF-MANAGEMENT PROGRAM in conjunction with a.i.r.NYC (a community-based organization in Harlem and the Bronx) to provide trigger reduction interventions.

*DEVELOP CARE COORDINATION TEAMS at each site, including primary care providers, nutritionists, nursing staff, behavioral health clinicians, and community health workers (CHW) who provide home- based assessment, linkage to community resources such as pest management, home cleaning, legal services, and self-management education.

*ENGAGE COMMUNITY PHARMACISTS in medication adherence counseling, including symptom management consultation.

*TRACK POPULATION OUTCOMES via an asthma registry and use report cards to incentivize provider compliance with written asthma plan development and maintenance.

*COORDINATE CARE via the Patient Navigation Center (PNC) to schedule appointments at specific intervals, facilitate post-discharge care, and link patients to the home-based assessment program and smoking cessation supports.

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.

In 2013, asthma was in the top ten of most prevalent primary diagnoses among both adult and pediatric Medicaid beneficiaries with three or more Lutheran ED visits. This data, in combination with high rates of smoking in Sunset Park and northern Bay Ridge and other key neighborhoods served by PPS partners such as Williamsburg-Bushwick and Flatbush, informs the PPS's strategy for active engagement. This project will target adults, children, and the families/caregivers of children with new or existing asthma diagnoses, with special emphasis on children. The project will serve PPS members with intermittent or persistent asthma diagnoses.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:
Lutheran:

*LFHC uses clinical software, Azara, to identify patients at risk for readmissions; the PPS will leverage Azara for risk stratification.

*Lutheran employs pre-discharge protocols to provide patient education on care plans, medication management, and prescription-filling services by leveraging existing relationships with local pharmacies, which will be critical for asthma patients presenting in a PPS ED or as inpatients.

PPS Partner Assets:
*Several PPS PCMH sites maintain open-access scheduling and have patient information sharing capabilities, providing a foundation for PPS-wide open-access and HIE capabilities.

*The PPS will expand existing community-based organizations' expertise in training and deploying CHWs to support patient and family self-efficacy and confidence in self-management.

NYULMC Population Health Management:

*Registered Nurse Clinical Care Coordinators (RN CCCs) through NYUPN, the clinically integrated network of NYULMC and the University Physicians Network IPA, assist patients in obtaining needed preventive health services. Through claims data, the RN CCCs work from EMR-based patient registries to conduct outreach and assessment.

*NYULMC population management expertise includes Medicare's Bundled Payment for Care Improvement initiative, Medicare Advantage plans, and commercial ACO contracts. By April 2015, NYUPN will manage 180,000 patients in risk arrangements with CMS and commercial payers.

Identified Vendors:
*a.i.r.NYC has longtime experience providing evidence-based asthma home visiting services in Harlem and the Bronx, with plans to expand to Brooklyn. The PPS plans to engage a.i.r.NYC to assist in the development and implementation of a culturally-competent home-based assessment program which includes trigger reduction interventions and engaging social service organizations to implement other needed services (e.g. legal aide, pest management and house cleaning).

The PPS identifies the following resources to be developed and/or repurposed:

Data & Analytics:

*Partner with Medicaid managed care (MMC) plans to develop a roadmap for value-based contracting and ensure data needs are met. The PPS will require timely, complete data from plans for successful Population Health Management (PHM).

Patient Navigation Center:
*Coordinate primary care provider scheduling/appointment reminders.

*Connect patients with community resources for social, behavioral, and physical support.

*Provide culturally competent, multi-language education and outreach materials to promote asthma self-management.

HIT:
*Develop an asthma registry to enable patient tracking and management across the PPS.

*Maximize HIE capabilities to enable PPS-wide care coordination.

Project Implementation & Training:

*Train primary care physicians, pediatricians, nurse practitioners, and physician assistants on asthma evidence-based clinical guidelines and diagnosis.

*Implement the PPS's tobacco cessation project in close coordination with asthma programming.

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.

