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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

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

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

The CNA confirms what knowledgeable residents, healthcare professionals and policymakers know already about the Bronx – it is the least healthy county in New York State. Poverty; cultural, immigration and language barriers; poor transportation services; and the transient nature of the population of the Bronx have confounded the borough's best efforts for sustained population health improvement. Poverty puts extreme pressure on meeting the needs of daily living – finding food, shelter, jobs and safety on the streets – leading to depression, and relegating wellness, health and healthcare to a secondary priority for many residents. On the supply side, the Bronx is under-resourced, with low rates of commercially insured individuals and low reimbursement. When compared to the NYC average rate per 1000 residents, the Bronx has shortages of 255 physicians, 256 physicians assistants, 288 psychiatrists, 316 nurse practitioners, and an astonishing 1324 social workers. With large portions of the borough inaccessible by subway and no trains that travel east-west, workforce commuting and patient access are both hampered. In addition, Bronx health care facilities pay PCPs and other health care providers less than surrounding counties in New York and New Jersey, so that qualified candidates are often lost to other locales.

The relative lack of services, lack of meaningful patient engagement, long wait times for visits and other inconveniences associated with accessing care, makes the emergency room a

rational "one stop shop" for many. Measured against NYC averages in 2012, the Bronx experienced 1971 more Potentially Preventable Hospitalizations (PQI) and 74,200 more Emergency Visits (PPV) than expected. In addition, the Bronx's rate of Potentially Preventable Readmissions (PPRs) is 5% higher than NYC as a whole. These results are the highest or second highest among the NYC Medicaid population, with circulatory conditions, respiratory conditions and diabetes as leading factors. Moreover, the highest overall ratios are found in a narrow cluster served by the major providers in the PPS, reach ing from Williamsbridge and Fordham–Bronx Park in the north, continuing southward along the east side of the Grand Concourse through Belmont, East Tremont, Claremont Village, and Morrisania, to Mott Haven.

With nearly 60% of the borough's population covered by Medicaid (with rates as high as 84.2% in some ZIP Codes) – representing 14.1% of the state's Medicaid population – the Bronx is "ground zero" for DSRIP. BPHC believes that DSRIP-enabled Medicaid levers present a powerful opportunity to address health, health care delivery and the social determinants of health systemically for a large swath of the Bronx population. While BPHC cannot eliminate poverty, it can fight its effects on health with:

a) Greater clinical integration among Bronx-based providers and expanded use of community-based and non-clinical care coordination resources to expand access to health services

b) Eventual financial integration, beginning with expanded provider incentives for treating the whole person, moving to value-based payment arrangements under Medicaid Managed Care

c) An information-sharing infrastructure and environment giving providers more visibility into and control over performance and outcomes

d) Governance that integrates services for addressing social determinants of health and conditions of poverty and enables neighborhood and Bronx-wide capacity planning to address shortages

Programs to address specific problems and sub-populations are further defined in detail in this and other project descriptions included as part of the DSRIP application.

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.

BPHC has assembled a diverse network of more than 160 members, including 40-plus community-based clinical provider organizations, 23 behavioral health/substance abuse centers, 20 home care services, 8 housing and homeless agencies, developmental disability providers, health plans and an additional 20-plus non-clinical community-based organizations (CBOs).

Across the network, care coordination/management resources will be expanded via training, workforce development and redeployment. Given workforce supply gaps in the Bronx and the relatively low potential to redeploy hospital staff, most of the expansion will need to result from recruiting or from utilizing community-based resources more efficiently. Additional workforce details are included in Section 5 – Workforce.

The many assets of Montefiore Medical Center (MMC) are a key BPHC enabler. MMC's Care Management Organization (CMO) is a leader in population health management (PHM) and value-based care, coordinating care delivered by nearly 3,500 providers across

the Bronx and Westchester for 300,000 individuals in multiple insurance programs. BPHC estimates that 45-55% of its attributed population is already under Medicaid Managed Care with the CMO. In addition, the MMC IPA represents the county's largest clinically integrated enterprise and MMC's BAHN Health Home and ACO are local leaders in PHM. BPHC will mobilize MMC's expertise and capabilities in care coordination and care management, medication management, patient stratification and patient engagement. Lead applicant SBH Health System also has significant experience with value-based contracting, managing 28,000 Medicaid and Medicare lives though relationships with two MCOs and participation in Montefiore's ACO and Health Home. PPS members CenterLight Healthcare and Visiting Nurse Service of New York (VNSNY) operate managed long term care plans/Health Homes and have robust PHM-based infrastructures to support them.

Montefiore and SBH provide a strong pipeline of physician capacity for the Bronx. Montefiore has one of the largest residency programs in the country, with over 1400 residents. SBH has recently committed to being the primary teaching campus for the Sophie Davis School of Biomedical Education at CUNY to as it becomes a full-fledged medical school focused on the education of primary care physicians to service diverse, needy communities. SBH is requesting capital to build a large-scale, mixed used development that will address many social determinants of health. The project includes 360 units of affordable housing (consistent with NYC's 2014 "Housing New York Plan"); primary, urgent care and outpatient behavioral health space; and commercial wellness facilities, including a pharmacy, day care center, fitness club, access to healthy food, nutrition and culinary education and public space, including green space for wellness education.

EHR, the PCMH model and data sharing are key components of PHM. BPHC will establish a program for monitoring and assisting Partners, especially small primary care practices, in adopting EHRs/EMRs, attesting to MU, achieving PCMH recognition and participating in HIE. BPHC founding members have close working and governance relationships with the Bronx RHIO and are already contributing data to it for HIE and analytics. BPHC has conducted initial due diligence on Bronx RHIO's DSRIP data management capabilities, as well.

Finally, BPHC will strengthen culturally competent connections between community members in need and help expand resources that can support them. Examples include contracting with a.i.r. nyc to provide home-based asthma self-management services, supporting employment of 21 new staff, and supporting 15 new peer educators at Health People, a CBO that provides evidence-based health education. BPHC will develop a web-based list of PPS social services providers to enable real-time referrals of patients and caregivers to resources that can meet their social needs.

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.

Patient and provider engagement, regulatory restrictions and IT readiness represent major challenges.

Patient engagement will be addressed through a number of interventions and techniques

described throughout the application, including:
a) Active patient outreach, screening, assessment, referral and enrollment from an expanded care coordination/care management workforce
b) Expanded patient interaction through peers serving as patient navigators, community health workers and care managers
c) Use of individualized patient care plans, appointment scheduling and reminders and follow-up on no-shows
d) Use of telehealth and remote monitoring

Provider engagement will be addressed with the following:
a) Promotion of and training on evidence-based protocols, team-based care, standards of care, interventions, tools and techniques for population health and care management
b) Expanded staffing of care coordination/care management functions, embedded in practices and backed up by BPHC central services (CSO) and Montefiore CMO
c) Metrics-based feedback on outcome and process performance
d) Financial incentives based on performance and adherence to protocols

BPHC's plans to address patient and provider engagement are centered on 5 priorities:
1) Leverage Health Home infrastructure to address health and social determinants of health more completely for a broader population
2) Greatly expand care coordination and care management, with emphasis on encouraging team-based delivery to expand capacity, using a Patient-Centered Medical Home (PCMH) model
3) Integrate behavioral health and primary care services
4) Provide good clinical and IT governance that supports the above with PPS-wide central services
5) Engage patients with targeted public health literacy and education campaigns
As described throughout this application, BPHC has developed specific strategies and initiatives to implement these priorities.
Multiple state program silos, limitations on billing for services across programs, co-location and data-sharing/patient consent present significant regulatory challenges under DSRIP. BPHC has made recommendations for resolving these regulatory issues in its commentary on DSRIP guidance to date and will continue to do so.
Finally, BPHC will work with Bronx RHIO to establish a technical assistance program to help Partners with adoption and use of EHRs, other HIT and HIE.

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.

