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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.

As demonstrated by the Community Needs Assessment (CNA), and as discussed at length in Section 5, the absence of integrated approaches to address the healthcare needs of our communities and the many social determinants of health adversely impacts the health status of New York City (NYC).

Potentially preventable visits (PPV) to emergency departments (EDs) are emergency visits for ambulatory care sensitive conditions (ACSCs) that may result from a lack of adequate access to care or ambulatory care coordination. Many PPVs are likely attributable to challenges related to access, patient engagement, and providers' ability to manage care provided to individual patients and across populations (see CNA need 1). Our PPS service area includes more than three million Medicaid beneficiaries and 450,000 uninsured individuals. Based on a Medicaid claims analysis provided by the NYS DOH Office of Quality and Patient Safety, we estimate that these beneficiaries account for at least 40,000 (PPVs) across NYC. In addition, risk-adjusted composite chronic illness quality indicators for the Medicaid population are 9% higher than expected (see CNA need 1). This is further evidence of our opportunity to improve quality by creating an integrated delivery system (IDS).

The CNA demonstrates a lack of access to primary care and behavioral health providers, and a lack of coordination among providers and community-based organizations (CBOs) (see CNA needs 1, 2, 4). The following comment from a Queens resident is illustrative of

responses from CNA primary data: "Overall challenges within the health system include ambulatory care provider capacity (ability to schedule appointments within an acceptable period of time as well as waiting times at the time of the appointment) and linkages and coordination within and between broader healthcare delivery systems."

The CNA highlights challenges in delivering culturally competent care and in engaging patients and families (see CNA need 3). A Brooklyn CNA respondent stated: "Some people, they have colon cancer for a long time. They discover it too late. Breast cancer. Sometimes it's too late. You can't survive because it's already spread. Why? Because they didn't get their mammograms. So our community back home, they never had these screenings, so when they come here, they never ask for it."

Finally, the CNA underscores challenges faced by NYC providers–especially public and safety net delivery providers–in ensuring appropriate care to over 1.5 million residents who either appear disengaged from the delivery system (i.e., non- and low-utilizers) or who lack insurance and thus ready access to essential non-emergency services (see CNA need 1).

To meet these community needs, we propose to accelerate development of an IDS capable of providing patient-centered care across the continuum and to target interventions that meet the needs of discrete populations and sub-populations. We will enter into formal contractual arrangements with many community-based providers and CBOs. Over time, we expect these arrangements to enable our PPS to accept financial risk for the health of populations under new, value-based payment models. In this shift, we expect to leverage our ownership of a managed care organization (MCO).

As part of clinical transformation, we will expand primary care capacity and also work to integrate it with behavioral health. In addition, we intend to enhance or develop new resources, programs and linkages to meet community needs. We expect these efforts to include an enterprise-wide enhanced care management platform to identify, stratify, and track, and leveraging the expertise of a cadre of patient navigators, care managers, and care coordinators. In addition, we intend to expand the capacity of and enrollment in our affiliated Health Homes, and to work with primary care providers (PCPs) to attain 2014 NCQA Level 3 patient centered medical home (PCMH) recognition and meet Meaningful Use standards.

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.

Across the four boroughs that comprise our PPS service area, our assets and resources include 12 hospitals, six large Diagnostic Treatment Centers (each having achieved NCQA 2011 Level 3 PCMH recognition), four Health Homes, and a robust network of providers across the care continuum. We provide more than 43% of inpatient medical care, 41% of mental health inpatient care and 30% of inpatient detox services to NYC's Medicaid population.

We also have assets and resources that support value-based payment models and population health management. Our PPS has experience working with a diverse set of partners under innovative value-based payment arrangements, including under several risk-sharing models with leading Medicaid MCOs.

Our PPS lead, HHC, derives nearly 30% of its overall inpatient and outpatient revenues from value-based payments made by MCOs. We expect to leverage HHC's ownership of one MCO (MetroPlus) that has approximately 400,000 Medicaid members, as well as the PPS's contracting experience with other MCOs. Additional assets include successful strategies implemented as part of HHC's Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO). HHC was one of only four NYS ACOs to meet quality and cost targets. We will benefit from SUNY-Downstate, a PPS partner, and their long-standing commitment to and expertise in medical education, to equip physicians and other health professionals with tools and strategies to care for patients and families. In addition, many community-based partners have deep experience working with the most vulnerable sub-populations, including those who lack insurance or a regular provider. Our PPS will enhance these relationships and leverage their CBO experience in order to strengthen our ability to identify, engage and track our patients.

Our PPS includes NYC's largest public delivery system, and includes as partners the city agencies that administer and implement public and mental health services. As a quasi-governmental organization, we will leverage existing relationships with government agencies, CBOs, and our long-standing network of Community Advisory Boards (CABs), to deepen connections with the communities we serve. Last, and most critically, we plan to engage and mobilize the thousands of diverse and mission-focused employees of HHC and our partners, particularly their commitment to provide efficient, high-quality, and culturally competent care to all patients and their families.

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.

Our PPS includes a fragmented providers and organizations, with limited ability to operate as a seamless continuum of care. To address this challenge, we intend to develop a Central Services Organization (CSO) to house population health functions required for DSRIP, supported by a robust analytics and health IT infrastructure. CSO functions are expected to include: protocol management, patient engagement, risk stratification, patient navigation and care coordination. We will also help critical partners expand health IT capabilities to support linkages and data sharing. Partner contracts will establish clear expectations and incentives to manage care across the continuum.

Of our diverse patient base, many are challenged to become engaged in care and prevention. We intend to work with our partners to identify, engage, and track patients–with special focus on low- and non-utilizers and the uninsured–who represent an opportunity to reduce preventable hospitalizations and ED admissions. Working with CBO partners, we will expand PPS cultural competency and health literacy programs (see Section 7). In addition, we expect to address the social determinants of health as we engage our patients, relying on a cadre of well-trained navigators, care coordinators, and community health workers.

Our large service area challenges us to be responsive to local needs. To address this challenge, our governance structure is organized into four borough-based hubs, each with a local Project Advisory Committee (PAC) and Steering Committee to ensure PPS consistency while enabling responsiveness to local issues and opportunities. With hub and citywide members, this structure will enable us to balance local needs with broader population health goals.

Medicaid payment and regulatory barriers prevent primary care and behavioral health integration and timely, informed service delivery including resources to address social determinants of health (e.g., supportive housing). As such, we will support Greater New York Hospital Association's advocacy for appropriate payment levels and regulatory relief. We will also work to improve linkages between the healthcare and social safety net systems.

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.

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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.

Our goal in continuing the development of an IDS is to improve the health of all New Yorkers, and to provide culturally competent, evidence-based, person-centered care in a population health management model across the care continuum, including social and community-based services, using value-based payment models. Our IDS model places the person and the family at the center and focuses on keeping people healthy and addressing social determinants of health.

We propose to adopt an evolutionary approach to build our IDS, beginning with the development of our CSO and leveraging HHC's considerable experience in managing full-risk payment arrangements for inpatient and related services. Initially, our PPS will rely on contracted relationships with providers across the continuum to create a clinically-linked system of care that will include CBOs with expertise in addressing social determinants of health. These contracted relationships will frequently include performance incentives, allowing our partners to gain experience with hybrid models of value-based payments. Over time, as partners gain experience delivering care in a clinically-linked system, we expect that a number of contracted relationships will evolve into risk-sharing arrangements and will entail greater integration of clinical and information flows.

Consistent with this evolutionary framework, and guided by our CNA findings, we are focused on eight inter-related strategies. First, we intend to develop a CSO to support enterprise-wide care management efforts and support the many functions of DSRIP implementation. To achieve this, by year-end 2015, we expect to have a fully-staffed CSO, including a fully-operational care management information platform, complete with patient and provider registries and the ability to send and receive real-time alerts to and from our primary care and facility providers.

Second, we intend to expand our community-based primary care capacity and capabilities, with an emphasis on effective partnerships with Health Homes and engaging physicians in care management and population health. Using PPS resources, including but not limited to our primary care and managed care partners, and building on the ongoing efforts to improve access to appointments, we will increase the number of PCMH-recognized providers, and increase both the number and conversion rates of Health Home-eligible patients. We will provide training and support for provider connectivity and provider-based care management, which will also include meeting Stage 2 Meaningful Use standards.

Third, we are focused on further integration of behavioral health into primary care and related services. While a number of our primary care sites already offer the Collaborative Care model, we plan to significantly expand the number of services provided in locations with both primary care and behavioral

health capacity. In a staged manner, we plan to expand and integrate across the four boroughs.

Fourth, we will implement more effective approaches to guide patients and their families through the full continuum of care, including the provision of preventive and primary care as well as the integration of post-acute providers and services. This will be accomplished through protocol-driven programs in patient navigation and care coordination and increased patient interaction with PPS-trained patient navigators, community health workers and dedicated care coordinators and care managers. Our Executive Committee will regularly monitor key performance and quality metrics related to this and other strategies, including potentially-avoidable admissions, re-admissions, and ED visits. Once our population and targets are established, the Executive Committee will establish specific annual goals for our PPS.

Fifth, deepening our existing relationships with CBOs will be essential to improving patients' health literacy and to supporting patient and family engagement. In turn, this will enable us to better address the social determinants of health, as defined by the World Health Organization as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. To accomplish these goals, we intend to enhance existing and establish new linkages to CBOs that have expertise serving their respective communities to ensure that all patients have access to the full continuum of care. Our Executive Committee, working through the Stakeholder Engagement Sub-Committee, will establish and track quarterly goals related to outreach to the uninsured and low- and non-utilizers.

Sixth, we must engage our workforce and unions to increase staff engagement, recruit and train additional staff, and offer current staff across our partners appropriate re-training and re-deployment opportunities. These activities will be central to the significant care model transformation work that DSRIP requires. As part of these activities we intend to contract for work, as needed, to augment capacity and expertise. This will include developing contracting vehicles to ensure that incentives for partners are aligned with our PPS's population health goals. We also intend to work with other PPSs on pipeline, skills development, and the development of common job descriptions and capabilities.

Seventh, we will expand our reliance on value-based payment and contracting models, building on an already-strong foundation. Our contracting strategy with PPS partners will include, where appropriate, incentives for better patient-centered care and improved care management and care coordination. Our Executive Committee will review the current balance of fee-based and value-based payment models, and will develop concrete annual goals for the continued migration to value-based payments.

Finally, we must identify opportunities to align inpatient capacity with emerging models of ambulatory care. Beginning in 2015, at the direction of our Executive Committee, we intend to undertake a detailed and rigorous analysis of capacity in Brooklyn, which we and others have long-identified as lacking critical ambulatory care capacity and likely having excess inpatient capacity. Working closely with NYS, NYC, our SUNY-Downstate partner, the Brooklyn Healthcare Improvement Project (BHIP) and community leaders and advocates, our IDS strategy includes appropriate actions to align Brooklyn's inpatient capacity and distribution with the steadily declining per capita reliance on inpatient care.

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.).

As discussed in Section 2, our governance strategy is rooted in a commitment to the communities and patients we serve. As a public hospital-led PPS, our governance structure is designed to provide: (1) a strong and effective role for community-based service organizations; (2) expert guidance to our partners to implement DSRIP projects, including Project 2.d.i; and, (3) strategic oversight and direction as we integrate our projects, investments, and partners into a single IDS that is able to provide culturally competent, evidence-based person-centered care in a population health model across the care continuum, including social and community-based services, using value-based payment models.

Our Executive Committee, advised by the Project Advisory Committee (PAC) and informed by the work of subcommittees—Care Models, Business Operations, and Stakeholder Engagement—is charged with overseeing our evolution into a successful IDS, including our ability to accept financial risk to manage the health of population and an emphasis on fulfilling our mission to serve all, regardless of ability to pay. Our governance structure will continuously review implementation, operations and performance and make adjustments as necessary.

The Executive Committee will be accountable to the PPS sponsor and to our communities for: (1) organizing projects and initiatives around the CNA-expressed needs of our patients, their families and their communities, as measured by successfully meeting the Domain 1 timing, scale, and scope targets associated with project-specific milestones; (2) increasing the proportion of value-based payments made to major partners of the PPS, recognizing that the hospital system already derives 28% of its revenue on the basis of value-linked contracts, including full capitation; assuring timely creation of an integrated care management platform to enhance PPS partners' ability to share information and work collaboratively to help patients and their families navigate the full continuum of care (as measured by assessing the proportion of our partners with real-time connection to the platform); (3) expanding the proportion of PPS-attributed patients; (4) enhancing primary care capacity across the PPS's four borough-based hubs, with an emphasis on integrating behavioral health and primary care; (5) aligning inpatient capacity with demand, recognizing that the decline in per capita demand for inpatient services will be offset at least in part by an increased base of engaged patients resulting from Project 2.d.i outreach and engagement strategies (this work will be informed by an effort to conduct a citywide assessment of inpatient capacity and need and to estimate the net effect of declining per capita utilization with an expanded base of engaged patients); and, (6) promoting effective collaboration among partners.

With regard to subcommittee functions, the Care Models Subcommittee will be responsible for reviewing and recommending clinical processes, protocols and pathways applicable to all partners. The Business Operations and Information Technology Subcommittee will be responsible for reviewing and recommending processes and protocols for the adoption and use of information technology that will be applicable to all partners. This subcommittee will also be responsible for making recommendations

regarding how DSRIP funds will be distributed, subject to the approval of the Executive Committee and HHC. The Stakeholder and Patient Engagement Subcommittee will be responsible for reviewing and recommending processes and approaches related to community and patient engagement activities.

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.

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
R.A.I.N. Inc.	Community-Based Care Transitions Program	2015	2018	R.A.I.N. provides coordination and linkage to providers who specialize in disease management.
Queens Community House (QCH)	Community-based Care Transitions Program	2013	2015	QCH has been participating as a part of the Queens Collaboration Coleman Model with participating hospitals. QCH has trained bilingual coaches who establish hospital-based communications with patients at high risk for avoidable readmission. The model includes one home visit, with follow-up calls to effect change in behaviors for better health management and linkage with a wide range of community-based services.
Total Care Pharmacy, Inc., Specialty Care Pharmacy, Amato Pharmacy, Medical Center Pharmacy, Total Care Pharmacy Bx, Inc.	Community-based Care Transitions Program	2014	2018	Total Care Pharmacy provides transitional services when patients are discharged, including follow-up on medication adherence and side effects.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Chronic Conditions			case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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.