The PPS will employ the following approaches to addressing anticipated project challenges:

*To assist patients with identifying often undetected and unmitigated home environmental triggers, CHWs working in an a.i.r.NYC-developed model will conduct home visits to help patients identify and remediate/reduce these triggers.

*To assist parents and caregivers who are often unaware of symptoms and warning signs of exacerbations that could result in an ED visit, the PPS will implement clinical guidelines that emphasize the importance of consistent medication use and provide multiple, accessible points of culturally- competent asthma education through PCMHs and community-based organizations.

*To reduce the time required by primary care providers to complete patients' asthma action plans, CHWs will assist patients with completing plans during home visits and the PPS will support training for PMCH case managers to review plans during primary care provider visits.

*To assist Medicaid beneficiaries who often lack financial resources to access legal services to help mitigate home-based environmental triggers, the PPS will leverage a.i.r.NYC's pro bono legal partnerships to support PPS patients and use the PNC to make referrals to these resources.

*To mitigate or eliminate care fragmentation, the PPS will implement an HIE platform to enable data- sharing among PPS partners and Brooklyn PPSs.

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.

The Brooklyn-based PPSs, Brooklyn Bridges, Collaborative Care of Brooklyn, and the New York City Health and Hospitals Corporation, have collaborated to select the Asthma Home-Based Self-Management project and align key interventions related to its implementation. During the

January-March 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized home-based environmental intervention protocols, development of workforce strategy, workforce training efforts, strategies to engage social service organizations, data partnership with MMC plans, and selection of culturally competent patient education resources to support this project.

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. <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.

The PPS will require capital funds to develop a care management platform, telehealth and remote monitoring tools, and patient registries, as well as enhance Brooklyn RHIO capabilities and EMR systems for partner organizations. These care planning tools are critical to providing care management services

as well as enabling community health workers to assist patients and caregivers in completing asthma plans at home and sharing with primary care providers in real time.

The PPS also will use capital funds to deploy a centralized PNC that will provide navigation services including telephonic triage and appointment scheduling to improve care coordination and PHM. Specifically, capital funding will support the design and implementation of the PNC, implementation of IT infrastructure, and integration of a scheduling system to support the PNC's centralized care coordination activities.

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
God's Love We Deliver	Balancing Incentives Program Grant	2014	2015	The Balancing Incentive Program (BIP) is a Medicaid program to increase access to non-institutional long-term services and supports (LTSS) creating a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
Little Flower Children and Family Services of New York	Bridges to Health NYS Medicaid Waiver Program	2010	2015	The State Bridges to Health program supports home services for foster children who have emotional problems, developmental disabilities or are medically fragile.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non- DSRIP delivery reform initiatives that differ from this project's goals and activities.

The BIP provides funding to support service enhancements such as remote patient monitoring to improve non-institutional long-term services and supports (LTSS). This DSRIP project will not duplicate activities provided by BIP funding as BIP does not specifically target this type of chronic disease management. This DSRIP project can learn from and leverage this partner's experience in

improving care for this specialty Medicaid population.

Bridges to Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization and other out-of-home care. This asthma project will provide services to all pediatric populations in its service area, as applicable. The DSRIP project will supplement the home services that Bridges to Health funding provides to foster children. This DSRIP project can learn from and leverage this partner's experience in improving care for this specialty population.

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
1) New York State Department of Health
2) New York City Department of Health and Mental Hygiene
3) a.i.r.NYC
4) NYC Treats Tobacco

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.

Cigarette use alone results in an estimated 25,000 deaths in New York State (NYS) annually, and 570,000 New Yorkers are afflicted with serious disease directly attributable to their smoking. According to the Brooklyn CNA, while Brooklyn's smoking rates among adults are on par with the New York City (NYC) and NYS rates at 16%, 15.5%, and 16.2%, respectively, the rates within Brooklyn vary widely by neighborhood. Among Coney Island residents, the CNA documents that nearly one-quarter (23%) report being current smokers. High smoking rates are also found in Williamsburg/Bushwick, Greenpoint, Bay Ridge/Bensonhurst, East New York/New Lots, and Bedford Stuyvesant/Crown Heights, where rates range from approximately 16-19%. Despite the comparable smoking rates across Brooklyn and NYC, rates of medical assistance with smoking cessation are lower in Brooklyn than in NYC at 5.1% vs. 5.8%, respectively.