BPHC, HHC, Bronx-Lebanon and Advocate, the 4 Bronx PPSs, have collaborated on the CNA. In addition, BPHC and HHC have conducted joint planning sessions related to their overlapping PPSs. Discussions have encompassed six levels of coordination and integration:
1) Project Planning – common DSRIP project selections for the Bronx
2) Requirements (Clinical & IT) – common frameworks, project approaches and detailed

designs
3) Borough-wide PPS Partners – sharing common or leveraging each other's Bronx-specific partners
4) Infrastructure (Training, Administration & IT) – common vendors, solutions and/or shared services
5) Funding & Incentives – shared investments and reward systems
6) Governance & Oversight – shared structures and cross-representation

Planning will continue during the implementation phase and will include the Bronx-Lebanon Hospital PPS going forward, with the understanding that there is potential for joint protocol development and shared IT, CSO and Member services and economies of scale on the following projects, at minimum:
a) Health Home At-Risk Intervention Program
b) ED Care Triage
c) Integration of Primary Care and Behavioral Health Services
d) Expansion of Asthma Home-Based Self-Management Program
e) Both Domain 4 Projects

BPHC has collaborated with the Bronx-Lebanon and Montefiore Mid-Hudson PPSs in actively engaging Bronx RHIO in an effort to develop joint cross-RHIO/cross-PPS solutions with overlapping and surrounding RHIOs, including Interboro RHIO, Healthix and HealthlinkNY. In addition, BPHC and the Montefiore Mid-Hudson PPS are discussing shared services and joint planning for Montefiore CMO use and joint IT services for analytics and care coordination and management systems. The Westchester Medical Center PPS has been invited to participate in both of the above collaborative activities (RHIO and shared services).
Finally, BPHC has held serial partnership and collaboration discussions over summer/fall 2014 with Advocate, the fourth PPS overlapping the Bronx, and has welcomed continued collaboration once Advocate's final DSRIP configuration is solidified.

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.

The Bronx currently has 3,794 hospital beds (2.74/1,000 population, a decline from 3.14/1,000 in 2004). Since 2009, SBH has closed 81 medical and surgical beds and has repurposed space for new clinical programs such as hospice, sleep labs and wound care. In addition, in 2013, SBH closed a 24-bed detox unit to create an ambulatory center focused on asthma, diabetes and geriatric services, and Montefiore repurposed Westchester Square Medical Center acute care units as an ED/ambulatory surgery center. In light of these recent reductions, BPHC does not believe that there is material excess hospital bed capacity in our PPS and that a 25% reduction

in preventable hospitalizations will result in only a 1-1.5% reduction in demand.
The Bronx has 46 nursing homes with 11,732 beds, much higher capacity than NYC and NYS rates, indicating a potential excess of nursing home beds. Beds are filled almost to capacity, suggesting that social factors prevalent in the Bronx – severe poverty, disability rates and inadequate housing – are generating strong demand and, if addressed, may allow reductions. Based on these estimates and due to BPHC's restricted influence over Bronx-wide supply and demand for institutional services, the PPS's focus will be on expanded growth of community-based providers and care management resources to shift inappropriate care out of emergency rooms, avoid readmissions and reduce potentially avoidable admissions. BPHC's action plan for this strategy is to build an integrated delivery system on five pillars of IDS transformation:

1) Appropriate Utilization
2) Chronic Condition Management and Population Health
3) Primary Care/Behavioral Health Integration
4) Patient Engagement
5) Central Services Support

For the first four categories, BPHC will organize subsets of PPS participants appropriate to each challenge into Rapid Deployment Collaboratives, facilitated by the newly-formed BPHC Central Services Organization (CSO). The fifth area, Central Services Support, will be developed by the CSO under SBH's direction.
Each area will focus on specific IDS strategy milestones for achieving an integrated, collaborative, and accountable service delivery structure, many of which will be implemented in other projects described in the application.

1) Appropriate Utilization Milestones: Establish standard protocols, processes, and methodologies and expand care management resources dedicated to: (i) Redirecting at-risk, rising risk and frequent ED patients to appropriate community-based care (Project 2.b.iii); and (ii) Managing and supporting patient care transitions (Project 2.iv), based on Partner contracts and arrangements, a major expansion of the care management workforce in the Bronx, the Patient-Centered Medical Home (PCMH) model and other evidence-based best practice.
2) Chronic Condition Management and Population Health Milestones: a) Finalize contracting arrangements with Partner care management agencies and Health Homes for rising-risk patients not currently eligible for care management (2.a.iii); b) Implement standardized, evidence-based disease management protocols network-wide for cardiovascular disease and diabetes at minimum (Projects 3.b.i and 3.c.i); c) Implement a comprehensive evidence-based home visiting program to address root causes of asthma exacerbations (Project 3.d.ii); and d) Provide integrated governance and resource planning to strengthen mental health and substance abuse infrastructure (Project 4.a.iii) and to improve access to and retention in HIV care (Project 4.c.ii).
3) Primary Care/Behavioral Health Integration Milestones: a) Establish standard protocols and processes for integrating behavioral health and primary care, so that patients with BH needs presenting at a hospital or provider site are treated or appropriately referred/tracked for BH treatment and patients presenting at BH sites are treated or referred/tracked for their physical health in coordination with a PCP (Project 3.a.i); and b) Begin training primary care teams on Collaborative Care Model (aka IMPACT model).
4) Patient Engagement Milestones: a) Develop standard evidence-based screenings and patient profiling/stratification administered by community health workers and PCMHs; b) Implement patient engagement and activation mechanisms to promote patient

self-management and patient enrollment/engagement in PPS/IDS programs; c) Develop a strategy to recruit/train community residents to serve as linguistically and culturally appropriate peer outreach workforce; and d) Develop a comprehensive strategy for telehealth, remote monitoring, digital health apps and patient engagement.

Each Collaborative will kick off at DSRIP commencement and will execute activities identified in the Implementation Plan. For Central Services Support, BPHC is already executing against many of the following milestones.

1) Governance Milestones

a) Establish and staff the CSO to identify, oversee and provide integrated services, leveraging the expertise of key members, existing Health Home and accountable care efforts

b) Finalize the scope of Montefiore CMO and other qualified entities' role in care management, analytics and IT shared services and governance

c) Establish an IT Subcommittee to advise on data, analytics, HIE and other HIT governance issues.

2) Clinical Integration Milestones

a) Establish data analysis and predictive modeling capabilities

b) Design and implement patient and disease registries for patient tracking

c) Establish a program or programs for monitoring and assisting Partners with adoption and use of the PCMH model of primary care, EHRs, other HIT and HIE

3) Financial Integration Milestones

a) Engage Medicaid Managed Care payers (MCOs) to explore other incentive models as a precursor to expanding contracting for value-based reimbursement

b) Design an approach for basing a portion of provider compensation on incentive-based metrics, including a community incentive pool to fund compensation from earned DSRIP funding

c) Explore IPA or other formal contract or acquisition-based network expansion

d) Expand value-based payment contracts with MCOs

4) Information Sharing/IT Milestones

a) Contract with Bronx RHIO for HIE, central data management and analytics services, including patient matching and provider panel/master data management

b) Finalize scope of control, roles responsibilities and coordination among the CSO, Bronx RHIO, Montefiore CMO and Partners for central data management, data governance and other aspects of BPHC IT provisioning

c) Implement a care coordination management system with the objective of extending capabilities into the community while augmenting Montefiore CMO's central systems and services (based on a vendor selection decision expected to be completed by March 1, 2015)

BPHC has developed detailed operational and IT requirements and workflows for the above actions and will further detail them in the Implementation Plan due March 1, 2015. The state's technical support contractor has said that BPHC's planning framework in these areas is among the most complete in the state. Using this framework, BPHC has so far:

1) Developed a comprehensive requirements list and PPS IT architecture,

identifying HIE, analytics and care management as priorities
2) Conducted an assessment of Partner IT capabilities and PCMH status
3) Performed due diligence on Bronx RHIO for HIE, central data governance and analytics and begun implementation and contingency planning for those areas to enhance or augment current Bronx RHIO capabilities
4) Explored care management synergies with the 3 Health Home BPHC Partners, the Montefiore CMO and others
5) Begun a procurement of a care coordination management system (CCMS)
6) Begun outlining an early straw model concept of operations and model of care
Milestones and features of the integrated delivery system are described in more detail in other project descriptions submitted with the application.