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

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

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

The Community-Based Care Transitions (CBCT) supports care transitions for Medicare beneficiaries. Our PPS will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid population in participating hospitals. Funds will not be provided if doing so would supplant or duplicate CBCT funding.

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

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics.** Quarterly reports to the Independent Assessor will include project status and challenges as well

as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.a.iii Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services

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

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

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

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

8. Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).
9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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

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

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

The CNA detailed the total observed risk-adjusted expected ratio ("risk-adjusted O/E") of PPV EDs for NYC neighborhoods. Of 10 neighborhoods with the highest PPVs, five are in the Bronx (Highbridge-Morrisania, Crotona-Tremont, Hunts Point/Mott Haven, Fordham-Bronx Park, Pelham-Throgs Neck), three are in Brooklyn (Bedford-Stuyvesant-Crown Hts, E. New York, Williamsburg-Bushwick) and two are in Queens (Jamaica, W. Queens).

The CNA also provided data for certain risk-adjusted Medicaid Prevention Quality Indicators (PQIs). PQIs are a set of measures developed by the Agency for Healthcare Research and Quality for use in assessing the quality of outpatient care for a set of ACSC conditions. For chronic obstructive pulmonary disease (COPD) or asthma in adults ages 40 and older, the risk-adjusted O/E is 1.05 for NYC and 1.06 in our service area. Twenty neighborhoods were higher than NYC, including: Manhattan (Central Harlem/Morningside Hts, Washington Heights/Inwood, Upper W. Side, E. Harlem, Chelsea/Clinton); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Williamsburg/Bushwick, Downtown/Hts/Slope, Greenpoint); Bronx (NE Bronx, Highbridge/Morrisania, Crotona/Tremont, Hunts Point/Mott Haven, Fordham/Bronx Park, Pelham/Throgs Neck, Kingsbridge/Riverdale); and, Queens (Rockaway).

The PQI diabetes composite had a risk-adjusted O/E of 1.11 in our service area, the same as NYC overall. Twenty-two neighborhoods exceeded this ratio, including: Manhattan (Chelsea/Clinton, Central Harlem/Morningside Hts, E. Harlem, Upper W. Side, Gramercy Park/Murray Hill, Washington Hts/Inwood, Upper E. Side, Lower Manhattan); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Downtown/Hts/Slope, Williamsburg/Bushwick); Bronx (NE Bronx, Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, Fordham/Bronx Park, Kingsbridge/Riverdale); and, Queens (Rockaway, SE Queens).

With regard to congestive heart failure (CHF), the CNA provides a citywide analysis of the percentage of Medicaid beneficiaries with one all-cause admission. Our service area is slightly higher than NYS (61.5%

compared to 61.2%). The Bronx and Manhattan are higher than NYS, with rates of 67.7% and 65.0% respectively.

For Medicaid beneficiaries with a substance abuse clinical risk grouping condition, the prevalence across NYS is 6.4% compared to 6.1% in our service area. Manhattan has a particularly high rate in comparison, with a prevalence of 11.2%.

Results from CNA primary data collection indicate that community members lacked resources to assist with basic social needs and that providers often failed to recognize or address these issues, focusing instead to a "quick but possibly ineffective medical solution" (CNA need 5).

Our PPS selected Project 2.a.iii because of the need to comprehensively address chronic conditions in NYC (see CNA needs 1, 5). This includes expanding the availability of care management services and ensuring that social determinants of health are addressed in the care of those with chronic disease (see CNA need 5). We will emphasize patient navigation and establish linkages to community support services (see CNA needs 3, 5). Our PPS understands that in a rising risk model, patients who go without these services are likely to having decreased outcomes and increased utilization (see CNA needs 1, 2, 5).

We intend to develop a Health Home At-Risk Intervention program that deploys a set of services including assessment, care plan development, outreach and education, support for patient self-management and action plan development (as indicated by the patient's diagnosis), linkages to community services and social supports, and navigation services. This program will be supported by a robust IT-enabled care management solution that is currently undergoing a procurement. It is expected to expand on existing IT functionality (e.g., registry, care plan, alerts/reminders) within the PPS.

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

Our PPS will design the intervention to engage the following patient population in care: individuals with a single chronic disease who are unable to effectively manage their condition due to illness severity, poor control, or other barriers to care plan adherence that could result in a heightened risk of condition exacerbation or development of a second chronic condition (see CNA need 5). Our PPS will focus particularly on diagnoses that currently drive ED and hospital utilization in the patient population and less engaged individuals who do not have an established PCP or have been frequent ED users.

Specifically, we expect to engage populations that have a single diagnoses of a chronic disease (e.g., CHF, COPD, end-stage renal disease, diabetes, substance use disorder, asthma) and have at least one additional risk factor which affects their ability to manage their condition: primary or secondary diagnosis of a behavioral health condition, age, disability, functional status, and social determinants of health (e.g., poverty, homelessness, criminal justice history) (see CNA need 5).

Our PPS intends to inform implementation using a detailed understanding of geographic clustering and neighborhood characteristics, based on CNA findings. Particular neighborhoods of focus for outreach include Upper Manhattan, the Brooklyn neighborhoods of Bedford-Stuyvesant-Crown Heights,

Downtown-Heights-Slope, and East New York, Northeast Bronx and Fordham-Bronx Park, and Southeast Queens and Jamaica.

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.

Our PPS has a breadth of assets and resources that we intend to mobilize as part of DSRIP implementation. As described in 2.a.i, we are developing a CSO to provide an integrated platform to manage DSRIP projects and initiatives. The CSO will have a population health orientation and will also focus on the core DSRIP goal of achieving a 25% reduction in avoidable hospital use over five years.

The CSO will collaborate with both Health Home and PCMH teams within the PPS to develop a common framework for the deployment of care management and care coordination services. We have four Health Homes within our PPS, including HHC, Coordinated Behavioral Care (CBC), Community Healthcare Network (CHN), and Community Care Management Partners (CCMP). Total active enrollment across all Health Homes within our PPS is more than 14,000. A significantly greater number have been included in formal outreach efforts. The experience in outreach, active engagement, and care management will be a significant asset to our PPS. This will be bolstered by our relationships with Health Home subcontracted agencies. We also intend to leverage HHC's Health and Home Care Division, which provides care management services through a home-based model within a Certified Home Health Agency and through a telephonic House Calls program. Another PPS partner, Doctors On Call, also has a robust home visit program. Combined, our PPS will have the capability to ensure that the target population has access to the full continuum of care.

Additional assets and resources include chronic disease management and care management learnings from the MSSP and the Center for Medicare and Medicaid Innovation (CMMI) ED Care Management initiative to prevent avoidable ED and inpatient use. The latter project uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. Our PPS will also leverage the expertise of MetroPlus and its respective care management activities and expertise as well as expertise derived from care management services provided to our HIV population.

A majority of our PPS's primary care sites have achieved 2011 NCQA Level 3 PCMH recognition and a smaller subset have achieved 2011 Level 2 PCMH recognition (four sites located in Brooklyn; those sites will apply for Level 3 recognition in April 2015). These sites have experienced staff and workflows in place to support care management. HHC's PCMH activities focus on a range of chronic conditions (e.g., HIV, obesity, asthma, smoking cessation) and also have additional depth around managing patients with hypertension and depression. HHC will expand upon these assets through this project, in particular by building capacity to address other chronic diseases (e.g., diabetes) in similar depth.

Our PPS will leverage existing communication channels in order to conduct outreach and education to the target population and will enhance its already extensive resources to ensure that all patients, regardless of geography, have access to resources that span the continuum of care. In particular, our PPS will continue its partnership with the NYC Department of Health.

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.

While our PPS has significant assets, it anticipates major challenges related to lack of coordination between providers, recruiting and workforce issues, limitations and lack of standardization of health IT capabilities among partners, and limited capacity and strategies to address social determinants of health. As referenced in the CNA, these issues have historically impeded hospitals' and providers' ability to provide effective discharge and follow-up services, in turn limiting their ability to reduce avoidable readmission rates. In addition, PPS providers have a number of care management programs with different and often overlapping, populations and program structure. These programs also vary in terms of implementation, where they sit organizationally, staffing models, and specific activities. We anticipate that the CSO will address many of these concerns through the development and deployment of: (1) consistent care management services to the target population; (2) clear delineation of roles and responsibilities; and, (3) standard policies, procedures, care pathways and clinical protocols related to care transitions, referrals management, team-based care, and data sharing and reporting.

Our PPS is also concerned about patient engagement, particularly related to care plan completion. In addition, gaining consent to share patient information, especially from those with behavioral health needs, has been a persistent problem in other programs (e.g., the MSSP). As such, our PPS will make investments in PCMHs and work collaboratively with partner Health Homes to enhance capacity to serve the target population. Our PPS will also conduct culturally proficient patient education and outreach regarding the benefits of PCP, PCMH and Health Home engagement (see CNA needs 3, 4).

Finally, it will be challenging to recruit and train sufficient care management staff of various types and levels. HHC will work with CBOs to identify a pipeline of care management staff. Our PPS intends to contract with the 1199 SEIU Training and Employment Funds and other workforce training organizations (e.g., our PPS Partner, SUNY Downstate Medical Center) to ensure that care management staff are adequately trained.

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

As part of our planning activities to date, our PPS has collaborated with BPHC and CCB. We have achieved a number of important goals, including aligning project selection for this and other projects, and to begin identifying areas for collaboration during implementation and operations.

During implementation and operations, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; adoption of common core partner contracting vehicles; development of workforce strategy, including common job descriptions and functional

capabilities; workforce training efforts; data sharing; and, selection of culturally competent patient education resources to support this project.

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

1. **Scale of Implementation (Total Possible Points - 40):**
   DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

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

2. **Speed of Implementation/Patient Engagement (Total Possible Points - 40):**
   DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

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

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

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

Yes	No
☐	☒

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

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
New York City Health & Hospitals Corporation (HHC)	Center for Medicare and Medicaid Innovation (CMMI) Grant, Round 2: ED Care Management Initiative: Pr	September 2014	August 2017	HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from the ED. The target population for this initiative is patients with ambulatory sensitive conditions.
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
SUNY Downstate	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				services in outpatient primary care settings.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HICA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU) /Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				HU's Health Home program.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children- and family-focused agencies that provides Health Home services for children.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care to other disease states, beyond the focus areas supported by the H-MH program.

The NYS Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This DSRIP project will build on this existing infrastructure, but will serve a different and larger group of Medicaid patients who are not eligible for Health Home services. Similarly, our work in this project will build on work that our partners have begun through HARP and HCIA, expanding Health Home services to a wider population than is currently served by these programs.

With regard to HHC's ED Care Management initiative, the DSRIP Health Home At-Risk Program does not have as one of its activities to develop an ED Triage approach. The Health Home At-Risk Intervention can leverage promising practices and lessons learned from this CMMI grant.

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

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

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

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

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

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

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

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

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

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

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

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

ED care management programs often inadequately to address the follow-up care needs of discharged patients who have complex conditions or socio-economic challenges (i.e., homelessness, chronic pain, behavioral health). At-risk patients may lack referrals and warm hand-offs to specialty providers or other

partners able to address socio-economic factors that create barriers to follow-up care (e.g., lack of transport). Finally, there is a lack of effective patient education materials that address management of chronic diseases, how to access PCPs, and availability of specialized programs (e.g., behavioral crisis management) and also meet patient's language, culture and health literacy needs (see CNA need 3).

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

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

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

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

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

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

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

We have a range of assets and resources that will support implementation of this initiative. We have tested ED Care management pilots in a number of PPS hospitals (e.g., Elmhurst, Bellevue, Queens). In addition, there are telephone triage centers (Lincoln, Woodhull), open PCP panels (North Central Bronx, Jacobi), risk assessment tools (North Bronx Health Network), and "expedited passes" for ED patients to access their PCPs (Lincoln).

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

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

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

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

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

With these approaches, our PPS will retrain and redeploy staff as care managers, social workers, navigators, triage nurses, and physician advisors. We will also leverage peer care managers as an effective way to engage patients. For patients needing ambulatory withdrawal management services, the PPS will

explore opportunities to expand capacity. A newly developed CSO will house the PPS's care management and care coordination services.

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

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

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

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

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

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

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

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

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

2. <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.

To support the project approach, the PPS will enhance IT systems with required capabilities. Telephone triage teams and ED staff will, for the most part, be able to arrange follow-up PCP appointments for patients through an expanded and enhanced centralized scheduling system and make greater use of

open access scheduling. The PPS will work with PCPs to expand capabilities to "see" patients via telephone, email, or video chat. Enhanced data connectivity through the RHIO and encounter notification system that will provide real-time data feeds.

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

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

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

Yes	No
☒	☐

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

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

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home Care Management entity under subcontract with 4 NYS Health Home providers.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
Riverdale Mental Health Association	CMS Innovation Center Health Care Innovation Awards (HCIA)	2015	2015	As part of the HCIA award, Riverdale Mental Health Association provides the Parachute NYC Bronx Crisis Respite Center.
Visiting Nurse Service of NY	CMS Innovation Center Health	2014	2017	Mount Sinai School of Medicine received funds to pilot a hospital-at-home model (Mobile Acute Care Team Services).

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
(VNSNY)	Care Innovation Awards (HCIA)			VNSNY is a partner in this project but not the lead.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

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

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

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently eligible for Health Home services. Similarly, this project will build on work that our partners have begun through the Developmental Disability Care Coordination Pilot and HCIA, expanding services to a wider population than is currently served by these programs.

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

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

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

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

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

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

1. <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.

Data show there is opportunity to reduce Potentially Preventable Readmissions (PPRs) to hospitals. PPR risk-adjusted O/E ratios are 1.04 in Brooklyn, 1.13 in the Bronx, 1.17 in Manhattan, and 0.79 in Queens. In Brooklyn, the highest readmission ratios are found in north-central Brooklyn, Downtown, Bedford-Stuyvesant and Bushwick, and in Coney Island. In the Bronx, hotspots include Williamsbridge, Fordham-Bronx Park, Belmont, East Tremont, Claremont Village, Morrisania and Mott Haven. In Queens, service areas range from 0.64 to 1.50. Behavioral health 30-day readmission rates (all ages) are high: Brooklyn (22%), Bronx (17.9%), Manhattan (23%), Queens (25%).