Specific project interventions to address the issues and gaps identified in the CNA include:

Primary Care Clinical Improvement Interventions:
*IMPLEMENT A STANDARDIZED CLINICIAN TRAINING PROGRAM aimed at promoting the 5 A's (Ask, Assess, Advise, Assist and Arrange), providing prescriptions for nicotine replacement therapy (NRT), and making referrals to the NYS Smokers' Quitline and Asian Smokers' Quitline, as applicable.
*ENHANCE EMRS TO PROMPT CLINICIANS in the Brooklyn Bridges PPS to review the 5 A's and create an automated Quitline referral, where applicable.
*PROVIDE TECHNICAL ASSISTANCE TO CLINICIANS in instances where EMR is not modified to provide Quitline referrals.
*DEVELOP A TOBACCO CESSATION PATIENT REGISTRY to track PPS patients' tobacco use and cessation.

Community Interventions:
*DEVELOP AND DISTRIBUTE CULTURALLY COMPETENT OUTREACH AND EDUCATION MATERIALS IN PARTNERSHIP WITH COMMUNITY-BASED ORGANIZATIONS (CBOs) to target sub-populations with higher smoking rates, such as the Chinese and Arab communities.
*REBRAND CURRENT AND DEVELOP NEW TOBACCO USE CESSATION MEDIA CAMPAIGN MATERIALS AND LAUNCH AN OUTDOOR CAMPAIGN TARGETED TO THE CHINESE COMMUNITY in partnership with the New York City Department of Health and Mental Hygiene (DOHMH). Include referrals to a culturally and linguistically appropriate Quitline.

Policy Interventions:
*DEVELOP RECOMMENDATIONS AND FURTHER ENHANCE UNIVERSAL, CONSISTENT HEALTH INSURANCE BENEFITS for prescription and over-the-counter cessation medications in partnership with other PPSs and the DOHMH.
*DEVELOP RECOMMENDATIONS AND FURTHER ENHANCE BENEFITS TO INCREASE MEDICAID AND OTHER HEALTH PLAN COVERAGE of tobacco dependence treatment counseling and medications in partnership with other PPSs and the DOHMH.
*PROMOTE TOBACCO FREE ENVIRONMENTS ACROSS THE PPS by assessing partners' current policies, promoting model policies, and sharing best practices for implementation.

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.*

This project will target and engage tobacco-using adults age 13 and older in Brooklyn, with specific focus on populations with high tobacco use.

The CNA reports that smoking is prevalent in Brooklyn's Chinese and Arab communities, among others. The CNA states that among the Arab population, "smoking is considered an indicator of maturity and offering cigarettes is a common courtesy." Additionally, high rates of smoking in the community result in high rates of asthma, lung cancer, and other respiratory problems. The DOHMH 2011 Community Health Survey reported an adult smoking rate of 29% in Sunset Park and Northern Bay Ridge, neighborhoods that include many Chinese residents.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:
NYULMC has developed an extensive outreach and education program targeting the Lower East Side's Chinese community; these materials can be repurposed for use in Brooklyn.
*DOHMH has developed and evaluated media materials targeted to the Chinese community; these can be rebranded to be even more effective according to DOHMH.

*The NYS Quitline is a valuable asset to refer smokers. Additionally, the Asian American Quitline in California can be utilized to refer Asian smokers to a more culturally and linguistically competent resource.
*NYC Treats Tobacco, a Regional Cessation Center funded by the NYSDOH and led by the NYULMC School of Medicine, will provide standardized clinical trainings as well as technical assistance related to system changes to optimize adoption of evidence-based tobacco use treatment, including implementing an electronic system for seamless referrals to the NYS Quitline, among other examples.
*NYC Treats Tobacco is developing tools and trainings to implement evidence-based tobacco use treatment in mental health care settings.