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.).

BPHC sees its evolution into an integrated delivery system as proceeding through three phases:
Phase 1: Small populations (HH, MLTC, FIDA, delegated Medicaid Managed Care Organizations (MCO) populations, etc.), loosely coordinated supports (RHIOs, SHIN-NY, MU incentives, etc.)
Phase 2: Larger scale and more integrated under DSRIP, beginning now
Phase 3: Partnership with Medicaid Managed Care Organizations (MCOs), value-based contracting and incentive-based provider compensation through PPS
Phase 1, pre-dating DSRIP, involved organizations that are now part of BPHC entering into contracts and initiatives on their own or in partnerships with a handful of related organizations. Phase 1 brought subsets of the PPS together into working relationships and gave those organizations involved experience with population health management, care coordination, accountable care and value-based purchasing concepts and techniques.
Phase 2, prompted by DSRIP, has encouraged and enabled BPHC to conceptualize integration for population health management on a larger scale. DSRIP calls for the PPS to manage the health and social supports of an anticipated 250,000-350,000 patients holistically. BPHC's grassroots planning has afforded the opportunity to build stronger and broader relationships among the PPS's 160-plus partners in transparent and participatory project governance that has helped all participants understand roles, responsibilities and expectations of performance. The next steps associated with this phase include:
a) Complete recruiting and staffing for the Central Services Organization
b) Formalize governance
c) Execute a Master DSRIP Services Agreement (MDSA) that will serve as the basis of contracts between lead applicant SBH and PPS Partners

Management of day-to-day BPHC operations will be supported by the CSO and SBH leadership, which have a deep understanding of the healthcare needs of Bronx patient populations, and the resources to navigate coordinating care on the region, governed by SBH's board of directors. The CSO will be responsible for providing and/or outsourcing a range of services to

the PPS, including:
a) Clinical quality and care innovation supervision, performance monitoring, network adequacy and compliance with agreed protocols
b) Information technology services
c) Financial services: budgeting, planning and analysis for value-based payment, development of funds distribution methodology, sustainability and other financial services
d) Workforce training
e) Analytics
f) Back office and administrative services

Formal governance will flow from grassroots planning phase collaboration, populated from existing planning committees. The planning phase Steering Committee will evolve into an Executive Committee for implementation. The current Business & Operating Committee and its Finance, IT, and Workforce Development Workgroups will evolve into Financial, IT and Workforce Subcommittees. The current Clinical Delivery & Program Planning Committee will evolve into a Quality and Care Innovation Subcommittee. As detailed in Section 2 of the application, these bodies will be created with the following responsibilities:
a) Executive Committee: Strategic leadership, general oversight and compliance, with at least four subcommittees: (1) Finance and Sustainability: Funds distribution and monitoring CSO services; (2) IT: Create and update IT and data exchange processes and protocols with Partners; (3) Workforce: Develop and implement comprehensive workforce strategy; and (4) Quality and Care Innovation: Oversight of clinical processes and protocols and Rapid Deployment Collaboratives
b) Rapid Deployment Collaboratives: Tactical leadership of four strategies for transformation to an IDS

The MDSA will be executed by the time SBH and DOH enter into a DSRIP contract. Health Homes and the BAHN ACO will be parties to the agreement.
Beginning April 1, 2015, BPHC will move into Phase 3, laying the groundwork for contracting with Medicaid Managed Care Organizations (MCOs) and other payers as an integrated system under value-based payment arrangements. This will involve:
a) Immediately instituting regular monthly meetings with MCOs to review utilization trends, performance issues, and planning for payment reform
b) Adding MCOs to the PPS, most likely participating in governance through the Finance and Sustainability Subcommittee
c) Creating an independent physician association to be integrated with the Montefiore IPA in order to leverage Risk and Shared Savings contracts already in place through the Montefiore CMO

BPHC understands that governance and organizational structure must evolve as DSRIP program objectives and goals move toward sustainability and value-based contracting in the later years of the program. BPHC will evaluate these structures periodically during the DSRIP program, influenced by the PPS Rapid Cycle Evaluation process and recommendations, to ensure that they are meeting DSRIP goals and objectives and Member needs over time.
Successful implementation of BPHC's care model in DSRIP's early years is essential to engaging MCOs in discussions related to expanding existing and creating new contracting

structures to implement further value-based arrangements. BPHC may also seek to engage Medicare and commercial payers regarding extending payment reform and associated clinical programs to additional populations.
BPHC also views performance and incentive-based payments for Partners as essential to driving integration. The Financial and Sustainability Subcommittee will design, implement, measure and continuously evaluate Partner compensation aligned to patient outcomes and BPHC goals. Finally, the Subcommittee will make recommendations for network expansion through acquisition or contracting that may further evolve delivery system integration.

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

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

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

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

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

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

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

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

Yes	**No**
☒	☐

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

BPHC will need capital funds to develop a shared health IT infrastructure to support BPHC-wide population health management efforts. Efforts will include (1) development and dissemination

of a care management platform, telehealth and remote monitoring tools, and patient registries; (2) enhancement of Bronx RHIO capabilities and EMR system licenses for partner organizations; and (3) development of analytic and reporting processes and network management; (4) network and infrastructure upgrades; and (5) procurement of a learning management system for training. Taken together, this strategy will support communication among BPHC partner organizations and help achieve a coordinated and accountable service delivery structure, both of which are critical to this project's success.

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

These improvements will develop the services needed to meet DSRIP project objectives, facilitate population health management, and address current provider shortages.

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
Jewish Association Serving the Aging	Balanced Incentives Program (BIP)	2014	2015	The Balancing Incentive Program (BIP) is a Federally funded State Medicaid program developed to increase access to non-institutional long-term services and supports (LTSS). This is intended to create a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children	BIP	2014	2015	See BIP description above.
Health People, Inc.	BIP	2014	2015	See BIP description above.
United Cerebral Palsy Association of NYC	BIP	2014	2015	See BIP description above.
Project Renewal	BIP	2014	2015	See BIP description above.
God's Love We Deliver, Inc.	BIP	2014	2015	See BIP description above.
Montefiore Medical Center	Bundled Payments for Care Improvement	2014	2017	The Bundled Payments for Care Improvement Initiative, a program developed by the Center for Medicare and Medicaid Innovation, enables organizations to enter into Medicare payment agreements that are linked to services beneficiaries receive for episodes of care. These episodes are focused on acute care inpatient hospitalizations and post-acute care for selected diagnoses.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Montefiore Medical Center	Montefiore Hospital Medical Home Demonstration	2012	2014	The Montefiore Hospital Medical Home Demonstration is a two-year program funded by NYS and CMS to improve care continuity for Medicaid recipients receiving primary care in residency training sites.
SBH Health System	SBH Health System Hospital Medical Home Demonstration Waiver	2012	2014	The SBH Health System Hospital Medical Home Demonstration is a two-year program funded by NYS and CMS to improve care continuity for Medicaid recipients receiving primary care in residency training sites.
St. Mary's Healthcare System for Childre	Money Follows the Person		2014	The Community-based Care Transitions (CBCT) Program is a Federally funded program that tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
Institute for Family Health	Community-based Care Transitions Program (CBCT)	2011	2016	The Community-based Care Transitions (CBCT) Program is a Federally funded program that tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.
Counseling Services of New York	Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recovery Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children (HH)	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management. NOTE: Other entities participating in HWRI are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cabrini of Westchester	Medicare Shared Savings Program	2014	2015	The Medicare Shared Savings Program (MSSP) is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. NOTE: Other entities participating in MSSP are listed in Appendix I.
SBH Health System	CMMI Pioneer ACO	2013	2015	The Pioneer ACO is a Federally funded program that is consistent with, but distinct from, the Medicare Shared Savings program. The program supports ACOs and their participants as they facilitate coordination among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Organizations are experienced in providing care coordination and patient-centered care. NOTE: Other entities participating in CMMI Pioneer ACO are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.
While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid

initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.
Balancing Incentive Program. While BPHC can leverage participating providers' experiencing improving care for this specialty Medicaid population, BPCH will not duplicate funding as BIP does not target the type of chronic disease management provided through this project.
Bundled Payments for Care Improvement Program. We will build on the experience of implementing providers to develop our care management/coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.
Montefiore and SBH Health System Hospital Medical Home Demonstrations. This DSRIP project will significantly expand the types of sites and populations receiving care continuity and primary care services.
Community-based Care Transitions. BPHC will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid population in each of our hospitals. Funds will not be provided to these providers if doing so would supplant or duplicate CBCT funding.
FIDA. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.
HARP. This DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.
Money Follows the Person. DSRIP funding will not be provided to Money Follows the Person participating providers if doing so would supplant or duplicate MFP funding.
NYS Health Home program. Our projects 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.
Health Workforce Retraining Initiative. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.
The Medicare Shared Savings Program and CMMI Pioneer ACO program target Medicare patients served through ACOs. We will build on the experience of these participants to establish our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.

6. <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 the implementation of the <u>IDS strategy and action plan</u>, <u>governance, completion of project</u>

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.

Addressing the needs of individuals with single chronic conditions who are at risk for decline in health status and co-morbidities through project 2.a.iii, Health Home At-Risk Intervention Program, is a high priority in the Bronx. Chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes, contribute to high health system costs, and account for the highest proportion of potentially preventable hospital admissions in the borough. Community members rank chronic conditions as a top health concern, often impacted by conditions of poverty. A higher proportion of Bronx households (29%) live below the federal poverty level than in NYC (19%) or NYS (14%) as a whole, with rates as a high as 40% in some lower-income neighborhoods (CNA Community Need 6). Social service needs exceed demand in the borough, and more than half (57%) of the Bronx population are non-native English speakers; 41% of non-citizens have limited English proficiency. These factors present documented barriers to health care access, leading to more severe chronic illnesses.

These gaps are compounded by provider shortages. While the Bronx's rate of primary care physicians per population (115.6/100,000 population) is lower than the NYC (134/100,000) and NYS (120/100,000) rates, access to physicians is even more limited for Medicaid and uninsured patients, and acute primary care shortage plague several Bronx neighborhoods with high prevalence of chronic illness. Almost one-third of Bronx residents live in one of the borough's eight HRSA-designated Health Professional Shortage Areas, and four Bronx neighborhoods – Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven – fall in the NYS Health Foundation-funded study's category of highest need in the state for community health center expansion (CNA Community Need 2).

Care management services present a well-documented strategy for expanding access to care, addressing chronic health issues and improving patient outcomes for high-need populations. But PPS members and CNA informants identified care management gaps at critical junctures in care. According to providers, the system is highly fragmented: there is lack of provider knowledge of and engagement in care coordination services, inadequate/inconsistent IT to conduct care management, inadequate risk stratification to identify "at-risk" populations, and limited discharge planning/referrals after hospital stays (CNA Community Need 5).

These needs inform our selection of the Health Home At-Risk Intervention Program. Through this program, BPHC will (1) expand access to multi-disciplinary care teams within Level 3

PCMHs; (2) deploy additional care managers into PCMHs and community settings; and (3) strengthen the existing Health Home (HH) care management infrastructure to better manage and retain patients in HHs. These strategies will help BPHC achieve the dual mission of addressing the needs of patients who are at-risk of becoming HH eligible as well as increasing referral, retention and program efficacy for beneficiaries who are already eligible for HHs. Specifically, BPHC will:
a) Provide technical assistance to BPHC primary care practices where needed to reach PCMH Level 3 NCQA recognition.
b) Embed approximately 500 care managers within PCMHs, primary care practices, and HHs to identify and provide care management services to "at-risk" HH individuals. Care managers will develop and monitor patients' care plans, follow up on missed appointments, arrange transportation, and help link individuals to appropriate social services. BPHC will also train care team members to identify and refer patients with special needs or multiple chronic conditions to HHs for a more comprehensive assessment and placement with the "best fit" care management agency.
c) Work with the PPS's three Health Homes to deploy care managers to targeted outreach sites and develop shared Health Home standards, as discussed in section (c).

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.

Using New York State Department of Health (SDOH)-provided claims data from March 2013 to February 2014, BPHC estimates that approximately 37.5% of our Round 3 attributed Medicaid beneficiaries have at least one of the chronic illnesses targeted by our Domain 3 projects. We expect to target for active engagement a segment of those with single chronic illnesses who, based on their history of care plan adherence and/or social needs, are judged to be at-risk and could benefit from care management and care coordination services. Our proposed number of actively engaged individuals will be reflected in the January 12 scale and speed submission, which will use updated attribution data expected to be released by the State.
The PPS will focus in particular on patients with cardiac, gastroenterology, and respiratory conditions, who alone accounted for 40% of readmissions to SBH Health System and Montefiore Medical Center (MMC) in 2012.
We will further stratify this population by identifying additional social factors known to create service barriers, particularly among populations who are at-risk for these issues, including homeless and dual eligible (Medicare & Medicaid) populations.
Last, BPHC expects to prioritize geographic areas with heightened disease prevalence and utilization of health services, including Kingsbridge-Riverdale, Northeast Bronx, Pelham-Throgs Neck, and Fordham-Bronx Park.
Our PPS's DSRIP projects 3.a.i (integration of physical health and behavioral health), 2.b.iv (30 day readmission), 3.b.i (cardiovascular disease management), 3.c.i (diabetes disease management), and 3.d.ii (expansion of asthma home-base self-management) will concurrently address these sub-populations by providing disease and care management services to

individuals with chronic medical and behavioral health conditions. These strategies will help improve outcomes for this population across BPHC.

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

To achieve this DSRIP project's goals, BPHC will expand use of the following assets and resources within our PPS:
(1) Build upon the care management experiences of our PPS's partner Health Homes to strengthen Health Home services and expand the reach of care management personnel.
Our three partner HHs – Bronx Accountable Healthcare Network Health Home, Community Care Management Partners, and Coordinated Behavioral Care – have already agreed to the strategies described in section (a) and have been highly participatory in shaping this project's interventions.
These HHs have extensive care management experiences that will be used to develop shared standards related to education and training, care planning and management technology, and continuous quality improvement. These standards will apply to all care management personnel, including those affiliated with HHs and those embedded in PCMHs, to ensure a uniformly heightened standard of quality and effectiveness. Performance standards will be implemented through service contracts between PCPs/PCMHs and HHs in order to clearly delineate roles and responsibilities and standard policies related to patient referrals, co-management, and data sharing/reporting. These protocols will help provide much needed coordination and referrals to help individuals find the "best fit" care management agency, ensure access to needed social services, and better address "movers" who transition between sites.
To further leverage our HH's care management experiences, BPHC will contract with Health Homes to deploy care managers to sites with high potential to identify and connect "at-risk" and HH eligible individuals to PCPs and care management resources. Outreach sites will include EDs and hospital inpatient units, Riker's Island discharge units, foster care agencies, transitional housing, adult homes, and other CBOs.