Twenty-one UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for four Prevention Quality Indicator (PQI) measures: PQI for COPD or asthma; PQI for respiratory composite; PQI for chronic composite; PQI for heart failure. Given that these neighborhoods include a significant proportion of the PPS's total Medicaid population (69%), we will enhance patient engagement activities in these areas.

Our PPS identified several factors that contribute to patients' lack of engagement in follow-up care. First, HHC analyses estimate that 41% of patients who had an ED visit did not have a PCP. CNA interviews revealed that care management staff have difficulty reaching a patient's PCP to arrange follow-up. Patients noted having trouble finding and accessing a PCP. PCP appointments may not be available for weeks and may involve lengthy waits during the visit. This contributes to a lack of adherence to discharge regimens and how to deal with adverse drug events (see CNA need 2).

Second, care management programs are often inadequate to address follow-up needs of discharged patients with complex medical conditions and other risk factors (e.g., homelessness, substance abuse, co-morbid behavioral and physical health conditions) (see CNA need 5). Programs may not adequately engage families in caring for recently discharged patients. CNA interviews revealed that post-discharge, individuals have difficulty adhering to medical recommendations in under-resourced and stressful home environments. Providers "have no clue, for the most part, as to where these homeless people are landing… what connection they have to medical services." Providers "don't even ask the question – is there enough food in the home or do you need a referral to a food pantry or Meals on Wheels program?"

Third, the health care system lacks data connectivity. This results in delayed transfer of a complete discharge summary to follow-up providers, lack of health information exchange and system interoperability between all parties (e.g., providers, managed care plans).

Fourth, there is a lack of effective patient education materials that address topics such as management of chronic diseases, how to access a PCP during and after hours, and availability of specialized programs (e.g., substance abuse, behavioral crisis management) that are also responsive to patients culture, language and health literacy needs (see CNA need 3).

To address these gaps, our PPS will pursue a two-pronged approach. First, we will enhance and standardize Project RED (Re-engineered Discharge) in all hospitals. Second, we will strengthen coordination of medical and social services outside the hospital walls.

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 patient population we expect to engage includes all uniquely attributed patients with one or more discharges from hospitals in the PPS. Our PPS will intensify efforts to engage patients in medical and professional shortage areas, and the 21 neighborhoods with consistently poor PQI performance (e.g., ratios greater than 1.0 for respiratory conditions, chronic diseases, and heart failure), including Bedford/Stuyvesant/Crown Heights; Highbridge/Morrisana; Washington Heights/Inwood; Pelham/Throgs Neck; Flatbush/E. Flatbush; Jamaica; Williamsburg/Bushwick; East New York; Hunts Point/Mott Haven; Central Harlem/Morningside Heights; NE Bronx; Canarsie/Flatlands; E. Harlem; Downtown/Heights/Slope; Rockaway; Stapleton/St. George; Chelsea/Clinton; Upper W. Side; Kingsbridge/Riverdale; Upper E. Side; and, Gramercy Park/Murray Hill. Project efforts will be closely coordinated with 2.d.i activities to engage low- and non-utilizers (see CNA need 1).

Among the 21 targeted neighborhoods, the 10 poorest have 21-43% of the population below 100% FPL. These 10 neighborhoods also have 11%-26% who are non-US citizens, 7%-36% who speak English "less well," 20%-40% of adults with less than a high school education, and 9%-17% living with a disability.

At-risk patients will be identified using a standardized risk assessment tool, which will look at frequent admissions in the past year (e.g., more than 2-3), readmissions within 30 days within the past year, specific diseases within cardiac, renal, diabetes, respiratory and/or behavioral health disorders, substance abuse, sickle cell, diabetes with peripheral vascular disease, ESRD with CHF), use of high alert medications/polypharmacy, health literacy, socio-economic support/status including homelessness, and need for chronic pain management (see CNA needs 3, 4, 5).

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.

Our PPS has a number of assets and resources to support this project. Our PPS has pilot tested care transition models, including Project RED, and has established an Integrated Care Management Council. CHF was the initial focus of Project RED and approximately five facilities expanded to include COPD in early 2014. MetroPlus's existing care management programs, including the House Calls program, will be leveraged, as will expertise gained through learning collaboratives on care management and care transitions.

With this foundation, our PPS will pursue a two-pronged approach. First, we will extend Project RED to all hospitals in the PPS and will target all at-risk patients. Currently, with one exception, Project RED is implemented to some degree in the PPS's acute care hospitals but still lacks standardized protocols and risk assessment tools. At-risk patients (e.g., cardiac conditions, renal failure, diabetes, respiratory conditions, behavioral health, and other socio-economic factors) will be identified and provided with more intensive care management. Tools will be standardized and will emphasize patient and family engagement. All PPS hospitals will address the medical conditions targeted for this project; however, each will phase-in interventions based on the prevalence of their respective readmission trends.

Although Project RED calls for a two-day patient follow-up post discharge, care management teams at most of the PPS's acute hospitals already follow patients for the desired 30 days post-discharge. Any remaining PPS hospitals will be brought up to this 30-day standard.

Second, our PPS will enhance Project RED by strengthening coordination outside the hospital walls with PCPs, post-acute providers and other CBOs. The latter is particularly important given that CNA key informants noted that "we have absolutely zero knowledge of community resources." Relationships include building on our already strong collaboration with the four Health Homes in our PPS (e.g., HHC, CBC, CCMP, CHCN) and relationships with CBOs that provide Health Home-related services via subcontract. In addition, we will work closely with PPS and community physicians, diagnostic testing centers, PCMHs, skilled nursing facilities, the NYC Department of Homeless Services and other partners.

Our PPS will develop standard processes and protocols to ensure accountability for safe and effective transition of care between the hospital and post-acute partners. We will also develop protocols for patient education materials on disease management, lifestyle, and medication management that meet patient's culture, language and health literacy needs.

To support the project, our PPS will retrain and redeploy staff as care managers, navigators, and care coordinators. For patients needing ambulatory withdrawal management services, we will explore opportunities to expand capacity. A newly developed CSO will house the PPS's care management and care coordination services.

Our PPS will enhance IT systems to support a range of functions. Care management staff will, for the most part, be able to arrange follow-up PCP appointments for patients through expanded and enhanced centralized scheduling systems and make greater use of open access scheduling. We will work with PCPs to expand capabilities to electronically communicate with patients. Enhanced data connectivity will support the sharing of timely and standardized inpatient discharge information to follow-up providers, exchange of information across members of the care team, and the establishment of feedback mechanisms from community partners to care management teams. We hope to pilot test alert and early notification systems to inform providers when a patient presents to the ED.

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.

Limited capacity at the primary care clinics hinders timely appointments with PCPs for follow-up care (see CNA need 2). To address this, our PPS will work internally and with partners to implement one or more of the following strategies: extend hours, expand capacity, hire staff, improve open access capabilities, and expand use of telehealth services. We also plan to strengthen Health Home services by contracting with CBOs to provide outreach and care coordination, work with MetroPlus's Housecalls program which delivers remote care management services and leverage experience gained through work on our Medicare MSSP ACO to enhance outreach and engagement efforts.

Care coordination for homeless patients is challenging (see CNA need 5). According to the CNA, providers "have no clue, for the most part, as to where these homeless people are landing… what connection they have to medical services." The PPS will work with the NYC Department of Homeless Services to address issues that hinder the access of homeless patients to care.

Conveying information about health care and services is complex given the ethnic and racial diversity in each borough (see CNA need 3). According to focus groups, information is best shared by "people seeing people who look like them, that are like them, who speak like them…" The PPS will work with many CBO partners familiar with local neighborhoods to develop and disseminate educational materials that meet patient's culture, language and health literacy needs.

Many aspects of the proposed interventions rely on enhanced IT systems. The PPS will address five foundational elements of the IT system including: (1) centralized population health management data capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) alignment of electronic health records within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and (5) HIE with RHIO/SHIN-NY and private HIE.

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

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

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

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

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

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

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

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

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

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

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

a. Will this 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 enhance IT systems with required capabilities. Care transition teams will, for the most part, arrange follow-up PCP appointments for patients through expanded and enhanced centralized scheduling processes and greater use of open access scheduling. The PPS will work with PCPs to expand capabilities to "see" patients via telephone, email, or video chat. Enhanced data connectivity will support timely and standardized inpatient discharge information to follow-up providers and establish feedback mechanisms from community partners to care management teams regarding the patient's engagement to ensure coordination with any future inpatient services. This connectivity will also ensure timely exchange of information across members of the care team (e.g., between care managers and providers, and between providers from various specialties).

In addition, capital investment is required for the construction or renovation of existing space for patient-friendly and accessible wellness centers which will provide culturally and linguistically competent education on disease management, blood pressure checks, and patient navigator support on how to access a PCP during and after hours and availability of specialized programs (e.g., substance abuse, behavioral crisis 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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health	Health Homes for Medicaid	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Care Network	Enrollees with Chronic Conditions			
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association /Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Center				growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.
R.A.I.N.	Community-Based Care Transitions Program	2015	2018	R.A.I.N. provides coordination and linkage to providers who specialize in disease management.
Total Care Pharmacy, Inc., Specialty Care Pharmacy, Amato Pharmacy, Medical Center Pharmacy, Total Care Pharmacy Bx, Inc.	Community-Based Care Transitions Program	2014	2018	Total Care Pharmacy provides transitional services when patients are discharged, including follow-up on medication adherence and side effects.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.
New York City Health & Hospitals Corporation (HHC)	Medicare Shared Savings Program	June 2012	December 2016	HHC ACO, Inc. (the HHC ACO) was formed by HHC in June 8, 2012, to further the goals of the Medicare Shared Savings Program (MSSP).
Arms Acres and	Health Homes for Medicaid	2014	2018	Arms Acres and Conifer Park provides services to NYS

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Conifer Park	Enrollees with Chronic Conditions			Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health	2012	2016	CAMBA provides Health Home care management services, under subcontract, to

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Care Innovation Awards (HCIA)			individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

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

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

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and

supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

The Community-Based Care Transitions (CBCT) supports care transitions for Medicare beneficiaries. Our PPS will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid population in participating hospitals. Funds will not be provided if doing so would supplant or duplicate CBCT funding.

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

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed

by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

In order to be eligible for this project, a PPS must already be pursuing 10 projects, demonstrate its network capacity to handle an 11th project, and evaluate that the network is in a position to serve uninsured (UI), non-utilizing (NU), and low utilizing (LU) populations. Any public hospital in a specified region has first right of refusal for implementing this 11th project. Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project. Finally, in order to participate in pay-for-reporting outcome metrics in Demonstration Years (DY) 4 and 5, the PPS will submit data as specified.

Project Objective: The objective of this 11th project is to address Patient Activation Measures® (PAM®) so that UI, NU, and LU populations are impacted by DSRIP PPS' projects. Feedback from the public comment period resulted in the state to include UI members in DSRIP, so that this population benefits from a transformed healthcare delivery system. Please refer to the body of literature found below on patient activation and engagement, health literacy, and practices to reduce health care disparities:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955271/
http://content.healthaffairs.org/content/32/2/223.full
http://www.hrsa.gov/publichealth/healthliteracy/
http://www.health.gov/communication/literacy/
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page
http://www.hrsa.gov/culturalcompetence/index.html
http://www.nih.gov/clearcommunication/culturalcompetency.htm

Project Description: This project is focused on persons not utilizing the health care system and works to engage and activate those individuals to utilize primary and preventive care services. The PPS will be required to formally train on PAM®, along with base lining and regularly updating assessments of communities and individual patients. This project encapsulates three primary concepts, which drive the requirements for this project:

- Patient activation
- Financially accessible health care resources
- Partnerships with primary and preventive care services

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. Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.

2. Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.
3. Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.
4. Survey the targeted population about healthcare needs in the PPS' region.
5. Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.
6. Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).
   - This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
   - Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.
7. Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.
8. Include beneficiaries in development team to promote preventive care.
9. Measure PAM® components, including:
   - Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.
   - If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.
     - Individual member score must be averaged to calculate a baseline measure for that year's cohort.
     - The cohort must be followed for the entirety of the DSRIP program.
   - On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.
   - If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
     - The PPS will NOT be responsible for assessing the patient via PAM® survey.
     - PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.
   - Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.
10. Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.

11. Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage community health care resources (including for primary and preventive services) and patient education.
12. Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.
13. Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.
14. Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive health care services and resources.
15. Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.
16. Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.
17. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, 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. The project description should consider three primary activation concepts: *patient activation*, *financially accessible health care resources*, and *partnerships with primary and preventive care services.*

According to the CNA, there are approximately 1.3 million uninsured (UI) residents in our PPS service area, with the greatest number residing in Queens and the fewest in Manhattan. In addition, the State attributed 694,685 non-utilizers (NUs) low-utilizers (LUs) in the PPS and 1,141,563 uninsured to our PPS (based on December 13, 2014 DSRIP performance attribution results). The CNA estimated that nearly 21% of all individuals in our service area live below 100% of the FPL, 18.6% are non-US citizens, 22% of adults have less than a high school graduation, and 24.6% speak English "less than well" (CNA need 3). These rates exceed NYC and NYS averages and have been shown to be associated with disconnectedness from the health care system.

This project will be implemented to close CNA-identified gaps and to improve the outcomes of UI and LU/NU Medicaid beneficiaries in our service area (CNA need 1). Our approach will: activate patients by leveraging existing provider and community-based staff, including health plan partners (e.g., MetroPlus), to improve patient engagement as measured by PAM or another instrument; strengthen existing and develop new partnerships with entities providing primary care and preventive services and increase use of these services (CNA need 2); identify the range of available services that are financially accessible and educate our population about their availability; reduce inappropriate use of inpatient and emergency

services (CNA need 1); and, improve Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.

To achieve these goals, our PPS will employ a multi-pronged approach including: outreach and patient identification; eligibility determination for and enrollment in healthcare coverage; and, patient activation, patient education, and linkages to care for all patients, regardless of insurance status.