The PPS identifies the following resources to be developed and/or repurposed:
*Expand relationships with Chinese and Arab community partners as well as the NYS Office of Mental Health for engagement in the PPS's tobacco use cessation workgroup and to assist with developing culturally competent messaging to target specific sub-populations with high rates of tobacco use.
*Develop a PPS-wide smoke-free policy and provide technical assistance to implement it by building on partners' existing smoke-free policies.
Implement the PPS's Patient Navigation Center (PNC) to connect patients with appropriate community resources for social, behavioral, and physical support services, as well as provide another avenue for making referrals to the NYS Quitline.
*Enhance EMR capabilities to facilitate physician prompts of the 5 A's and more effective referrals to the NYS and the Asian American Quitlines (i.e., opt-to-quit, etc.).
*Implement PCMH Level 3 requirements to indicate tobacco use status in EMRs for 80% of patients 13+ years old in the Brooklyn Bridges PPS.

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.

The PPS will employ the following approaches to address anticipated project challenges:

*To minimize competing demands on CBOs, the PPS will identify opportunities for these organizations to integrate tobacco cessation services into their existing services and programs. The PPS initially will pilot this approach at Lutheran's Family Support Center by incorporating tobacco cessation into Women, Infants, and Children (WIC) programming and other family support services.
*To address cultural norms within the Chinese community that make tobacco cessation particularly challenging, the PPS will repurpose NYULMC's culturally competent outreach and education materials developed for the Chinese community and employ their peer navigator model to provide education and link smokers to treatment (e.g. ASQ services). The NYULMC's

model may also be expanded to other communities with ingrained cultural norms around tobacco use, such as the Arab community.
*The PPS will also repurpose DOHMH's media materials and leverage its expertise in public heath approaches to tobacco control.
*To encourage health insurance companies to create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications as well as coverage of tobacco dependence treatment counseling, the PPS will partner with other PPSs and the DOHMH to develop a strategy to engage health insurance companies.
*To create clinical decision support capabilities and facilitate Quitline referrals, the PPS will assist with EMR enhancement and implement a HIE platform to enable data sharing across the PPS.
*To address the disparities in tobacco use among patients with mental health and substance abuse problems, the PPS will partner with the NYC Treats Tobacco's Regional Cessation Center to tailor interventions to this population.

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.

The PPS will identify opportunities for coordination and collaboration with other Brooklyn PPSs and PPSs throughout NYS to engage health insurance companies in creating universal, consistent health insurance benefits for prescription and over-the-counter cessation medications as well as coverage of tobacco dependence treatment counseling. These collaborations will leverage existing relationships with PPSs in Brooklyn as well as the coordination provided by DOHMH.

During the January-March 2015 implementation planning period, the PPS intends to collaborate to share best practices and lessons learned on tobacco use cessation management, particularly for low socioeconomic status populations and those with behavioral health conditions.

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.

The PPS's Tobacco Cessation Workgroup, formed during the planning process, will continue meeting to complete the PPS implementation plan. Key milestones in implementation of this project include:
*Establishing a work plan, timeline, and milestones for project implementation (Q4, DY0);
*Convening a collaborative of CBOs to plan and set milestones for community campaign (Q2, DY1);
*Convening a collaborative of PPSs undertaking the tobacco cessation project and partnering with DOHMH (Q2, DY1);
*Agreeing upon project commonalities and shared resources (Q2, DY1);
*Agreeing upon a data sharing system to address reporting and implementation needs (Q3/Q4,

DY1); and
* Repurposing and initial placement of outdoor media campaign (Q1, DY2).

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.

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.

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

Project Objective: This project will increase early access to, and retention in, HIV care.

Project Description: This project is targeted at increasing the percentage of HIV-infected persons with a known diagnosis who are in care by 9% to 72% by December 31, 2017.