(2) Leverage existing Montefiore resources to identify and refer at-risk patients.
BPHC will build upon two existing assets provided by BPHC partner hospital MMC: (1) A risk stratification tool that uses claims and clinical data to identify at-risk patients, which will provide a starting point to identify and target this project's patient population; and (2) A Care Management Resource Unit (CMRU) that administratively coordinates patient referrals from the ED to HHs, PCPs, and other non-hospital providers. This resource can be used to address individuals' social needs, which present significant challenges to Bronx residents according to the CNA. BPHC will contract with MMC to assist SBH in establishing a CMRU-like unit that can serve attributed patients.
BPHC will also out-station HH representatives in the EDs to identify at-risk patients and connect them with the CMRU and hospital staff. This will enable warm hand-offs between providers and sites.

(3) Mobilize provider- and community-based resources to achieve project strategies.
Four hundred fifty-six of the PCPs in BPHC have already attained 2008 or 2011 NCQA Level 3 PCMH recognition, enabling them to more quickly meet 2014 NCQA standards through the addition of care managers to support at-risk HH patients. Montefiore Medical Center and other PPS partners operate school-based clinics which will be leveraged to identify both HH and at-risk HH children.
In addition, BPHC's HHs and hospitals have established relationships with mental, behavioral, and social service providers that will be relied upon to refer at-risk HH patients for services that meet their psychosocial needs. These efforts will be enhanced by the development of a web-based CBO provider service directory to facilitate direct referrals to support services like housing services, employment/vocational services, and food banks/food pantries. Developed under project 4.a.iii, this tool will help address social and economic factors that hinder good health outcomes.

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.

There is a lack of patient education and engagement about the risk factors, causes, and treatments for chronic diseases in the Bronx. In predominantly low-income immigrant and minority communities, economic, social, and linguistic difficulties create barriers to accessing primary care and increase reliance on the emergency department as a one-stop-shop for health services. BPHC will address this issue by helping PCPs to offer extended hours (evenings and weekends), adding care managers to their care teams, providing more resources for culturally-competent and locally-based patient education (e.g., employing peer-led patient engagement sessions through Bronx CBO Health People), and adding a patient portal. These new resources, combined with technical assistance to attain 2014 PCMH recognition, will materially strengthen access to and utilization of the primacy care infrastructure in the Bronx.
Interviews with BPHC members have identified significant variation in IT systems, use of HIE, and non-standard protocols across MCOs and HHs and their downstream care management agencies. This has created communication and coordination lapses across providers that result in lost opportunities to improve outcomes for at-risk patients. In addition to developing IT performance standards for Health Homes, the CSO will address these issues by building on existing and adding new IT capabilities, including a care plan and management platform, patient registries, direct messaging, patient risk stratification, and expanded HIE to increase information sharing among providers. These capabilities will be phased in during DY 1 and 2 across the PPS network.
As BPHC and other PPSs implement community based projects, the competition for workers will grow, creating challenges for recruitment of care management staff. As such, BPHC plans to coordinate with other PPSs to collaborate rather than compete for staff. BPHC will make targeted investments in workforce expansion and training. We are already working with the area community colleges, CBOs, 1199 training fund and NYSNA to identify a pipeline of peers and other care managers who can provide home and community-based navigation, education

and care management services. We will offer competitive salaries, use flexible hours, and employ job sharing as feasible to improve recruitment and retention.

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.

BPHC and the New York City Health and Hospitals Corporation (HHC) PPS have collaborated to select the Health Home At-Risk project and align key interventions related to its implementation. During the January–March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues, including Bronx-Lebanon Hospital Center's PPS, to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally-competent patient education resources to support this project. These efforts will be aided by implementation of a "care management taxonomy" across the aligned PPSs to ensure that there is clear, consistent terminology to describe care management roles, titles, and functions, and compensation levels, thus alleviating confusion and improving coordination.
Additionally, a critical component of the Health Home At-risk project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the PPS's network. The BPHC PPS plans to address IT implementation and Bronx RHIO utilization challenges with the other Bronx PPSs.

1. **<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.

2. **<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.

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.

BPHC will need capital funds to develop a shared health IT infrastructure to support BPHC-wide population health management efforts. Efforts will include (1) development and dissemination of a care management platform, telehealth and remote monitoring tools, and patient registries; (2) enhancement of Bronx RHIO capabilities and EMR system licenses for partner organizations; and (3) development of analytic and reporting processes and network management. Taken together, this strategy will support communication among BPHC partner organizations and help achieve a coordinated and accountable service delivery structure, both of which are critical to this project's success.

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
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.
Counseling Services of New York	New York State's Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recovery Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.
Cabrini of Westchester	Medicare Shared Savings Program	2014	2015	The Medicare Shared Savings Program (MSSP) is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. NOTE: Other entities participating in MSSP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	CMMI Pioneer ACO	2013	2015	The Pioneer ACO is a Federally funded program that is consistent with, but distinct from, the Medicare Shared Savings program. The program supports ACOs and their participants as they facilitate coordination among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Organizations are experienced in providing care coordination and patient-centered care. NOTE: Other entities participating in CMMI Pioneer ACO are listed in Appendix I.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of New York	HH	2012	Ongoing	See above for HH description.
Center for Urban Community Services	HH	2012	Ongoing	See above for HH description.
Morris Heights Health Center	HH	2014	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.
While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.
FIDA serves dual eligible individuals through managed long term care plans. FIDA enrollees are likely to participate in this project given that it targets individuals with high needs. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.
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.
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 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.
The Medicare Shared Savings Program and CMMI Pioneer ACO program target Medicare patients served through ACOs. We will build on the experience of these participants to establish our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.
The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

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

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

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

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

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

2.b.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.

In response to utilization patterns and survey data in the CNA documenting that Bronx residents do not have ready access to primary care services and/or do not know where to access the right services at the right time, Bronx Partners has selected Project 2.b.iii, ED Care Triage for At-Risk Populations. More than 25% of Bronx residents noted challenges in accessing health services and nearly half (46%) of reported using an ED in the last year.

Other indicators of need support this project selection: the Bronx has the highest rate of potentially avoidable inpatient hospitalizations and the second highest rate of preventable emergency room visits (PPV) of any NYC borough; Bronx-wide, NYS, and NYC PPV rates are 42/100, 36/100, and 34/100 beneficiaries, respectively. SDOH data indicates that a high number of these PPVs are attributable to frequent ED visitors with low severity medical and behavioral health issues who could be more appropriately addressed in primary or urgent care settings. According to the CNA, gaps in healthcare access are commonly attributed to lack of insurance, cost of co-pays, and inability to "get an appointment soon or at the right time" (CNA Community Need 8). Community members also link these issues to conditions of poverty and social need – factors that disproportionately affect the Bronx.

These gaps are compounded by provider shortages. Almost one-third of Bronx residents live in one of the borough's eight HRSA-designated Health Professional Shortage Areas, and four Bronx neighborhoods – Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven – fall in the NYS Health Foundation-funded study's category of highest need in the state for community health center expansion (CNA Community Need 2). Together, these factors increase reliance on emergency rooms for on-demand care and contribute to high rates of potentially avoidable ED visits and readmissions in the borough.

While EDs present an important touch point to enhance care coordination for non-urgent patients, PPS informants and CNA findings indicate a lack of ED staff dedicated to identifying and connecting non-urgent patients to more appropriate services, e.g., primary care, Health Homes (HH), and social services. Lack of data on patient service use and challenges identifying patients' PCPs have also been documented. These issues create barriers to successful care management and care transitions from the ED.

Through this project, BPHC will establish ED care triage programs to connect patients who use the ED frequently for low severity non urgent problems with primary care providers, HHs, and other community resources.