For outreach and patient identification, our PPS will leverage internal resources (e.g., hospital ED data and hospital-based application counselors) and contract with CBOs to provide outreach and assistance. CBOs will undertake focused activities to identify LU/NU patients. We will work with NYS-designated Navigators and other organizations with expertise in providing culturally responsive services and ensuring patients understand available financially accessible resources. In addition, our PPS will coordinate outreach with NYC agency partners including, but not limited to, the NYC Department of Health and Mental Hygiene (DOHMH) and the NYC Human Resources Administration (HRA). Finally, we expect to leverage patient assistance and managed care resources, including those offered through MCOs (e.g., MetroPlus, HealthFirst).

For eligibility determination and enrollment in coverage, we will contract with CBOs and leverage MCO partners to educate and assist patients. This will include the use of MCO-maintained lists which identify PCPs assigned to NU/LU enrollees. We will then conduct outreach to reconnect beneficiaries to their PCP. This may include the use of telephonically-based health coaches and proactive work with respective MCOs and PCPs. We will also continue work with the Mayor's task force on immigrant healthcare formed in late 2014.

Once identified, we will connect patients to services (e.g., clinical, care management, care coordination) and provider linkages to social services and supports in order to provide whole-person care (CNA needs 1 - 5). Programs may include PCMH, Health Home, or other relevant programs or services. Enrolling patients in these care models is the most direct path to improve patient engagement and to ensure that patients access the right care at the right place and time. Expanding and enhancing our PPS's primary care footprint through project 2.a.i (e.g., increased staffing, increased hours at existing facilities, and contracting for primary care services) will be an essential component to ensure adequate access to care for all PPS beneficiaries (CNA need 2).

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. Note: Only the uninsured, non-utilizing, low-utilizing Medicaid member populations will be attributed to this project.

We expect to engage uninsured, LU or NU individuals. Our State-determined portion of LU/NU individuals is 694,685 and our State-determined portion of uninsured individuals is 1,141,563. This results in a total interim attribution for this project of 1,836,248. These data reflect December 13, 2014 DSRIP performance attribution results.

Our PPS will initially focus on those with chronic illness, immigrants, those with limited English proficiency, and the undocumented, as these groups have been shown to have lower insurance rates and irregular contact with the healthcare system (CNA needs 1, 3). As we engage these population groups, our PPS will expand our reach to a population.

In addition, we expect to collaborate closely with two emerging citywide initiatives to address the needs of undocumented immigrants and those recently released from incarceration. By linking our efforts in this project to other related efforts to engage hard-to-reach patients and families, we expect to meaningfully impact the rates of inappropriate hospitalization and ED visits, the quality of care provided, and ultimately, the health of our communities.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. Please demonstrate that the PPS has network capacity to handle an 11th project and how the PPS is in a position to serve these UI, NU and LU populations. In addition, identify any needed community resources to be developed or repurposed.

Our PPS has a range of assets and resources that we will use to implement this project. HHC's work on Staten Island Health Access (SIHA) provided valuable learnings on how to effectively engage CBOs through contracts to conduct community outreach and enrollment and help enrollees access needed care. One MCO in our PPS, MetroPlus, has expertise gained through its CBO-related contracting work via its HIV Special Needs Plan. HHC has a Consumer Assistance Program (CAP) for which we closely coordinate with community providers, with an emphasis on coordination with behavioral health providers.

For outreach and identification, our PPS will partner and contract with CBOs to identify uninsured, LU and NU hotspots and to provide outreach in their respective communities. For the uninsured population, CBOs will link patients to insurance enrollment and financial assistance resources, as well as connect patients to PCPs. For LUs/NUs, our PPS will work in partnership with Medicaid MCOs to re-connect patients to their PCPs.

For eligibility determination and enrollment, our PPS has a minimum of 775 certified application counselors (CACs), including 570 at HHC, 200 at MetroPlus, and 5 at SUNY, with more to be trained in 2015. In addition, there are 120 managed care staff. All will be trained in PAM or another activation tool.

CACs located within PPS facilities will help uninsured patients apply for Medicaid or other health insurance through the Health Insurance Marketplace (New York State of Health) or HRA if they are uninsured. They will also help patients apply for charity care if they are ineligible for insurance or are underinsured. The PPS will arrange CAC training for CBO partners through MetroPlus on an as-needed basis. The PPS will also make educational materials and trainings available to partners with regard to relevant programs and services (e.g., HHC's charity care program, HHC Options, financially accessible health care resources) and will emphasize the importance of ensuring coverage and access.

For patient activation activities and linkage to care, the PPS will seek to educate insured patients as to approaches to more effectively use their coverage (e.g., making appointments with their PCP, access to

other services, etc.). Many of our partners have considerable experience engaging and addressing the unique needs of the target population. For example, the HHC delivery system has deep and long-standing relationships with CBOs focused on the target population, and as referenced above, MCO partners also have deep and longstanding relationships into the target communities. Our PPS intends to leverage these relationships, as well as work with our CABs and project advisory committee (PAC) to develop and implement creative strategies to seek out and engage the target population.

Based on our extensive experience partnering with CBOs, we will establish infrastructure to support the ability of CBOs to refer patients directly to appropriate physical or behavioral health providers. Managed care staff will educate patients on the use of their health plans, including member services, PCP assignment and authorizations. Our PPS expects to support partner CBOs to expand their capacity to ensure that we have the appropriate staff levels and expertise to find and engage the target population, consistent with implementation scale and speed estimates.

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.

Our PPS anticipates a number project challenges. First, we must find, identify and connect with the uninsured population, including the undocumented and those without formal connection to the healthcare system. To address this challenge, we will work with partners that have culturally-responsive approaches and engage trusted community leaders. We will also coordinate with CBOs that have existing relationships to the community and outreach expertise. We expect to target neighborhoods identified in the CNA as having high rates of uninsured.

Second, we anticipate challenges to overcome cultural barriers for new immigrants, some of whom have not had contact with a formal healthcare system. Enhancing CBO relationships will help build bridges to these communities. Activities may include, but will not be limited to, providing training support and establishing linkages to the PPS care management systems and MCO relationships. The use of community health workers and peer educators will also support outreach and engagement efforts.

Third, we expect there to be affordability concerns related to coverage and access. To address this barrier we will seek to provide education about various programs offered by some of our partners to provide a range of free and low-cost services, including HHC's Options program. In addition, our PPS may seek state regulatory relief on co-pay collection requirements.

Fourth, we believe that barriers may exist to implementation of a consistent approach to the use of PAM or other activation tool. Because consistency across the PPS is essential, we will work within our PPS and across NYC to identify options to standardize roles, qualifications and training as needed.

Fifth, we anticipate that improving health literacy will be challenging. To address this, we will develop "plain language" materials that meet commonly-accepted health literacy standards.

Finally, the complexity of our healthcare system and the diverse needs of patients will prove challenging. This complexity is evidenced by our broad patient base which has a variety of physical and behavioral health needs and is complicated by many risk factors related to the social determinants of health (e.g., lack of stable housing, food insecurity, relationship to the criminal justice system).

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

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

With regard to Project 2.d.i, we expect to coordinate with other NYC-based PPSs to address hot spot identification, training on coverage options and financial assistance (charity care) resources, and ensure that other PPSs have robust mechanisms and pathways to help patients ineligible for insurance. We will also work with other NYC PPSs in our service area to identify additional capacity, as needed, to support Project 2.d.i implementation activities.

In addition, we will develop mechanisms to ensure that NU/LU patients who have existing relationships with providers, who may be part of another PPS, are directed in a timely manner to their "home" provider and health system. We expect to target neighborhoods identified in the CNA as having high rates of uninsured, and to collaborate with other PPSs and city agencies to further coordinate outreach. As part of our citywide role to implement this project, we intend to convene the PPSs as well as relevant city agencies on a regular basis.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

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

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

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

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

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

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

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

Yes	No
☒	☐

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

This project will require capital funding. This funding is necessary to purchase mobile devices to assist with engaging patients in the community and in certain "hot spots" such as emergency rooms. Mobile devices will allow navigators to provide on-the-go outreach and education.

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care	Health Homes for Medicaid	2012	2018	CCMP is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Management Partners (CCMP) Health Home	Enrollees with Chronic Conditions			
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc.(ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc.(ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
Arab American Family Support Center	New York State of Health	August 2013	September 2018	Arab American Family Support Center provides in-person enrollment assistance.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Bronxworks	New York State of Health	August 2013	September 2018	Bronxworks provides in-person enrollment assistance.
Brooklyn Alliance	New York State of Health	August 2013	September 2018	Brooklyn Alliance provides in-person enrollment assistance.
Brooklyn Perinatal Network	New York State of Health	August 2013	September 2018	Brooklyn Perinatal Network provides in-person enrollment assistance.
CACF	New York State of Health	August 2013	September 2018	CACF provides in-person enrollment assistance.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Chronic Conditions			between 300 – 900 members per month.
Community Service Society	New York State of Health	August 2013	September 2018	Community Service Society provides in-person enrollment assistance.
Hispanic Federation	New York State of Health	August 2013	September 2018	The Hispanic Federation provides in-person enrollment assistance.
Joseph P Addabbo Family Health Center	New York State of Health	August 2013	September 2018	The Joseph Addabbo Center provides in-person enrollment assistance.
NADAP	New York State of Health	August 2013	September 2018	NADAP provides in-person enrollment assistance.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

Project 2.d.i expands on enrollment activities currently performed by Navigators under the NY State of Health (NY's state-based marketplace) by working with individuals after they have obtained health insurance. This ensures that current uninsured do not become future low- or non-utilizers. Project 2.d.i will follow the patient from uninsured status through their first visit and beyond. Project 2.d.i will also build on care management work being done by partners through Health Home programs to help low-and non-utilizing Medicaid population engage in their care.

Work related to 2.d.i is not duplicative of these other programs in that 2.d.i activities are focused on those who are not already engaged in regular 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 scale of project implementation, completion of project requirements and patient engagement progress in the project.

a. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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.

Our PPS has chosen to implement all three models for primary care and behavioral health (BH) integration in order to address the high prevalence of BH diagnoses among Medicaid beneficiaries in the PPS (see CNA need 4), as well as the population's inappropriate use of ED and inpatient services (see CNA needs 1, 4).

The CNA documents the prevalence of mental health (MH) and substance abuse (SA) diagnoses across NYC neighborhoods. Eight of ten Manhattan neighborhoods have MH diagnosis rates above city and state averages (19.5% and 22.8% respectively). Of these, six have MH rates above 30% (Chelsea/Clinton, Gramercy, Park/Murray Hill, Upper West Side, Lower Manhattan, Upper East Side, and East Harlem), and one (Chelsea/Clinton) is above 50%. The prevalence of MH diagnoses in the other boroughs is lower, with three neighborhoods in the Bronx above the state average (Kingsbridge/Riverdale, Hunts Point/Mott Haven, Crotona/Tremont), two neighborhoods in Brooklyn (Downtown/Heights/Slope, Coney Island/Sheepshead Bay) and one

Queens neighborhood (Rockaway). Of the adults with BH disorders discharged from inpatient facilities in 2013, 83.5% had one or more chronic medical conditions.

SA trends are similar, with the highest prevalence occurring in Manhattan; nine of ten neighborhoods experience higher than city and state averages (6.2% and 6.4% respectively), and the same six neighborhoods have prevalence rates above 12%. In the Bronx, one neighborhood has rates above 12% (Hunts Point/Mott Haven), and four have above average rates. In Brooklyn, four of eleven neighborhoods have above-average rates. SA is not as prevalent in Queens, where all rates are below the average.

New York's Medicaid beneficiaries with MH and SA diagnoses are high users of inpatient and ED services: 42.3% and 58.4% of MH and SA patients had at least one ED visit and 32.3% and 65% had at least one admission. Readmission rates for individuals with MH diagnoses are high as well: 23.3% in NYC and 20.9% for NYS.

The CNA documents low utilization of BH resources and CNA participants noted that resources are difficult to access. The CNA also notes that individuals may not access resources due to stigma, inconvenience or lack of knowledge (see CNA need 3). The CNA indicates that almost one-quarter of the population in the PPS (24.6%) speak English "less than very well." In eight neighborhoods across the PPS–which combined represent one-third of the total PPS service area population–more than one-third of the residents speak English "less than very well" (CNA need 3). Immigrant populations may be more likely to experience stigma around mental, emotional, and behavioral (MEB) health and may be less familiar with their communities' health resources.

To address the needs of individuals with co-morbid physical and behavioral health needs (CNA need 4), our PPS will pursue all three models described in the application: (1) physical co-location of behavioral health providers into primary care sites; (2) physical co-location of PCPs into behavioral health sites; and, (3) expanding implementation of Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model for depression across the PPS service area.

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 CNA findings and by leveraging existing capacity and expertise in providing Collaborative Care, the target population for all three models–(1) physical co-location of behavioral health providers into primary care sites; (2) physical co-location of PCPs into behavioral health sites; and, (3) expanding IMPACT–will be individuals ages 12 and older receiving care at HHC or SUNY primary care clinic sites, community-based BH sites, federally qualified health centers and diagnostic and treatment centers. Our PPS will focus on patients with serious mental illness (SMI) and serious emotional disturbance, taking into account those with high medical service utilization (see CNA need 4). These patients are overwhelmingly low- and moderate-income, with one-fifth (20.9%) below the FPL.

Co-occurring chronic diseases, including diabetes, COPD, asthma and cardiovascular disease are common among the target population. These populations also tend to have high ED and inpatient utilization. As such, our PPS will coordinate these efforts with activities occurring within 2.b.iii, 2.b.iv, 3.d.ii and 4.a.iii (see CNA needs 1, 4, 5).

Our PPS will prioritize integration among sites that meet the following criteria: achievement of 2011 Level 3 NCQA PCMH; patient population of at least 1,500, experience with either IMPACT or co-location, and location in areas with a high prevalence of BH diagnoses and/or documented barriers to access.

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.

Our PPS has a range of assets and resources that will enable us to achieve the goals of this DSRIP project. Our PPS will leverage the extensive experience and expertise of PPS members that have implemented IMPACT and co-location models. Sites participating in NYS's Medicaid Collaborative Care Program, part of the Hospital-Medical Home Demonstration Program, will build on this capacity to add SBIRT, invest in systems that address DSRIP patient tracking requirements, and facilitate the development of integrated treatment plans and service delivery information between primary care and BH clinicians. Some sites will serve adolescents and/or transition to an on-site service model.