This project is also targeted at increasing the percentage of HIV-infected persons with known diagnoses who are virally suppressed to 45% by December 31, 2017.

Project Requirements: Each of the four HIV/STD Projects contain the same 13 sector projects. PPS implementing this project will need to review these projects and chose at least 7 or more that are impactful upon their population, state why the sector projects were chosen, and then develop their Domain 4 project using those sector projects. The PPS at any time may add additional sector projects if it is determined these will add to the impact of their project.

1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.
2. Increase peer-led interventions around HIV care navigation, testing, and other services.
3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.
4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.
5. Assure cultural competency training for providers, including gender identity and disability issues.
6. Implement quality indicators for all parameters of treatment for all health plans operating in New York State. An example would be raising the percentage of HIV-positive patients seen in HIV primary care settings who are screened for STDs per clinical guidelines.
7. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.
8. Educate patients to know their right to be offered HIV testing in hospital and primary care settings.
9. Promote interventions directed at high-risk individual patient, such as therapy for depression.
10. Promote group or behavioral change strategies in conjunction with HIV/STD efforts.
11. Assure that consent issues for minors are not a barrier to HPV vaccination.
12. Establish formal partnerships between schools and/or school clinics, and community-based organizations to deliver health education and support teacher training programs.
13. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.

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
1) New York State Department of Health 2) New York City Department of Health and Mental Hygiene 3) PPS HIV Collaborative

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.

HIV was the ninth leading cause of death in Brooklyn in 2012 and the fifth leading cause of premature death. Accordingly, 23% of CNA survey respondents consider HIV to be a health concern of the community and 40% feel that additional health education is needed.

In 2011, 26,945 People Living with HIV/AIDS (PLWHA) resided in Brooklyn, or 1,072 per 100,000. In addition to significant geographic disparities across the borough, racial and ethnic disparities also exist. The rate of new HIV diagnoses among black/African American people in Brooklyn is more than five times the rate among Whites, a greater disparity than observed in New York City (NYC) or New York State.

While Sunset Park does not have a particularly high prevalence of PLWHA compared to other Brooklyn neighborhoods (656 per 100,000), it does stand out as a service utilization hotspot, with 1.8% of Medicaid beneficiaries having HIV-related service utilization in 2012. Over 10% of these beneficiaries also had a hospitalization (not necessarily related to HIV). Furthermore, the ratio of Medicaid beneficiaries to HIV resources is higher in Sunset Park compared to other Brooklyn neighborhoods, suggesting that the community may be under-resourced.

A PPS HIV Collaborative of seven PPSs in NYC (Brooklyn Bridges, the New York City Health and Hospitals Corporation, Community Care of Brooklyn, Bronx Partners for Healthy Communities, Bronx-Lebanon Hospital Center, Mt. Sinai Hospitals Group, and New York Hospital of Queens) is facilitating joint planning to develop common approaches and resources to address the identified gaps in HIV care, many of which span boroughs. The PPS will collaborate with these PPSs on several sector projects, including: 1, 2, 4, 5, 7, 9, and 13. In addition, given Lutheran's strong network of school-based health centers, the PPS will pursue the sector 12 project independently in an effort to establish partnerships with schools and community-based organizations to deliver health education and teacher training.

The PPS HIV Collaborative will seek to address the identified gaps in care by promoting

widespread screening, early intervention, patient engagement in culturally competent care, and patient education.