First, BPHC will expand the Clinical Navigator (CN) Program, the ED Triage program currently operated by Montefiore Medical Center (MMC), to additional MMC and SBH Health System facilities. Through this ED Triage program, BPHC will deploy approximately 12 nurses specially

trained on evidence-based care management principles (Clinical Navigator RNs) to all 5 BPHC EDs where they will identify and assess lower risk patients and provide medical screening examinations to validate non-emergency need. Following assessment, Clinical Navigator RNs will present patient information and history to ED physicians, who will determine if the patients are candidates for admission or for referral to non-ED services. Clinical Navigator RNs will schedule timely PCP appointments for all patients including those who do not have a PCP, and connect them to their HH care manager or refer the patient to a HH if appropriate.
Second, BPHC will help divert behavioral health patients away from the ED by increasing referrals to the Parachute NYC program. Parachute NYC aims to stabilize patient in the home or community respite setting to avoid unnecessary ED use and inpatient admissions. Parachute provides three levels of support: crisis respite centers, mobile treatment units, and peer support lines.

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.

This project will target ED users with multiple visits who have low to moderate severity diagnoses. Specifically, this project will seek to actively engage a proportion of attributed patients with two or more low severity ED visits (ESI Level 3 or above) at our PPS EDs, including those with a behavioral health diagnosis, an important sub-population for this project. Data (2013) from PPS hospitals further substantiate the need to address this patient population; between 36%–45% of total BPHC ED visitors were frequent ED utilizers who had problems categorized as ESI Level 3 or above (low to moderate severity), and between 72% and 95% of these patients visited but were not admitted to the hospital.
Our proposed number of actively engaged individuals will be reflected in the January 12 scale and speed submission, which will use updated attribution data expected to be released by the state. However, according to SDOH Round 3 attribution data using March 2013 – February 2014 claims, at least 28,000 attributed patients had two or more low-severity visits to BPHC EDs. We will initially focus engagement efforts on neighborhoods with the highest rate of PPVs: Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven.
In addition to visit frequency, we will target two additional sub-populations: (i) individuals with chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes, who account for the highest proportion of potentially preventable admissions in the Bronx; and (ii) frequent ED users who have many social risk factors that drive preventable ED utilization.
Our PPS's cardiovascular, diabetes, and asthma disease management DSRIP projects will concurrently address sub-populations with frequent ED use, which will help improve outcomes for this population across BPHC.

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

To achieve this DSRIP project's goals, BPHC will expand use of the following assets and resources within our PPS:
(1) Build upon Montefiore's successful ED Triage program for DSRIP implementation and training.
As discussed in section (a), the ED triage project intervention will build upon Montefiore Medical Center's (MMC) Clinical Navigator (CN) program. The program is currently operated in three MMC facilities and has achieved measurable success identifying and targeting lower risk ED patients for diversion and referral to non-ED sites. For example, between April 1, 2014 and June 30, 2014, 65% of individuals who participated in the program were diverted from MMC. While the program components described in section (a) are based on MMC's CN model, they have been modified through PPS planning to address DSRIP goals and lessons learned from implementing providers.
BPHC will leverage MMC's extensive experience designing and implementing the CN program in order to expand the model across BPHC hospital facilities. For example, BPHC will utilize the training program developed by Montefiore CMO Center for Learning and Innovation to provide RNs who do not have case management experience with training on best practices and evidence-based principles for successful case management. BPHC will also contract with the Montefiore CMO to assist with training/recruitment and provide technical assistance for implementation. This approach will help BPHC bring the CN program to scale quickly and in a standardized manner.

(2) Leverage other Montefiore resources to identify and refer at-risk patients.
BPHC plans to leverage a MMC risk stratification tool that uses claims and clinical data to identify at-risk patients. This will provide a starting point to identify and target this project's patient population – ED users with multiple visits who have low to moderate severity diagnoses – across BPHC EDs. In addition, MMC's existing Care Management Resource Unit (CMRU) administratively coordinates patient referrals to important post-discharge support services, e.g, transportation, social services, housing, in close consultation with Clinical Navigator RNs. BPHC will contract with MMC to assist SBH in establishing a CMRU-like unit that can serve as a referral resource for SBH patients.

(3) Leverage the capabilities of Health Homes to provide care management and improve linkages to non-hospital providers.
BPHC's three Health Home partners have extensive experience working with Medicaid beneficiaries who are not engaged in care and in sustainably linking patients to PCPs. Through DSRIP Project 2.a.iii, BPHC will out-station Health Home representatives in the ED and team them with CMRU and CN staff to enable warm hand-offs to PCPs, Health Homes, and other community resources.

(4) Build upon the experiences of BPHC members who have already implemented the

Parachute NYC program for Bronx residents.
Riverdale Mental Health Association (RMHA) was selected by NYCDOH to house the Bronx ten-bed crisis respite center, which has been operational since September 2013. RMHA has played a significant role in PPS member project planning to date, and it will be a valuable asset as we raise awareness and expand Parachute resources to PPS members. VNSNY, also an active BPHC planning partner, has implemented the Mobile Crisis element of the program and will continue to work with BPHC during implementation.

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 BPHC has significant assets, we anticipate navigating challenges related to patient reliance on the ED, lack of availability of patient data at point of care, and low awareness of the Parachute NYC program.
Patient reliance on the ED is deeply engrained in the Bronx population. The CNA found that patients' perceptions of long wait times for medical appointments and of "one stop shopping" in EDs contributes to high ED use. To address these issues, BPHC will increase access to primary care by (i) expanding community health centers' scope of services and hours, (ii) using open access scheduling to help get same day/next day appointments, and (iii) opening at least two new urgent care centers and one additional respite facility to make additional sites available for at-home or in-community stabilization. BPHC's CSO will additionally develop more effective and culturally appropriate approaches to patient education that market the benefits of PCP engagement and the downsides of ED use.
IT challenges across providers present additional barriers to ED triage and care coordination efforts. Many of the alternatives to the ED, including urgent care centers, Parachute NYC, PCPs, and CBOs do not have EMR data sharing capabilities and are not connected to the Bronx RHIO. Without these capabilities, patient information is not accessible at the point of care and cannot be shared electronically with patients' PCPs. Based on strategies developed by the PPS's IT planning team, during DY 1 and 2, BPHC will implement common assessment and risk stratification tools; make a care planning application accessible to all providers with whom the patient is engaged; promote greater adoption and use of EHRs and HIE among providers; and utilize a patient portal.
Finally, the Parachute NYC program has experienced low utilization rates due to restrictive eligibility criteria and lack of provider knowledge about the program. To increase program engagement, BPHC will expand the program eligibility criteria to include individuals who are homeless and/or who have substance use issues. These populations tend to have high ED utilization and can benefit greatly from care management services. In addition, the PPS will engage in a multi-media provider and patient awareness campaign to build awareness, trust, and engagement in the Parachute program.

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.

BPHC and the New York City Health and Hospitals Corporation (HHC) PPS have collaborated to select the ED triage project and align key interventions related to its implementation. During the January–March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Additionally, a critical component of the ED triage project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the PPS's network. The BPHC PPS plans to discuss IT implementation and address Bronx RHIO utilization challenges with the other Bronx PPSs to address this.

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)

Yes	No
☒	☐

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

BPHC will require capital funds to support expansion of crisis respite centers, mobile treatment units, urgent care centers and NYC sobering centers. Specifically, capital funding will be needed for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions across these sites. These capital improvements are needed to successfully curb preventable ED utilization among frequent, low severity utilizers, especially those in the behavioral health population.