Many of the sites within our PPS have achieved 2011 NCQA PCMH recognition and/or provide some degree of co-location and/or the IMPACT model for depression: 36 adult primary care sites have some form of co-location, of which 29 have 2011 NCQA Level 3 PCMH recognition; 37 of 54 pediatric sites have 2011 NCQA Level 3 PCMH recognition and one has received 2011 Level 2 PCMH recognition; and, 17 adult clinics and two family medicine clinics are in some stage of implementing IMPACT for depression, with the family medicine clinics having achieved 2011 NCQA PCMH Level 2 recognition.

Our PPS has strong provider- and community-based resources that will be mobilized to enhance access to behavioral and physical healthcare, improve health outcomes, and reduce inappropriate ED and inpatient utilization (see CNA needs 1, 4). Because of the work done to achieve PCMH recognition, sites will be ready to quickly implement components of this project to establish co-location and/or implement the IMPACT model.

The PPS also includes four Health Homes–HHC, CBC, CCMP, and CHN. Our PPS worked with these organizations throughout the planning period to lay the foundation of joint development of services, staffing and training standards. Their expertise in care management for individuals with BH issues and co-morbid conditions will be leveraged as needed during implementation planning and throughout the DSRIP performance period. Our PPS will also continue to enhance our relationships with CBOs in order to improve social determinants of health.

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.

While our PPS has a range of assets and resources to support implementation and operations, we anticipate a number of project challenges. We anticipate challenges with implementing co-location given that readiness varies across sites. We will address these challenges by developing more detailed approaches to transition existing Collaborative Care sites to co-location models. This will include a staged implementation and prioritizing sites that meet minimum criteria.

We also anticipate health IT challenges, including varying EHR capabilities, care management tools, and RHIO connectivity. To address this concern, we will develop an enterprise-wide care management platform that will support data sharing across the PPS. We will also help critical partners expand health IT/EHR/HIE capabilities to support linkages and data sharing across the PPS.

We expect that the process to gain consent to share patient information will be challenging. To address this challenge we will develop a process to obtain patient consent, and we will support the implementation of this process at all project sites.

Finally, we anticipate challenges around capacity to provide services (see CNA need 2). To address this challenge we will take a multi-pronged approach, including implementing one or more of the following strategies: increasing staffing levels, increasing hours, and contracting as needed. In addition, we will work to ensure appropriate use of psychiatrists so that psychiatrists treat the most serious BH disorders and stable patients are transferred to PCPs with psychiatric consultation available as needed.

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.

HHC has worked collaboratively with Bronx Partners for Healthy Communities and Community Care of Brooklyn to align project selection. During the January - March 2015 implementation planning period, we intend to collaborate further with our 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. Post-application, we intend to broaden this collaboration to other PPSs in our service area,

Additionally, a critical component of 3.a.i is the ability to share data not only within each individual PPS but also across PPSs to collect information about patients who may access care outside of our PPS network. We anticipate working collaboratively with other PPSs to address these issues during implementation planning.

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.

Capital funding will support space reconfiguration for sites that implement or expand co-located services.

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
SUNY Downstate	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
AHRC New York City	Developmental Disability Care Coordination Pilot (Part of an 1115 Waiver)	2014	2015	The purpose of this pilot is to provide MLTS without capitation (i.e., primarily care coordination) for people with intellectual and developmental disabilities.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract, including coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.
Harlem United (HU)/	Health Homes for Medicaid	2012	2018	Harlem United is a member of the CCMP-led Health

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Upper Room AIDS Ministry, Inc.	Enrollees with Chronic Conditions			Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes including HHC and VNSNY.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
FEGS Health & Human Services	Health Homes for Medicaid	2012	2018	FEGS is a NYS-designated Health Home in Nassau and

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Enrollees with Chronic Conditions			Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care to other disease states, beyond the focus areas supported by the H-MH program.

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

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

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

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

c. Detailed Implementation Plan: By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

d. Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

The prevalence of cardiovascular disease (CVD) among Medicaid beneficiaries in NYC far exceeds that of other chronic diseases. In NYC, 30% of Medicaid beneficiaries have been diagnosed with a cardiovascular related condition, while only 10% have been diagnosed with a respiratory related condition, 11% with a diabetes related condition, and 20% with a mental health related condition.

Heart disease is the leading cause of death and the second leading cause of premature death in the four boroughs that comprise our service area. In 2011, the age-adjusted CVD mortality rate per 100,000 was 249.3 in NYC and 242.3 in NYS.

The age-adjusted CVD hospitalization rate per 10,000 was 173.6 in NYC compared to 159.9 in NYS. Each borough has hot spots for CVD. Twenty-four UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for three Prevention Quality Indicator (PQI) measures related to CVD and risk factors (Circulatory Composite, Hypertension, Diabetes). Given that these neighborhoods encompass a large proportion (66%) of the Medicaid adult population, our PPS will enhance engagement efforts in these areas.

CNA focus groups identified concerns related to chronic conditions, including lack of sufficient information on health and health services. Other concerns included minimal knowledge, interest, and engagement in prevention services, and "a gap in primary care provider's ability to find specialists who are accepting Medicaid or different kinds of insurance."

Major CVD risk factors include hypertension (HTN), diabetes, hyperlipidemia, and smoking. Neighborhoods across NYC had a risk-adjusted O/E ratio for the HTN PQI measure greater than one: Manhattan (9 neighborhoods), Brooklyn (6 neighborhoods), the Bronx (7 neighborhoods) and Queens (3 neighborhoods). Similarly high risk-adjusted O/E ratios (i.e., greater than one) were identified across NYC: Manhattan (8 neighborhoods), Brooklyn (6 neighborhoods), the Bronx (7 neighborhoods) and Queens (2 neighborhoods). The CNA noted that diabetes is considered by many residents and key informants to be the most significant health issue in Brooklyn.

To address these gaps, our PPS will pursue a multi-pronged approach, with a focus on the ABCs of the Million Hearts Campaign. This includes improving prescribing and adherence to aspirin prophylaxis among eligible patients, improving blood pressure control by updating and strengthening implementation of HTN guidelines, improving cholesterol control by updating current cholesterol management and treatment guidelines, and increasing smoking cessation by enabling PCPs to distribute nicotine replacement therapy at the point-of-care (see CNA needs 1, 5). Our PPS will also focus on improving diabetes control using the Collaborative Care Model, currently used for depression (see CNA need 5).

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

Our PPS expects to engage the following patient population: all uniquely attributed adult patients (ages 18+ years) with cardiovascular conditions based on a defined set of ICD-9 diagnosis codes. The project will intensify efforts in medical and professional shortage areas, and the 24 UHF neighborhoods where three risk-adjusted O/E ratios for PQI measures related to CVD and risk factors (Circulatory Composite, Hypertension, Diabetes) are greater than one. This includes the following neighborhoods: Bedford/Stuy/Crown Heights, Fordham/Bronx Park, Crotona/Tremont, Highbridge/Morrisana, Washington Heights/Inwood, Pelham/Throgs Neck, Flatbush/E. Flatbush, Jamaica, Williamsburg/Bushwick, East New York, Hunts Point/Mott Haven, Central Harlem/Morningside Heights, NE Bronx, Canarsie/Flatlands, East Harlem, Downtown/Heights/Slope, Rockaway, Stapleton/St. George, Chelsea/Clinton, Upper West Side, Kingsbridge/Riverdale, Upper East Side, Lower Manhattan, and Gramercy Park/Murray Hill. Project efforts will coordinate with 2.d.i activities to engage low- and non-utilizers.

The PPS will leverage and enhance use of clinical patient registries and care coordination/management platform to identify patients to engage based on health risk and socio-economic factors (see CNA needs 3, 5). Among the 24 targeted neighborhoods, the 10 poorest have 26-43% of the population below 100% FPL. These 10 neighborhoods also have 13%-26% who are non-U.S. citizens, 7%-38% who speak English "less well," 20%-44% of adults with less than a high school education, and 9%-17% who live with a disability.

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.

Our PPS will pursue a multi-pronged approach to help achieve the goals of this DSRIP project, with a focus on the ABCs of the Million Hearts Campaign and diabetes control. Existing assets and resources include: HHC's successful Treat to Target program; the NYS Quitline and NYC Treats Tobacco to support smoking cessation activities; health IT components, such as clinical registries, to track patients across a number of indicators; Stanford's evidence-based Chronic Disease Self-Management Program which educates patients regarding self-management activities; and, community-based partners with expertise addressing socio-economic risk factors (e.g., housing, education, transportation).

Using these assets and resources as a foundation, our PPS will first improve the prescribing of and adherence to aspirin prophylaxis among eligible patients. We will disseminate guidelines and leverage clinical registries to identify eligible patients not taking aspirin.

Second, we will improve blood pressure control by using and expanding existing clinical registries to identify patients needing follow-up care, to monitor blood pressure and strengthen implementation of HTN guidelines. Blood pressure checks will be available on a drop-in basis without a co-pay. Additional clinic personnel will be trained to take blood pressure measurements.

Third, the PPS will update current cholesterol management and treatment guidelines with recent changes in recommendations, and followed by wide dissemination and implementation. Further the PPS will use assets such as clinical registries to identify patients needing follow up and track cholesterol control rates over time.

Fourth, we will improve diabetes control. Existing assets include diabetic group classes and experience implementing the Collaborative Care Model for depression, which we intend to expand to include controlling A1c, blood pressure, and LDL.

Fifth, we will increase smoking cessation efforts by enabling PCPs to distribute nicotine replacement therapy at the point-of-care, which removes a co-pay and a pharmacy trip. We are also redesigning smoking-specific EHR measures to meet Meaningful Use standards and to be more provider-friendly. This will facilitate follow-up and referrals to the NYS Quitline, and will connect patients with additional resources. We will strengthen its partnership with New York City Treats Tobacco to obtain technical assistance and provide trainings on best practices to multi-disciplinary teams that provide smoking cessation services in PPS facilities.

To support the project, the PPS will train staff in guidelines and new roles. A newly developed CSO will house the PPS's care management services. The CSO will develop common job descriptions, clinical protocols, metrics and other services, as needed.

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.

We anticipate a number of challenges in implementing this initiative. First, PCPs may find it difficult to reach clinical targets. To address this challenge we will provide clinical protocols, continually assess fidelity to standards, and institute corrective actions. Our extensive capacity in cardiac specialty care will be available to high-risk or complicated patients who need more intensive management.

We also expect difficulties with effective engagement of chronically ill patients over the long term, particularly with regard to behavior change. To address this challenge we will deploy peer educators and care managers to support patients, with heavy reliance on the recommended evidence-based Stanford Model.

MCO policies that are contrary to project goals (e.g., prohibition on 90-day refills and fixed dose combination pills) will present challenges. To address this challenge, we will work with MCOs to encourage policy changes that promote medication adherence. Care managers and pharmacists can also help with medication adherence.

Finally, we expect to face challenges associated with recruiting and training sufficient care management staff. To address these challenges we will work with community colleges and local partners to develop a pipeline of care management staff. We will train nurses and other members of the care team, as appropriate, to help patients with self-management.

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.

We are collaborating with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB) to align project selection and begin joint project planning. During the January-February 2015 implementation planning period, we intend to collaborate further with our 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, a critical component of the CVD project is the ability to share data not only across each individual PPS but also between PPSs in order to quickly receive information on PPS patients who may visit a clinical setting outside of the PPS' network. We plan to discuss IT implementation as part of our PPS collaboration and expand these discussions with other PPSs in the service area. Areas for additional collaboration include, but are not limited to, issues such as selection and adoption of common screening tools across PPSs, common risk stratification models, adoption of common core partner contracting vehicles, and coordinated HIE initiatives.

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 enhance IT systems with needed capabilities. This will require establishing enhanced data connectivity through the RHIO and other HIE capabilities. Funding will support: functionality for secure notifications/messaging; work with PCPs to meet Meaningful Use and PCMH Level 3 standards; enhancing care coordination/management platforms that include functionalities to target patients with CVD or significant risk factors and that capture social determinants of health; and, establishing electronic communications with patients and CBOs to support coordination of clinical and social services.

Technology needs include: (1) hardware to improve access to enhanced software systems (e.g., second computer monitors to compare information from different systems) and large computer screens to review EHR, registry and other data during quality improvement, population health management and patient case meetings; (2) equipment to enhance communication

with patients (e.g., secure smartphones phones for staff to call and email patients, laptops/tablets for staff or community health workers visiting patients); (3) hardware for video conferencing with patients as needed; and, (4) telemonitoring capacity for patients and providers. Telemonitoring will include electronic activity monitoring devices (e.g., blood pressure cuffs, glucometers, scales, fitbits, medication dispensers) and connectivity to PPS health IT systems.

Construction or renovation of existing space for patient friendly and accessible wellness centers (e.g., purchase of health kiosks to offer culturally competent education on disease management, blood pressure checks, and patient navigator support to access a PCP during and after hours, and availability of specialized programs; clinic space with room for a nurse manager to conduct patient visits and to follow-up with patients via phone or electronically; to add rooms and needed equipment for nurse manager visits and community health worker counseling; and, clinic space for community health worker and peer coaching/counseling sessions).

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health Home				
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association /Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/	Health Homes for Medicaid Enrollees with	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Postgraduate Center for Mental Health	Chronic Conditions			Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/ Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				enrolled in HU's Health Home program.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

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>scale of project implementation,</u> <u>completion of project requirements</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.

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.

The CNA revealed an average Medicaid pediatric asthma rate of 412.3 cases per 100,000. The Observed/Risk Adjusted Expected ratio ("risk-adjusted O/E") of pediatric asthma across NYC is 1.23 and 1.24 in our service area. Fifteen neighborhoods exceeded 1.23: Brooklyn (Bedford/Stuy/Crown Hts, Flatbush/E. Flatbush, Canarsie/Flatlands, E. New York); Manhattan (Central Harlem/Morningside Heights, E. Harlem, Upper W. Side); Bronx (NE Bronx, Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, Fordham/Bronx Park); and, Queens (Rockaway, SE Queens, Jamaica).