Interventions that address CNA identified opportunities and gaps include:
*IMPLEMENT A VIRAL LOAD SUPPRESSION (VLS) INITIATIVE to achieve and sustain suppression of HIV viral loads to undetectable levels.
*INTEGRATE HIV SCREENING AND IMPROVE SYSTEM LINKAGES by integrating HIV into primary care and establishing relationships with community-based organizations (CBOs) to support routine screening and community-based testing.
*IMPLEMENT PRE-EXPOSURE PROPHYLAXIS (PrEP) FOR HIGH RISK NEGATIVES.
*IMPLEMENT ADDITIONAL SUPPORT GROUPS to empower people with HIV to achieve confidence in self-management.
*ENSURE THAT CULTURAL COMPETENCY IS INTEGRATED INTO HIV TREATMENT by developing sustainable models for ongoing needs assessments and staff training.
*TRACK POPULATION OUTCOMES via an HIV registry and use report cards to incentivize provider compliance with standards of care.
*ENSURE ALL HIV-POSITIVE PATIENTS ARE SCREENED AND TREATED FOR DEPRESSION.
*PARTNER WITH SCHOOLS AND CBOs to deliver effective HIV prevention programs, including CDC evidence-based interventions geared towards African American and Latino youth, such as Becoming a Responsible Teen (BART) and Cuidate!, respectively.

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.*

The target population for this project is HIV-infected individuals ages 13 and over (undiagnosed and diagnosed) and those at high-risk of becoming infected (i.e., individuals eligible for PrEP). This target population is inclusive of several sub-populations that have historically experienced different risks and challenges related to HIV, including women of color, men who have sex with men and transgender people, immigrants, and African Americans and Latinos.

The NYC Department of Health and Mental Hygiene (DOHMH) estimates that City-wide there are 133,635 individuals infected with HIV, 18,709 of whom are unaware of their HIV positive status. DOHMH further estimates that 30,429 individuals in NYC are at high-risk for HIV acquisition and eligible for PrEP. This estimate is based on the DOHMH Community Health Survey of 2012 and the High Risk Behavioral Survey of 2014. Therefore, the complete target population for this project is 164,064 City-wide.

Within Brooklyn, the highest prevalence of PLWHA is observed across the neighborhoods of Bedford Stuyvesant-Crown Heights, Williamsburg-Bushwick, East Flatbush-Flatbush, East New York, and Downtown-Heights-Park Slope. Together, these neighborhoods account for over 75% of PLWHA in Brooklyn. In addition to addressing high HIV-service utilization in Sunset Park, the

PPS will target patients in these "hot spot" neighborhoods through its network of primary care providers and clinics, including existing school-based health centers in Bedford Stuyvesant and Flatbush.
The target population is inclusive of persons with co-occurring diagnoses and social factors that play a strong role in their ability to access care and maintain care routines. The level of co- factors and co-morbidities as well as the range of cultural needs within the target population lend to the complexity of this project, and are a central organizing point for collaborative efforts within the PPS, as well as with the PPS HIV Collaborative.

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.

To achieve this project's goals, the PPS will mobilize the following existing assets:

Community Assets:
*NYC is fortunate to have a wealth of CBOs, healthcare agencies, non-profit groups, private industry, and government agencies dedicated to ending the AIDS epidemic. This project will benefit from the shared understanding and pooled resources of this network. Additionally, NYC benefits from several federally-funded HIV programs, including: Ryan White Part A and CDC prevention programs (71 funded agencies); 8 Ryan White Part C and 10 Part D programs; and, the DOH/DOHMH NYLinks project. The PPS HIV Collaborative will utilize these resources, PPS- specific resources, and develop new resources to address the common sectors of this project.

LFHC Assets:
*LFHC has a long history of providing HIV primary care and has well-integrated routine testing in its primary care and dental services, providing more than 15,000 HIV antibody tests annually. LFHC maintains a large portfolio of City, State, and federal contracts to provide HIV-related services and has an active HIV-focused Community Advisory Board that includes consumers and community members. All of the clinicians providing HIV treatment at LFHC are AAHIVM certified.

The PPS identifies the following resources to be developed and/or repurposed:
Engage Partners:
*The PPS will partner with Medicaid managed care (MMC) plans to develop a roadmap for value-based contracting and ensure data needs are met. The PPS will require timely, complete data from plans for successful population management.
*Leverage CBOs' expertise in training and deploying peer community health workers to support patient and family self-efficacy and confidence in self-management. Key community partners, given their expertise in working with HIV patients to address social barriers, will include: CAMBA, Harlem United, God's Love We Deliver, Turning Point, Caribbean Women's Health

Association, and Diaspora Community Services.