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
Montefiore Medical Center	Bundled Payments for Care Improvement	2014	2017	The Bundled Payments for Care Improvement Initiative, a program developed by the Center for Medicare and Medicaid Innovation, enables organizations to enter into Medicare payment agreements that are linked to services beneficiaries receive for episodes of care. These episodes are focused on acute care inpatient hospitalizations and post-acute care for selected diagnoses.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Visiting Nurse Service of NY	Parachute NYC	2012	2015	The Parachute NYC program is funded by NYC DOHMH and the Center for Medicare and Medicaid Innovation to provide coordinated care and psychiatric treatment to the SMI population and those in psychiatric crisis.
Riverdale Mental Health Association	Parachute NYC	2012	2015	See Parachute NYC description above.
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.
Counseling Services of New York	Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recovery Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes for Medicaid Enrollees with Chronic Conditions and for Childre	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.
Cabrini of Westchester	Medicare Shared Savings Program	2014	2015	The Medicare Shared Savings Program (MSSP) is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. NOTE: Other entities participating in MSSP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	CMMI Pioneer ACO	2013	2015	The Pioneer ACO is a Federally funded program that is consistent with, but distinct from, the Medicare Shared Savings program. The program supports ACOs and their participants as they facilitate coordination among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Organizations are experienced in providing care coordination and patient-centered care. NOTE: Other entities participating in CMMI Pioneer ACO are listed in Appendix I.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

The Bundled Payments for Care Improvement Program supports payment arrangements for Medicare organizational providers on behalf of Medicare beneficiaries. We will build on the experience of implementing providers to develop our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.

The Parachute NYC program provides alternatives to hospitalization for SMI populations and those experiencing psychiatric crisis. BPHC's model will build on existing implementation of the Parachute program, but this project will expand use of and access to the mobile crisis unit, peer

counseling, and respite centers for our engaged population. In addition, DSRIP funding will not overlap for a significant period with Parachute funding, as Parachute's support ends in June 2015.
FIDA serves dual eligible individuals through managed long term care plans. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.
The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.
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. Our projects 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.
The Medicare Shared Savings Program and CMMI Pioneer ACO Program target Medicare patients served through ACOs. We will build on the experience of these participants to establish our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.
The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

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. 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.

Addressing avoidable readmissions through Project 2.b.iv, Care Transitions Intervention Model to Reduce 30-day Readmissions, is a high need in the Bronx. The Bronx's rate of potentially preventable readmissions (PPRs) is 5% higher than NYC and 13% higher than NYS as a whole. Bronx hospitals also have 13% more PPRs than expected. Readmissions are most common for patients with chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes – conditions that are also associated with substantial utilization and costs.

Community members consider chronic conditions to be a top health concern, often linked to conditions of poverty. A higher proportion of Bronx households (29%) live below the federal poverty level than in NYC (19%) or NYS (14%) as a whole, with rates as a high as 40% in some lower-income neighborhoods. More than half (57%) of the Bronx population are non-native English speakers and 41% of non-citizens have limited English proficiency. These economic, cultural and linguistic barriers contribute to challenges accessing the healthcare system, non-compliance with discharge regiments following hospitalization or discharge from a skilled nursing facility (SNF), and high readmission rates.

These gaps are compounded by provider shortages. Almost one-third of Bronx residents live in one of the borough's eight HRSA-designated Health Professional Shortage Areas, and four Bronx neighborhoods – Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven – fall in the NYS Health Foundation-funded study's category of highest need in the state for community health center expansion.

While pre- and post-discharge care transition services offer strategies to reduce avoidable readmissions and improve linkages to community providers, gaps currently exist in discharge planning and follow-up processes (CNA Community Need 7). According to the CNA, community members have difficulty adhering to medication recommendations in under-resourced home environments and have trouble making appointments due to limited public transportation services. In addition, Bronx patients and caregivers are frequently discharged without clear understanding of their discharge plan, and there is lack of coordination between discharge planners and non-hospital/SNF providers, such as Health Homes, home care, and palliative care services.

These needs inform our selection of the Care Transitions to Reduce 30-Day Readmissions Program. Through this program, BPHC will implement two models that provide care transitions and community-based supports for patients at high risk of readmission for 30-days post-hospitalization or SNF discharge.

BPHC will implement the "BPHC Transitional Care Program," a hybrid of evidence-based care transitions programs (BOOST, Naylor, Coleman and RED).

In this model, a nurse care transitions manager works within a broader care team to:

i. Identify and target patients with medical-only conditions who are most at risk for readmission;

ii. Provide pre-discharge visits that educate patients and caregivers about their conditions and how to manage them, review discharge summaries and care plans, and perform medication reconciliation;

iii. Improve linkages to post discharge care by evaluating the need for pharmacy consultation, making appointments and following-up with PCPs, and coordinating patient

referrals to Health Home care managers and social service CBOs; and
iv. Provide multiple post-discharge contacts and continued linkages to community-based supports over a 30-day transition of care period.
The second model, the Critical Time Intervention (CTI), addresses the needs of behavioral health patients, a population currently excluded from many care transitions programs. CTI is a nine-month empirically-based intensive care transitions model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals and shelters.

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.

BPHC has analyzed New York State Department of Health (SDOH)-released claims data from March 2013 through February 2014 to identify patients who were at highest risk of readmission based on diagnoses and payer. This definition includes diagnoses most at risk for readmission, such as cardiac, renal, diabetes, respiratory, and behavioral health conditions as per the DSRIP toolkit. BPHC also identified individuals who are Health Home eligible as well as dual eligible, as these populations experience high social needs and comorbidities that present additional readmission risk factors.
Active engagement is defined as completing a care transition plan prior to discharge and not readmitted within a 30-day period. We expect to target for active engagement a portion of those at high risk for readmissions, which will be determined based on the size of the target population and PPS capacity. We anticipate that we will reduce the readmission rate by 25% over pre-DSRIP baseline levels. Our proposed number of actively engaged individuals will be reflected in the January 12 scale and speed submission, which will use updated attribution data expected to be released by the State. However, our analysis of New York SDOH-released claims data from March 2013 through February 2014 using Round 3 attribution data identified 9,200 patients who were at highest risk of readmission based on diagnoses and payer.
The PPS will focus in particular on patients with cardiac, gastroenterology, and pulmonary conditions, who alone accounted for 40% of readmissions to SBH Health System and Montefiore Medical Center (MMC) in 2012.
We will prioritize areas with the largest proportion of Bronx PPVs and PPRs, which include Fordham-Bronx Park and along the Grand Concourse to the South Bronx.
Our PPS's primary care–behavioral health integration (3.a.i), diabetes (3.c.i), cardiovascular (3.b.i), asthma (3.d.ii), and Health Home at-risk (2.a.iii) DSRIP projects will concurrently address sub-populations at risk for hospital and SNF readmissions, which will help improve outcomes for this population across BPHC.

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

To achieve this DSRIP project's goals, BPHC will expand use of the following assets and resources within our PPS:
(1) Leverage the extensive experience of BPHC hospitals and PPS partners who have already implemented versions of both care transitions programs.
First, BPHC will leverage the extensive experience of BPHC hospitals who had implemented Bronx Collaborative, the care transitions program on which this project is based. Funded by the New York State Health Foundation in 2009, the Bronx Collaborative (BC) was a care transitions program designed to lower hospital readmission rates though enhanced discharge planning and post-hospitalization follow-up for at-risk patients at Montefiore Medical Center (MMC), SBH Health System, and Bronx-Lebanon Health Center. During its operational period, the program achieved measurable success, resulting in a high number of referrals to PCPs, Health Homes, and other non-hospital providers and a 33% reduction in readmissions for program participants. BC was terminated in 2011 when the grant ended.
BC will serve as a core model for the BPHC Transitional Care Program implementation at SBH and MMC sites. While the program components described in section (a) are based on the BC model, they have been modified through PPS member planning to better address the DSRIP target population and incorporate lessons learned from implementing providers. To further leverage the BC experience, BPHC will utilize the rigorous 75-hour training program specially designed by Montefiore CMO Center for Learning and Innovation to train staff of the BC program. BPHC will also contract with Montefiore CMO to provide training and technical assistance on implementation.
Second, with respect to Critical Time Intervention (CTI), the Center for Urban Community Service (CUCS), the lead training organization for CTI, is a member of BPHC. During implementation, BPHC will leverage CUCS' certified trainers to provide education and training on the model.