For asthma among younger adults (18-39 years), the risk-adjusted O/E in NYC is 1.20 and 1.22 in our service area. Seventeen neighborhoods exceeded 1.20: the Bronx (Highbridge/Morrisania, Hunts Point/Mott Haven, Crotona/Tremont, NE Bronx, Fordham/Bronx Park, Kingsbridge/Riverdale, Pelham/Throgs Neck); Manhattan (Central Harlem/Morningside Hts, Washington Hts/Inwood, E. Harlem, Chelsea/Clinton); Brooklyn (Canarsie/Flatlands, Bedford/Stuy/Crown Hts, Flatbush/E. Flatbush, E. New York, Williamsburg/Bushwick); and, Queens (Rockaway).

For COPD or asthma in adults ages 40 and older, risk-adjusted O/E for NYS is 1.04, 1.05 for NYC and 1.06 in our service area. Twenty neighborhoods exceeded 1.05: Manhattan (Central Harlem/Morningside Hts, Washington Hts/Inwood, Upper W. Side, E. Harlem, Chelsea/Clinton); Brooklyn (Flatbush/E. Flatbush, Bedford/Stuy/Crown Hts, Canarsie/Flatlands, E. New York, Williamsburg/Bushwick, Downtown/Heights/Slope, Greenpoint); the Bronx (NE Bronx, Highbridge/Morrisania, Crotona/Tremont, Hunts Point/Mott Haven, Fordham/Bronx Park, Pelham/Throgs Neck, Kingsbridge/Riverdale); and, Queens (Rockaway).

The CNA links asthma prevalence and associated utilization to poor environmental conditions (e.g., housing, pollution) and other social determinants of health. The CNA notes that areas with high rates of serious housing violations and rat sightings overlap with high respiratory PQI hospitalizations and asthma-related utilization. In the Bronx, for example, asthma is among the most significant health concerns commonly attributed to indoor and outdoor environmental conditions. Similarly, 35% of CNA survey respondents from Upper Manhattan selected asthma as one of the biggest health concerns. Poverty is also an important factor in asthma prevalence; poor households are more likely to have potential triggers (e.g., pest infestation, mold).

Our PPS selected 3.d.ii because of the opportunities to improve health outcomes (see CNA need 5). The initiative will include: development of a uniform, evidence-based approach to ensure that the target population is provided with a range of home-based services (e.g., self-management education, home environmental evaluation and strategies for remediation, linkages to social services); procedures to provide, coordinate and link patients to resources for evidence-based trigger reduction interventions (e.g., changing indoor environment to reduce exposure to asthma triggers); development of evidence-based curricula for providers and staff; and, bidirectional care pathways supported by a range of health IT functionality.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography,

disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

Our PPS intends to engage the following population: patients with new or existing diagnoses of asthma who reside in our service area (see CNA need 5). The initial implementation will focus on engaging patients ages 0 – 18 with asthma (and their families) in the following neighborhoods: South Bronx, Northern Manhattan and North Central Brooklyn. As part of the intervention, we will identify patients with two or more ED visits in the last six months and will conduct enhanced outreach to this population (see CNA need 1).

After initial implementation, our PPS will leverage our experience and expand engagement activities to other geographical areas, focusing first on other neighborhoods in Brooklyn and the Bronx with higher ED and inpatient rates and also on other age groups. As with the pediatric population, the PPS will conduct enhanced outreach to patients with two or more ED visits in the last six months.

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.

Our PPS has a range of assets and resources to support this project. Woodhull Medical and Mental Health Center, a hospital in our PPS, is one of 13 organizations in the country selected by the National Asthma Control Initiative – National Institute of Health as a demonstration project for the effectiveness of the most recent national guidelines for asthma management. As part of this project, Woodhull will develop and expand its Physician Asthma Care Education Reinforcement (PACER) program to serve as a model to overcome barriers to guideline-based medical care. Woodhull was also identified as the "Provider Spotlight" for NY State in a recent national publication by the Centers for Disease Control and Prevention (CDC): Asthma Self-Management, Education and Environmental Self-Management: Approaching to Enhance Reimbursement. In addition to Woodhull's exemplar program, it has an asthma registry to help identify and track patients with asthma.

HHC also has long-standing relationships with DOHMH, developing and implementing programs like Asthma Friendly School Guidelines, Managing Asthma in Daycares, Use of Community Health Workers for Asthma Self-Management Education, and leveraging their "Healthy Homes" program which is anticipated to play a key role in identifying home environmental triggers and developing mitigation strategies. HHC is also an active participant in regional asthma coalitions (e.g., North Brooklyn Asthma Action Alliance, R.E.S.P.I.R.A.R.) and will leverage this involvement to support ongoing work to learn promising practices and improve coordination.

Our PPS also intends to enhance existing and develop new collaborations with entities such as the NYC Departments of Education, Aging and Housing Violations, the NYC Office of School Health, public schools, the YMCA, pharmacies, day care organizations, senior centers, and other CBOs. These relationships will help to promote education and training around asthma, awareness, and allow for other areas of collaboration. For each type of organization, our PPS will set standards for communication by including information tailored to specific exchanges (i.e., discharge

communication to PCPs will have a set of required data elements, referral/coordination with Health Homes will have required set of information).

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.

Based on previous work, our PPS anticipates a number of challenges. First, we will require additional staffing and infrastructure to scale up existing asthma home-based activities within the PPS. To address this challenge, we intend to develop a strategy to recruit and train community health workers. We may also seek to leverage the workforce of other CBOs to augment existing capacity.

We also anticipate that patient retention in home-based programs may be challenging. To address this concern we will consider patient incentives related to trigger remediation (e.g., pillow cases, shower curtains, etc.) in order to improve retention.

Language and cultural barriers could impact our ability to identify and engage patients (see CNA need 3). We will address this concern by ensuring that training provided to community health workers emphasize the importance of meeting the culture and language needs of the population.

We will work closely with CBOs to implement this initiative and we know there are varying health IT capabilities. As such, we expect to identify core health IT capabilities (i.e., using an electronic asthma action plan) and work with partners to develop these capabilities.

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.

As part of planning activities to date, our PPS has collaborated with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and identifying areas for collaborate during implementation and operations. We have also jointly reached out to CBOs with expertise providing asthma home-based management services to discuss augmenting capabilities in order to meet the needs of our population.

During implementation planning, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; adopting common core partner contracting vehicles; developing workforce strategy, including common job descriptions and functional capabilities; coordinating workforce training efforts; identifying data sharing issues; and, selection of culturally competent patient education resources to support this project.

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

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:

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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.

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
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Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Chronic Conditions			care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children- and family-focused agencies that provides Health Home services for children.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/ Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				to 300+ patients by 2016.

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.

Although this home-based asthma program intervention does not include a comprehensive care management component, the experience and capacity of our participating Health Homes and downstream care management and care coordination agencies will help ensure that this intervention is part of a broader patient-centered care management plan.

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.

3.g.i Integration of Palliative Care into the PCMH Model

Project Objective: To increase access to palliative care programs in PCMHs.

Project Description: Per the Center to Advance Palliative care, "Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment." (http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc)

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.

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. Integrate Palliative Care into appropriate participating PCPs that have, or will have achieved NCQA PCMH certification.
2. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT 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.

Palliative care helps to improve the quality of life of patients with a serious or life-threatening disease, with the goal of managing symptoms, side effects and related psychological, social, and spiritual problems. Each hospital within our PPS offers palliative care services to support patients and families in learning to manage symptoms, relieve pain, plan medical treatment and improve quality of life.

The CNA reported that 47,464 Manhattan residents were hospitalized with at least one chronic disease that could benefit from palliative care services. The majority of these hospitalizations were for adults over 65 years old.

There are five facilities, 67 physicians, and three nurse practitioners in Queens that offer pain management services to the uninsured and Medicaid populations. There are also eight hospice programs and six organizations that offer additional palliative care services. In Brooklyn, there are 12 facilities offering pain management services to the uninsured and Medicaid populations and 23 organizations offering hospice services. In the Bronx, there are seven facilities offering pain management and 30 facilities providing hospice services. These facilities include nursing homes, health centers, and hospitals. While these resources are important, patients and families need more tools, particularly in the primary care setting, to support their chronic illness and resulting palliative care needs.

The CNA noted that the prevalence of chronic conditions that benefit from palliative services is higher than the availability of such services. Given the aging population, this disparity is likely to worsen. For example, by 2020, 11.7% and 13.6% of Queens and Manhattan residents respectively will be 65 or older. By 2030, those percentages increase to 14.5% and 16.1%. Giving the aging of the population, this disparity will likely worsen as the prevalence of conditions suitable for palliative care increase with age.

Our PPS's approach to develop new or expand existing palliative care resources begins with increasing the availability of palliative care in the PPS service area by developing and deploying training and education for PCPs and staff on palliative care. Using evidence-based guidelines, the training will address: the importance of collecting advance directives and health care proxy data from patients; communication with patients around their palliative care needs (e.g., pain management); and, the transition from primary palliative care to specialty palliative care, including the establishment of referral criteria (see CNA need 1).

Our PPS will develop and implement an automated data collection and a tracking mechanism to follow palliative care initiatives across the PPS. The PPS will also work with Medicaid Managed Care (MMC) plans to identify issues related to coverage and provider networks, and develop written agreements with MMC plans on coverage and adequacy of palliative care services and networks, including hospice 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.

We expect to engage the following patient population: attributed patients, ages 18 and over, who are eligible for a primary palliative care intervention. The PPS has defined eligibility based on a series of ICD-9 codes associated with chronic diseases that could benefit from palliative care services (e.g., metastatic solid tumor cancers, advanced depression, COPD, generalized pain, stroke). In addition to having one of these diagnoses, the patient population will meet one at least one of the following utilization criteria: one hospitalization in a year, one ED visit in a year, and/or 3 or more outpatient visits in three months or 12 or more outpatient visits in 12 months (see CNA need 1).

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.

Our PPS has a range of assets and resources to help achieve the goals of this DSRIP project. There are palliative care teams in each of our PPS's 12 hospitals. Their expertise has informed the development of our approach and will continue to support its implementation, in particular by evaluating existing curricula and developing trainings for health care providers and their staff. Our PPS has 26 providers who are board-certified in palliative care or who have certifications pending. Outpatient palliative care services are provided at the following PCMH-recognized clinics in our service area: Bellevue, Metropolitan, Kings, Lincoln. In addition, University Hospital of Brooklyn has a palliative care clinic which providers services one session per week. Coney Island Hospital has a 19-bed Pain and Symptom Control Palliative Care Unit which can offer lessons learned around care coordination for patients receiving palliative care services.

Our PPS also has resources to support the development of a palliative care curriculum and training for providers and other members of the care team. This includes the expertise of SUNY Downstate Medical Center which has the capability to establish a fellowship program for physicians and certificate programs to train physicians, nurse practitioners, nurses, social workers, and other allied health professionals. In addition, there are palliative care organizations currently developing curricula for generalist palliative care that may provide a foundation for the education and training component of this intervention.

We also intend to leverage the capacity and expertise of our partners, with whom we have well-established relationships. This includes hospices operated by HHC's skilled nursing facility, Metropolitan Jewish Hospice and Homecare, Visiting Nurse Service of New York (VNSNY), Cavalry, and Rosary Hill. Rosary Hill is particularly valuable in that they provide inpatient end of life care for the undocumented. We will also work closely with VNSNY and their Compassionate Care Program.

HHC operates a Palliative Care Council that serves as a forum to facilitate the introduction of the principles and practice of palliative medicine and to advance the field of palliative care through innovation, education and research. For the purposes of this project, the Council can focus on integrating palliative care into PCMH clinical practice and could be used as a forum to address palliative care for all PPSs in our service area. HHC also has "PallTrack" which provides data on inpatient referrals within the HHC system. Combined, these resources have helped to inform the design of this intervention, and will continue to be of value during implementation planning.

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.

We have identified a number of challenges or anticipated issues that we intend to address. First, PCPs and their staff may be challenged to incorporate palliative care into their everyday clinical practice. This is due to sometimes short patient visits, workflow changes and data collection (e.g., advanced care directives), managing care transitions, and the need to establish new referral patterns. Our PPS will alleviate this burden by providing standardized training and materials to both providers and other members of the care team, as well as making available an enterprise-wide care management platform. In addition, we will explore the possibility of hiring specially trained physician extenders to support patients' palliative care needs.

Our PPS has also identified potential capacity issues vis-a-vis the availability of specialty palliative care. To address this, we will analyze capacity issues and develop a plan to bridge the gaps.

Finally, we anticipate challenges in managing handoffs between primary palliative care and specialty palliative care. Our PPS will determine the optimal processes for partners to track referrals made to palliative care from the inpatient or outpatient/community setting. In addition, providing training to members of the care team regarding handoffs will be crucial.

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.

We intend to work with all PPSs in NYC that have selected this intervention in order to coordinate approaches. As part of planning activities to date, our PPS has collaborated with Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and beginning identifying areas for collaboration during implementation and operations.

Through implementation planning, we expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; development of workforce strategy, including common job descriptions and functional capabilities;

workforce training efforts; data sharing; and selection of culturally competent patient education resources.

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

HHC will also make available the Palliative Care Council as a forum for cross-PPS coordination within NYC. This would enable palliative care teams from all PPSs to leverage the expertise of the Council and also to have a forum to coordinate and collaborate with peers to support the development of common materials and approaches.

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.

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
New York City Health & Hospitals Corporation (HHC)	NYS Hospital-Medical Home Demonstration Program	2011	2015	The purpose of this program is to improve the coordination, continuity, and quality of care for individuals receiving primary care services in outpatient primary care settings.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.

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.

The Hospital-Medical Home (H-MH) Demonstration Program supported many of our PPS facilities in achieving NCQA 2011 PCMH recognition and in implementing Collaborative Care. As part of DSRIP, we will build on this expertise to support these facilities in meeting 2014 Level 3 recognition. Our PPS will also expand the use of Collaborative Care beyond the focus areas supported by the H-MH program, such as training around palliative care.

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

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

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

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards <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.

Domain 4 Projects

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems (Focus Area 3)

Project Objective: This project will help to strengthen mental health and substance abuse infrastructure across systems.

Project Description: Support collaboration among leaders, professionals, and community members working in MEB health promotion to address substance abuse and other MEB disorders. MEB health promotion and disorders prevention is a relatively new field, requiring a paradigm shift in approach and perspective. This project will address chronic disease prevention, treatment and recovery, and strengthen infrastructure for MEB health promotion and MEB disorder prevention. Meaningful data and information at the local level, training on quality improvement, evaluation and evidence-based approaches, and cross-disciplinary collaborations need to be strengthened.