Patient Navigation Center (PNC):
*Coordinate primary care physician scheduling/appointment reminders.
*Connect patients across Brooklyn with borough-wide community resources for social, behavioral and physical support.
*Provide culturally competent, multi-language education and outreach materials to promote HIV testing, stigma reduction, and adherence to treatment plans.

HIT:
*Develop an HIV registry to enable patient tracking and management across the PPS.
*Maximize HIE capabilities to enable PPS-wide care coordination.

Project Implementation:
*Implement and train clinicians on HIV evidence-based clinical guidelines as well as PrEP prescribing guidelines.

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.

The PPS will employ the following approaches to address anticipated project challenges:

*To address social co-factors that inhibit successful access and retention in care, the PPS will engage CBOs to help develop and deliver community outreach and educational interventions, including support groups to encourage peer-led interventions and provider training on culturally competent care.
*To address challenges in recruiting and training community members to facilitate peer-led interventions, the PPS will develop training resources and curricula, such as a certification process.
*To engage and retain patients in HIV care, the PPS will work to integrate HIV screening into regular medical care, improve care management and coordination resources, and improve reporting ability on gaps in care.
*To better address the full spectrum of health needs of HIV patients, including the various medical and behavioral health co-morbidities, the PPS will leverage PPS care coordination assets, including: the PNC to improve access to care, the HIE platform to enable EMR data sharing across providers, and the integrated care project (3.a.i) to improve access to behavioral health resources.
*To address challenges of partnering with already overwhelmed schools and school personnel, the PPS will leverage existing school-based health centers, school activities, and events to integrate new prevention modalities.

*To address HIV from a population-level standpoint, the PPS will leverage and pool resources across the HIV PPS Collaborative, using collective knowledge and experiences to understand the evolution of the NYC HIV epidemic and effectively identify new sub-populations at risk and changes within known sub-populations.
*To address gaps in data availability and reporting, the PPS HIV Collaborative will work with MMC plans to advocate for increased access to surveillance data for health plans and expanded use of HIV quality metrics. These changes will facilitate improved care management capabilities, streamlined communication with primary care providers, and enhanced reporting on care delivery and patient health status.

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.

The seven PPSs in the HIV PPS Collaborative have engaged in joint planning for this project, committed to via a charter, and are dedicated to working together through implementation. While the combination of sectors and interventions will vary among PPSs, there is agreement to pursue certain key interventions collaboratively, including: integrating HIV screening and improving system linkages, improving cultural competency, implementing a viral load suppression initiative, and offering behavioral health screening. Throughout planning and implementation, we anticipate this collaboration to continue; including finalizing milestones, developing resources and shared materials, and agreeing on common protocols.

During project implementation, the PPS HIV Collaborative will follow a standard process of communication and regular meetings will be established to address issues related to operations planning, intervention implementation, performance measures, and data sharing.

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.

Consistent with application requirements, the PPS HIV Collaborative will continue to meet in early 2015 to complete a detailed implementation plan. Key milestones in implementation of this project include:
*Convening the PPS HIV Collaborative (Q2, DY1);
*Establishing a work plan and timeline for project implementation (Q3/4, DY1);
*Developing agreed upon milestones for project implementation (Q3/4, DY1);
*Agreeing upon project commonalities and shared resources (Q3/Q4, DY1); and
*Agreeing upon a data sharing system to address reporting and implementation needs (Q3/Q4, DY2).

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.

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
Village Center for Care d/b/a VillageCare	CMS Innovation Center Health Care Innovation Awards (HCIA)	2014	2017	Health Care Innovation Awards are Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology for people living with HIV/AIDS.

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.

While our Brooklyn Bridges partners' experiences will help inform the development and implementation of clinical projects, the partners identified above participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities.

VillageCare's efforts under this award will help inform Brooklyn Bridges' planning around medication and treatment adherence for this project, but will apply to a broader population and will be implemented through a large network of our partner sites.

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.