Project Requirements: The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

1. Participate in MEB health promotion and MEB disorder prevention partnerships.
2. Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.
3. Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
4. Share data and information on MEB health promotion and MEB disorder prevention and treatment.

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

Entity Name

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

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

   a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the

findings from the Community Needs Assessment with the project design. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

In NYC, high rates of substance abuse, addiction, poor mental health, and serious psychological distress contribute to high, and often preventable, health system costs (see CNA need 4). Nearly one-third of NYC residents reported moderate or severe psychological distress in the CNA. More than 9% of Medicaid beneficiaries have been diagnosed with an SA-related condition in: six neighborhoods in Manhattan (including Chelsea-Clinton and East Harlem), three in the Bronx (including Hunts Point/Mott Haven and Crotona-Tremont), and two in Brooklyn (Bedford/Stuy/Crown Heights and Downtown/Heights/Slope).

CNA data also showed high levels of utilization of MHSA services in NYC, which are also reflected in ED visits and inpatient admissions for MHSA issues. Citywide, 42% and 58% of Medicaid beneficiaries with MH and SA diagnoses had at least one ED visit, with an average of 2.98 and 4.34 ED visits, respectively.

Gaps in care are pronounced, as approximately half of CNA respondents noted that SA services were unavailable. Gaps are compounded by provider shortages, limited provider training in MHSA issues, and silos between provider types and programs that prevent coordination. Patients who have co-occurring MEB conditions often do not receive appropriate diagnosis, treatment, and care coordination. Also of concern is the lack of attention to adolescents, a vital group to engage in prevention and early intervention efforts.

To close these gaps, our PPS, together with CCB and BPHC, will undertake sector projects 1-3 with the goals of: promoting evidence-based practices in MHSA care; breaking down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and, targeting adolescents with MHSA education and outreach (see CNA need 6).

Under Project 1, the PPSs have established, and committed via a Charter, to a citywide MHSA Workgroup that will bring together a cross-section of MHSA providers to develop infrastructure and programs to transform MHSA services across NYC, and to develop a methodology to assess programs' impact on MHSA service utilization and care.

Collaborating with State and City agencies as appropriate, the Workgroup will identify and promote evidence-based programs that extend the reach of education, screening, and early intervention into existing health service footprints. In one such program, the Workgroup will adapt or develop culturally-sensitive educational materials (see CNA need 3) that inform adolescents about the nature of and risk factors for MHSA diseases (i.e., the fact that diseases frequently co-occur and begin during adolescence) and early warning signs.

Under Project 2, the PPSs will support the adaptation of the Collaborative Care (CC) model, which was designed to target adults and has demonstrated less clinical efficacy in adolescents, to specifically meet adolescent needs. The group will evaluate successful adaptations of the CC

model for adolescents, such as Reaching Out to Adolescents in Distress (ROAD) (see CNA need 6.)

Under Project 3, all activities and programs will consider cultural and linguistic factors, including: differences in views regarding mental health and use of addictive substances; intra-cultural issues; circumstances linked to MEB health such as trauma/violence; and, language access-related issues (see CNA need 3).

Our PPS will also coordinate its activities with work under Project 3.a.i., Integration of Primary Care and Behavioral Health services, and identify options to deliver services in community-based settings (e.g., withdrawal management).

While our PPS is not undertaking project 3.a.iv – Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs, the CNA has identified a need for these services and our PPS will explore whether and how we may be able to develop these capabilities in the future.

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

Our PPS expects to engage the following populations: all attributed patients ages 12 and above with MEB health diagnoses or substance use disorders (SUDs), as well as those at high-risk for developing SUDs, other MEB health diagnoses, and other health and social consequences linked to risky substance abuse and MEB needs (see CNA needs 4, 6.)

Specific targeted sub-populations include adolescents ages 12 - 25, a critical group for prevention and early intervention efforts given that up to 20% of adolescents experience an episode of major depression by age 18, yet few receive evidence-based treatment for their depression. In NYC, 32.9% of Medicaid beneficiaries are under age 19, according to the CNA, and key experts consulted in the CNA reported significant gaps in MHSA care in NYC for adolescents.

We will also engage the criminal justice re-entry population, which has dramatically heighted MHSA needs upon release and is a focal population of Mayor DeBlasio's administration (DeBlasio is dedicating $130 million over the next four years to address this population's health needs).

Lastly, we expect to enhance outreach to dual-eligibles and Medicaid patients with MH and SA diagnoses in geographic areas with heightened need for and utilization of MH and SA services based on CNA and focus group data. Collaborating with partner PPSs, we plan to emphasize work in "hot spot" areas such as Rockaway, Crotona-Tremont and Hunts Point-Mott Haven in Queens, East Harlem and Chelsea-Clinton in Manhattan and Crown Heights and Bushwick-Williamsburg in Brooklyn. Census data indicated that 17.7% of NYC's population consists of non-U.S. citizens and

23.2% of persons speak English "less than well." Based on the composition of the PPS's attributed population, we will work to ensure that all interventions and approaches are culturally sensitive.

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

We have a number of assets and resources to support our effectiveness in this project. First, we have extensive experience in delivering services to this population, given that our PPS provides more than 30% of inpatient detox and more than 41% of mental health inpatient care in NYC. We also have a significant foundation of MHSA providers and community programs upon which to build. Across NYC, there are 49 general psychiatrists and 231 social workers per 100,000 residents. The distribution of these professionals varies by neighborhood (e.g., Fresh Meadows in Queens has no psychiatrists that accept Medicaid patients). There is a wide range of MHSA programs throughout NYC, including mental health residential programs, mental health outpatient programs, alcohol and drug use services, and youth-targeting programs.

NYC's broader mental health support infrastructure is also extensive, with supportive case management programs and targeted case management programs serving patients with mental health needs. We work closely with programs such as Parachute NYC which provides alternatives to hospitalization for people experiencing emotional crises. In addition, organizations like the National Alliance on Mental Illness - NYC (NAMI-NYC) provide critical advocacy and education services that will inform our activities.

Despite this strong base of providers, as documented in CNA focus group, many programs have operated in silos and there has been no citywide coalition to promote much-needed MHSA infrastructure development. Through the Workgroup, we will convene key stakeholders (e.g., providers, payers, subject matter experts) to adapt, develop and disseminate resources such as training materials and educational programs. The Workgroup will also develop approaches to assessing progress. There are successful models of adolescent-focused CBO activities to explore and consider adapting, including the Turnaround for Children program, the Peer Health Exchange's peer-based mentoring, YMCA wellness programs, and middle- and high-school-based health curricula that could be expanded to more robustly address MHSA prevention and early intervention. In developing educational models for adolescents and adults (e.g., parents, teachers) on MHSA needs, our PPS will aim to develop and support partnerships among health professionals, CBOs, and/or middle and high schools that have strong experience in this arena, including the aforementioned programs.

MHSA project activities are also intended to support new and existing sites that are implementing the Collaborative Care/IMPACT model under project 3.a.i. Many clinics within our PPS have implemented this model. While valuable, the model almost exclusively targets adults and does not include the use of SBIRT. PPS partners will explore opportunities to develop and pilot adolescent-targeted adaptations of the Collaborative Care model using developmentally sensitive

materials and structured involvement of adolescents and parents in education and treatment (e.g., the ROAD model). These activities will enhance our ability to deliver services through the IMPACT model to a broader population.

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.

We anticipate a number of project challenges. First, there is a lack of patient education and engagement around risk factors, causes, and treatments for MHSA disorders (see CNA need 6). In many communities there are significant obstacles to care (e.g., misunderstanding of diseases, stigma associated with MHSA disorders, insufficient social supports). Parents of adolescents may also be reluctant to actively engage in MEB health promotion efforts due to their own biases or constraints. To address these concerns, MEB health promotion programs will need to be culturally responsive, particularly for ethnic minorities and immigrant populations, in order to effectively serve the target population. We will also work closely with community programs (e.g., the Arthur Ashe Institute) to address these concerns, looking for peer leaders and others to facilitate patient engagement and break down pronounced barriers to care.

There are also challenges in targeting adolescents with MHSA services, given that not all adult-appropriate MHSA models can be seamlessly applied to adolescents. To address this challenge we will develop adolescent-specific adaptations of the Collaborative Care model. This process will include the evaluation of practices that have reported success in reaching adolescents with similar demographics and needs as those in our service area. Further, to develop adolescent training materials that are used in a schools or other setting, we will consider evidence-based models such as peer-mentor programs and programs that leverage social media outlets to disseminate messages.

Finally, we are challenged by the fact that MHSA services are often siloed. As such, we will need to emphasize coordinating and integrating care through active prevention efforts, routine screenings to assess co-occurring conditions, and developing comprehensive treatment plans. Through the Workgroup, and in collaboration with State agencies, our PPS will identify particular obstacles to care coordination and then work to remedy those deficits.

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.

Throughout the DSRIP planning process, our PPS has participated in various MHSA joint planning sessions with CCB and BPHC to achieve consensus on the selected Sector Projects 1-3, with the goals of: promoting evidence-based practices in MHSA care; breaking down silos in care to

enable health professionals to collaborate and address the population's full range of MHSA needs; and, targeting adolescents with MHSA programming.

Through the citywide MHSA Workgroup, and guided by the Workgroup Charter, the PPSs have agreed to select this MHSA Infrastructure Project and align key programs related to its implementation. Specifically, we will bring together a cross-section of MHSA leaders in the citywide Workgroup to develop programs and resources under Sector Projects 1-3 that can more comprehensively support MHSA infrastructure. The Workgroup will research and propose evidence-based models to implement across NYC and its boroughs, with the models subject to borough-specific tailoring with sensitivity to social and cultural factors. Further, we will collaborate to review and expand upon existing Collaborative Care trainings to more appropriately address adolescent groups. And, consistent with Sector Project 3, all resources and programs will be culturally responsive in order to meet the needs of NYC's diverse communities.

During the 2015 implementation planning period, we intend to continue further collaboration with PPS partners and stakeholders to ensure alignment and coordination of standardized protocols, development of workforce strategies, workforce training efforts, and selection of culturally responsive patient education resources to support this project. We will also collaborate with other PPSs that have selected this project.

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.

Important implementation milestones:

Leadership & Coordination: Organize structure for citywide Leadership Workgroup meetings and identify participants and organizers (Q1/Q2 DY1); convene Workgroup meetings (Q3/Q4 DY1)

Gap Analysis: Review existing programs and CBOs to identify gaps and strengths (Q1/Q2 DY1)

Adolescent-Targeted Programs: Review evidence-based models to adapt the CC model (Q3/Q4 of DY1); develop curriculum (Q3/Q4 DY2); share curriculum with PPSs to integrate into the CC model (Q1/Q2 DY3); identify Dept. of Education contact; develop/implement school-based curriculum (Q1/Q2 DY3)

Adult-Targeted Programs: Review and revise educational materials and outreach initiatives targeting ethnic groups and high-impact neighborhoods, as needed (Q3/Q4 DY2); launch initiatives (Q1/Q2 DY3)

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
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan (HARP)	2015	Ongoing	Creation of HARPs for the severely mentally ill population.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
Arms Acres and	Health Homes for Medicaid	2014	2018	Arms Acres and Conifer Park provide services to NYS

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Conifer Park	Enrollees with Chronic Conditions			Medicaid Health Homes under subcontract, including coordination of behavioral health services for patients with chronic medical and behavioral conditions.
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
Comunilife	SAMHSA Treatment for Homeless	2010	2015	Comunilife provides supported enriched housing services for homeless persons with serious and persistent mental illness (SPMI).
Community Health Project, Inc. d/b/a Callen-Lorde Community Heatlh Center	Health Homes for Medicaid Enrollees with	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Currently, Callen-Lorde has been assigned approximately 150

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
	Chronic Conditions			patients of whom 85 are actively enrolled. The program is growing, with two new Health Home positions anticipated to open in the next two months. The program will scale up to 300+ patients by 2016.
Harlem United (HU)/ Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
				between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently eligible for Health Home services.
The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. HARP service providers and behavioral health enrollees are likely to participate in this project. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

Funding provided through the SAMHSA Treatment for Homeless program is not duplicative of activities described in DSRIP because our PPS does not intend to provide supported enriched housing to persons with serious and persistent mental illness through the MHSA 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.ii Increase 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
Adolescent AIDS Program
After Hours
Amida Care
Heartshare Human Services
HEAT Program
HousingWorks
St. John's Riverside Hospital

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.

The HHC CNA identified HIV/AIDS as a significant population-wide public health issue across NYC (see CNA need 6). Of the 42 neighborhoods in NYC, 23 (55%) have HIV prevalence levels at or above 1%, the level indicating a generalized HIV epidemic. In our PPS, the rate of HIV/AIDS in the Medicaid population is 1.4%, with the highest prevalence in Manhattan (2.1%) and the Bronx (1.9%). In 2012, 3,141 persons were newly diagnosed with HIV in NYC. In the same year, 1,889 individuals were diagnosed with late-stage HIV disease, AIDS. Thirty-two percent of AIDS diagnoses were made within 31 days of initial HIV diagnosis. This indicates that these individuals went undiagnosed and untreated, to the detriment of their personal health and potentially to others. The rate of viral load suppression—a key factor to reduce the transmission of HIV—in NYC is 61.2%, slightly lower than NYS (62.2%).

Co-occurrence of HIV with hepatitis, chronic illness, mental illness and SA creates a greater burden of disease and complicates prevention, care and treatment. The communities with the highest HIV burden also have a high proportion of poverty, and the lower survival rates among people with HIV correlate to communities with high levels of poverty. Additional HIV risk factors identified in the CNA include individuals who are foreign born, Black or Hispanic, and men who have sex with men (MSM). This demonstrates a need for more culturally and/or linguistically sensitive outreach strategies. Given the high level of co-morbidity and significant health disparities facing this population, the challenges patients with HIV experience provide a clear example of the need for healthcare delivery system reform.

Given the scope of the issues involved, seven PPSs in NYC are engaged in joint planning. Via a charter agreed to by our PPSs, we intend to continue this commitment through implementation planning and operations to address major gaps in access to, and retention in, HIV care. The PPSs, the NYC Department of Health and Mental Hygiene (DOHMH) and community partners are using DSRIP as an opportunity to develop common approaches and resources that can be used to achieve project goals and objectives.

The PPS HIV Collaborative identified common sectors from the Project Requirements, and developed a common list of interventions to address those sectors. The common sectors that our PPS will collaborate on are: 1, 2, 3, 4, 5, 7, and 9. Six interventions have been identified from the common list to address the identified needs of our target population and respond to these seven sectors.

The interventions chosen mirror the NYS AIDS Institute's priorities, the NYS Prevention Agenda, the CDC Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention, and interventions recommended by the DOH/DOHMH NY Links Campaign. These interventions are:
A) Integration of HIV Screening and Improved Linkage System (Sector 1)
B) Pre-Exposure Prophylaxis (PrEP) for High-Risk Negatives (Sectors 1, 9)
C) Peer Support Program (Sectors 1, 2, 4, 7, 9)
D) Evidence-based Patient Education/Participation and Social Marketing (Sectors 1, 3, 4, 7, 9)
E) Virology Fast Track Plus (Sectors 4, 9)
F) Multi-layered Cultural Competency Campaign (Sector 5)

Interventions were chose for their proven ability to impact the objectives of this project and to collaboratively address: identified gaps in HIV prevention (A, B, D); diagnosis and effective linkage to care (A, D); and, retention and improvements to quality of care (C, D, E, F) (see CNA need 6).

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.*

Target populations for this project are HIV-infected individuals (undiagnosed and diagnosed) and those at high-risk of becoming infected (i.e., individuals eligible for PrEP). DOHMH estimates that there are 133,635 individuals infected with HIV, 18,709 of whom are unaware of their HIV positive status. Furthermore, DOHMH estimates that there are 30,429 individuals in NYC who 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.

This target population is inclusive of several sub-populations that have historically experienced different risks and challenges related to HIV, including persons with co-occurring diagnoses such as mental health or SA disorders, social factors such as homelessness, and persons identified in the CNA as being high risk such as foreign born individuals, Black or Hispanic individuals, and MSMs (see CNA need 6). As these sub-populations are likely to change over the course of this project, we plan to work closely with our colleagues across the city to identify demographic shifts and adapt our interventions accordingly.

Given the cultural, ethnic, gender, and age diversity within the target population there is a great need for services to be provided in welcoming environments (see CNA need 3). This diversity and the level of co-factors and co-morbidities within the target population lend to the complexity of this project, and are central to collaborative efforts within our 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.

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 DSRIP project will benefit from the shared understanding and pooled resources of this network. Additionally, our PPS will benefit from NYC's strong infrastructure of HIV, including 71 Ryan White (Part A) and CDC prevention programs, eight Ryan White Part C and 10 Ryan White Part D programs, and the DOH/DOHMH NYLinks project.

Additionally, our PPS brings an array of HIV resources to this program. HHC, which has been recognized nationally and internationally for its HIV/AIDS initiatives, is the largest provider of HIV primary care in the state and sits on Governor Cuomo's End the Epidemic Task Force. HHC's 11 hospitals are all Designated AIDS Centers, offering rapid HIV testing, providers who specialize in HIV/AIDS care, and access to continuous and coordinated care. In 2014, 80% of HHC's HIV patients were linked to care within 90 days, and 87% were retained in care. HHC tested 200,000 unique patients for HIV in the last year, and 1.6 million since 2005. For HIV-positive patients, MetroPlus offers a special plan, which links members to a number of community-based AIDS organizations, including case management, legal services, housing services, peer counseling, and treatment education.

Our PPS also includes 22 Ryan White Programs and 35 HIV prevention/outreach and social service programs. There are over 70 additional Ryan White programs and 1,000 HIV programs within our PPS service area, which we will collaborate with as needed to implement our chosen interventions.

The PPS HIV Collaborative will utilize these resources, other PPS-specific resources, and develop new resources to address the following common sectors of this project:

Sector 1. Interventions will utilize the diverse knowledge and experience of the PPS HIV Collaborative to increase HIV testing and linkage to care services, increase viral load suppression (e.g., support ART adherence), and increase access to evidence-based prevention efforts. HHC has extensive experience related to HIV screening and linkage that will be utilized to fully integrate services. New resources will be developed to allow for the PPS HIV Collaborative to establish standard PrEP practices and develop a unified PrEP effort across NYC (see CNA need 6).

Sector 2. Peers have been a driving force designing, implementing, and continuously improving HIV prevention and care efforts in NYC, and are a key asset to this project. Evidence-based interventions will be implemented to provide new resources in order to more effectively integrate peers and provide peer support.

Sector 3. Evidence-based educational campaigns will be established and supplemented by a broad social marketing campaign. The PPS HIV Collaborative will bring its expertise, experience, and perspectives to provide a broad base of understanding for maximum reach and impact.

Sector 4. Interventions related to this sector will build upon the DSRIP work in Domains 2 and 3 and existing resources to improve the identification, referral, and linkage to services for individuals in need.

Sector 5. New cultural competency training and programming will be central to improve the access and utilization of services to ensure that key issues, such as conducting effective and respectful sexual histories, are addressed (see CNA need 3).

Sector 7. Interventions addressing this need will center on the use of peer leaders and support groups to provide relevant, effective resources.

Sector 9. Improving access to services for high-risk individuals and working to improve the identification, referral, and linkage for those individuals into existing services will be at the center of interventions for this sector.

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.

We anticipate a number of project challenges. First, HIV is a chronic, incurable disease that disproportionately impacts ethnic/racial and gender minorities. HIV patients have a high prevalence of SUD, homelessness, chronic trauma, and BH diagnoses as well as other chronic co-morbid conditions such as diabetes and heart disease. Given these factors, the HIV population can be hard to reach (see CNA need 3, 5). Moreover, individuals in the population often require a number of different services from different care providers along the continuum. The 4.c.ii implementation team will work with the broad list of PPS partners to connect these patients to appropriate care. We will also collaborate closely with the Domain 2 and 3 projects, to ensure strong coordination when patients are served by multiple projects.

It will also be a challenge to effectively address the social co-factors that constrain successful engagement in care. These include cultural perceptions and stigma of the disease that act as barriers to access and retention in care (see CNA need 3). In response, we will work closely with other PPSs and community service providers to identify this

population and engage them in care. Our PPSs will implement a number of interventions to address the needs of hard-to-reach and currently underserved communities, including: a multi-layered cultural competency campaign to more effectively identify needs, peer support programs, an evidence-based patient education social marketing campaign, integration of HIV screening and an improved linkage systems for services, and Virology Fast Track Plus.

Another challenge will be recognizing changes within our sub-population, and identifying new at-risk sub-populations. To address this, the PPSs within the PPS HIV Collaborative will continually share information about new hotspots in our local communities so that we will be able to recognize new trends early on. Once new sub-populations are identified, we will work together to modify our interventions and outreach strategies to adapt to the new target population.

Finally, in order to be successful, we cannot work in PPS silos. Instead, we must work together. The PPS HIV Collaborative will ensure that the PPSs effectively pool resources, particularly knowledge, experience, and perspectives, to improve project design and implementation.

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.

Seven PPSs, NYC DOHMH, and Amida Care, have engaged in joint planning for this project, to ensure continuity of efforts across the city. The seven PPSs, as well DOHMH and Amida Care, are committed to continue to work together through implementation, guided by our charter. While the combination of sectors and interventions will vary slightly among PPSs, the PPS HIV Collaborative has identified a core group of common sectors from the Project Requirements, and has developed a common list of interventions to address those sectors. Throughout planning and implementation, we anticipate this collaboration to continue, including finalizing milestones, developing resources and shared materials, and agreeing on common protocols.

A PPS HIV Collaborative Committee will be organized and a standard process of communication and regular meetings will be held 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 the detailed Implementation Plan, which will be submitted by March 1, 2015. We have identified a number of key milestones in this implementation planning process, including:
1) Convening a PPS HIV Collaborative Planning Committee (Q2, DY1)

2) Establishing a work plan and timeline for project implementation (Q3/4, DY1) 3) Developing agreed upon milestones for project implementation (Q3/4, DY1) 4) Agree-on project commonalities and shared resources (Q3/Q4, DY1) 5) Agree-on 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
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If yes: Please describe why capital funding is necessary for the Project to be successful.

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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.

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HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home Care Management entity under subcontract with 4 NYS Health Home providers.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2,200 members and conducting outreach to between 300 – 900 members per month.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

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

The experience and capacity of HARP programs, Health Homes and downstream care management, care coordination and patient self-management agencies and programs provides a foundation for this DSRIP project. Our work leverages this experience, but does not duplicate these services. Our project takes a population health approach to education and outreach to

improve infrastructure and outcomes for the HIV/AIDS population. Our project also focuses on cross-PPS collaboration to improve sharing of promising practices.

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.

Appendix

Additional Entities for Question 4.b

2.a.i Integrated Delivery System (IDS)

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Dates	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus Health Plan	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Dates	Description of Initiatives
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.

Name of Entity	Medicaid/Other Initiative	Project Start	Project End Dates	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Medicare Shared Savings Program	June 2012	December 2016	HHC ACO, Inc. (the HHC ACO) was formed by HHC in June 8, 2012, to further the goals of the Medicare Shared Savings Program (MSSP).

2.a.iii Health Home At Risk Intervention Program for Higher Risk Patients

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
MetroPlus	Health Homes for Medicaid Enrollees with Chronic	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this initiative.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.

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

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU)/Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus Health Plan	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.

2.b.iv Care Transitions Model to Reduce 30-Day Readmissions

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.
Harlem United (HU)/Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United is a member of the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity with subcontracts with 4 NYS Health Home providers.
MetroPlus Health Plan	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes including HHC and VNSNY.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides staffing, such as physicians, allied health providers and other employees deemed necessary by HHC, to the HHC Health Homes as part of this

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Queens Community House (QCH)	Community-based Care Transitions Program	2013	2015	QCH has been participating as a part of the Queens Collaboration Coleman Model with participating hospitals. QCH has trained bilingual coaches who establish hospital-based communications with patients at high risk for avoidable readmission. The model includes one home visit, with follow-up calls to effect change in behaviors for better health management and linkage with a wide range of community-based services.
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.
Visiting Nurse Service of NY (VNSNY)	CMS Innovation Center Health Care Innovation Awards (HCIA)	2014	2017	Mount Sinai School of Medicine received funds to pilot a hospital-at-home model (Mobile Acute Care Team Services). VNSNY is a partner in this project but not the lead.
New York City Health & Hospitals Corporation (HHC)	Health and Recovery Plan (HARP)	2014	Ongoing	HHC facilities have applied to the NYS Office of Mental Health to become approved HARP providers. It is expected that all HHC facilities currently offering BH services will participate with MCOs and specifically HARPs once BH is transitioned to managed care.
MetroPlus	Health and Recovery Plan	2015	Ongoing	Creation of HARPs for the severely mentally ill population.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Comunilife	Health and Recovery Plan (HARP)	2015	Ongoing	Comunilife is testing new payment models for integrating behavioral health care and physical health services.

2.d.i Project 11 Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
Public Health Solutions	New York State of Health	August 2013	September 2018	Public Health Solutions provides in-person enrollment assistance.
Safe Space	New York State of Health	August 2013	September 2018	Safe Space provides in-person enrollment assistance.
Seedco	New York State of Health	August 2013	September 2018	Seedco provides in-person enrollment assistance.
Single Stop USA	New York State of Health	August 2013	September 2018	Single Stop USA provides in-person enrollment assistance.
The Lesbian, Gay, Bisexual & Transgender Community Center	New York State of Health	August 2013	September 2018	The Lesbian, Gay, Bisexual, & Transgender Community Center provides in-person enrollment assistance.
Village Center for Care d/b/a VillageCare	CMS Innovation Center Health Care Innovation Awards (HCIA)	2014	2017	Through this program, VillageCare is building and testing a combination of technology-based tools to support patient self-management.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
FEGS Health & Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	FEGS is a NYS-designated Health Home in Nassau and Suffolk counties as well as a case management agency under subcontract with a number of NYC Health Homes.
Harlem United (HU)/Upper Room AIDS Ministry, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Harlem United (HU) provides services under subcontract to the CCMP-led Health Home in the Bronx and Manhattan, CHN in Queens and Maimonides in Brooklyn. Currently, approximately 900 clients are enrolled in HU's Health Home program.
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus Health Plan	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.

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

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.

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

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and link clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.
St. Mary's Healthcare System for Children	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	St. Mary's Healthcare System for Children provides remote patient monitoring of medically complex pediatric home care patients via an interactive voice response system to identify changes in condition and lapses in medication adherence, and to prevent avoidable ED visits and hospital admissions.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
God's Love We Deliver, Inc.	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Through this program, God's Love We Deliver, Inc. is tasked with increasing the number of referrals to managed long-term care (MLTC) services in NYC and expanding services to Westchester and Nassau Counties.
Physician Affiliate Group of New York, PC (PAGNY)	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	PAGNY provides necessary staffing, such as physicians, allied health providers and other employees as deemed necessary by HHC, to the HHC Health Homes as part of this initiative.

4.a.iii Strengthen Mental Health and Substance Use Infrastructure Across Systems

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
HELP/PSI	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HELP/PSI is a Health Home care management entity under subcontract with 4 NYS Health Home providers.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
MetroPlus Health Plan	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	MetroPlus provides contracting and care coordination services under subcontract to multiple Health Homes, including HHC and VNSNY.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.

4.c.ii Increase Early Access to, and retention in, HIV Care

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.

Name of Entity	Medicaid/Other Initiative	Project Start Dates	Project End Dates	Description of Initiatives
The Osborne Association/Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
Coordinated Behavioral Care IPA/ Postgraduate Center for Mental Health	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	The Postgraduate Center for Mental Health provides services to NYS Medicaid Health Homes under subcontract. Services include care coordination following the transition of targeted case management services.
Coordinated Behavioral Care IPA/Brooklyn Bureau of Community Service d/b/a Brooklyn	Health Homes for Medicaid Enrollees with Chronic Conditions	2013	2015	Brooklyn Community Service provides care coordination services under subcontract to participating agencies in the Brooklyn Health Home and CBC Pathways to Wellness Health Home.
Village Center for Care d/b/a VillageCare	CMS Innovation Center Health Care Innovation Awards (HCIA)	2014	2017	Through this program, VillageCare is building and testing a combination of technology-based tools to support patient self-management.