(2) Build upon existing Montefiore resources to identify and refer at-risk patients.
BPHC will build upon two existing resources provided by MMC: (1) A risk stratification tool that uses EHR data to identify patients most appropriate for care management services, which will provide a starting point to identify and target this project's patient population; and (2) A Care Management Resource Unit (CMRU) that administratively coordinates patient referrals, which will address patients' social needs by coordinating referrals from nurse care transitions managers and other discharge staff to transportation and community-based social services providers. BPHC will contract with MMC to assist SBH in establishing a CMRU-like unit that can serve SBH patients.

(3) Leverage BPHC's existing community-based home and community based provider networks.
To ensure we close the care transition loop and extend support beyond 30 days for higher at-risk individuals, we will expand use of BPHC partners' skilled and non-skilled home care services. This will include PPS partner Methodist Home for Nursing and Rehabilitation, which is planning to convert 40 skilled nursing beds to an acute care step-down unit capable of

receiving medically complex patients discharged from the hospital who need residential care, short-term rehabilitation and connection to community-based/care transitions services. Through DSRIP Project 2.a.iii, BPHC will out-station HH representatives in the ED and team them with CMRU and hospital discharge staff to enable warm hand-offs to PCPs, Health Homes, and other community resources. In addition, under project 4.a.iii BPHC and its collaborating PPSs will build a web-based CBO provider service directory that will facilitate direct referrals to post-discharge support services like housing services, home food delivery services and volunteer home visiting programs that mitigate social factors that often pose barriers to attending to health concerns.

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.

PPS stakeholders/Members identified significant communication and care coordination lapses among provider types, particularly between hospitals, PCPs, and Health Homes. Without adequate resources and incentives to improve coordination, care coordination and transition services will remain limited. Based on strategies developed by the PPS's IT planning team, the CSO will address these issues by building on existing and adding new IT capabilities, including a care plan and management platform, patient registries, direct messaging, patient risk stratification, standardized e-discharge summaries, and expanded HIE. These strategies will increase information sharing among providers, the care transitions team, PCPs, Health Homes, and home-based service provider Incentives will be addressed through the development of the IDS as part of 2.a.i.

Recruiting and training care management staff, particularly those with experience and training working with mental health and behavioral health patients, presents another challenge to care coordination and readmission reduction efforts. According to the CNA, lack of funding and low salaries have made hiring quality care management staff difficult to date. To address these challenges, BPHC will work with the area community colleges, CBOs, 1199 training fund and NYSNA to help recruit and train a pipeline of care management staff and offer competitive salaries, use flexible hours, and employ job sharing as feasible to improve recruitment and retention. As noted in section (c), BPHC will also use CUCS to train staff on CTI, which will help address current gaps in identifying and treating behavioral health needs.

Finally, BPHC will implement several strategies to address social determinant barriers to care, which have posed barriers to patient engagement and led to unnecessary readmissions. Specifically, BPHC is selecting among several evidence-based assessment tools that detect social barriers to care to build into the care transition model. All staff supporting care transitions will be trained or re-trained on cultural competency and health literacy using curriculum developed through the CSO. In addition, BPHC also plans to implement a web-based directory of preferred CBO providers that incorporates service scope and contact information, and develop e-referrals as part of the BPHC portal.

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.

BPHC and the New York City Health and Hospitals Corporation (HHC) PPS have collaborated to select the 30-Day Readmissions project and align key interventions related to its implementation. During the January–March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues, including Bronx-Lebanon Hospital Center's PPS, to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Additionally, a critical component of the 30-Day Readmissions project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the PPS's network. The BPHC PPS plans to discuss IT implementation and address Bronx RHIO utilization challenges with the other Bronx PPSs to address this.

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.

BPHC will require capital funds to expand crisis respite centers, which could provide non-medical support for individuals post acute care discharge. Specifically, capital funding will be needed for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions for these sites. In addition, the CSO will develop and disseminate a care management platform, telehealth and remote monitoring tools, and patient registries, as well as enhance Bronx RHIO capabilities and EMR system licenses for partner organizations. These efforts and their accompanying capital needs are critical to increasing information sharing among providers, the care transitions team, PCPs, Health Homes, and home-based providers and to facilitating population health management.

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

Yes **No**

☒ ☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Jewish Association Serving the Aging	Balanced Incentives Program (BIP)	2014	2015	The Balancing Incentive Program (BIP) is a Federally funded State Medicaid program developed to increase access to non-institutional long-term services and supports (LTSS). This is intended to create a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children	BIP	2014	2015	See BIP description above.
Health People, Inc.	BIP	2014	2015	See BIP description above.
United Cerebral Palsy Assocations of NYC	BIP	2014	2015	See BIP description above.
Project Renewal	BIP	2014	2015	See BIP description above.
God's Love We Deliver, Inc.	BIP	2014	2015	See BIP description above.
Montefiore Medical Center	Bundled Payments for Care Improvement	2014	2017	The Bundled Payments for Care Improvement Initiative, a program developed by the Center for Medicare and Medicaid Innovation, enables organizations to enter into Medicare payment agreements that are linked to services beneficiaries receive for episodes of care. These episodes are focused on acute care inpatient hospitalizations and post-acute care for selected diagnoses.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Visiting Nurse Service of NY	Parachute NYC	2012	2015	The Parachute NYC program is funded by NYC DOHMH and the Center for Medicare and Medicaid Innovation to provide coordinated care and psychiatric treatment to the SMI population and those in psychiatric crisis.
Riverdale Mental Health Association	Parachute NYC	2012	2015	See Parachute NYC description above.
Institute for Family Health	Community-based Care Transitions Program (CBCT)	2011	2016	The Community-based Care Transitions Program is a Federally funded program that tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
Montefiore Medical Center	CBCT	2013	Ongoing	See CBCT description above. NOTE: Other entities participating in CBCT are listed in Appendix I.
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Counseling Services of New York	Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recovery Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cabrini of Westcheste	Medicare Shared Savings Program	2014	2015	The Medicare Shared Savings Program (MSSP) is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. NOTE: Other entities participating in MSSP are listed in Appendix I.
SBH Health System	CMMI Pioneer ACO	2013	2015	The Pioneer ACO is a Federally funded program that is consistent with, but distinct from, the Medicare Shared Savings program. The program supports ACOs and their participants as they facilitate coordination among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Organizations are experienced in providing care coordination and patient-centered care. NOTE: Other entities participating in CMMI Pioneer ACO are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management. NOTE: Other entities participating in HWRI are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.
While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.
Balancing Incentive Program. While BPHC can leverage participating providers' experiencing improving care for this specialty Medicaid population, BPCH will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.
Bundled Payments for Care Improvement Program. We will build on the experience of implementing providers to develop our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.
Parachute NYC. BPHC's model will build on existing implementation of the Parachute program, but this project will expand use of and access to the mobile crisis unit, peer counseling, and respite centers for our engaged population. In addition, DSRIP funding will not overlap for a significant period with Parachute funding, as Parachute's support ends in June 2015.
Community-based Care Transitions (CBCT). BPHC will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid

population in each of our hospitals. Funds will not be provided to these providers if doing so would supplant or duplicate CBCT funding.
FIDA. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.
HARP. This DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.
NYS Health Home program. This 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.
Medicare Shared Savings Program and CCMI Pioneer ACO Program. We will build on the experience of these participants to establish our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients.
Healthcare Workforce Retraining Initiative. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 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.

Data drawn from the CNA and SDOH amply document a high need for Project 3.a.i, Integration of Primary Care and Behavioral Health (PC-BH), in the Bronx. According to the CNA, Bronx residents report higher rates of serious psychological distress (7.1%) than New York City as a whole (5.5%). Community members have indicated that behavioral health issues, including anxiety, depression and substance abuse, are among the most pressing health issues facing residents. In addition, over half (54.4%) of Bronx adults with behavioral health issues served by NYS Office of Mental Health programs in 2013 had one or more chronic medical condition. Individuals who have high rates of mental and physical health conditions and severe alcohol and substance abuse disorders have substantial utilization of ED services. Social factors like poverty, unemployment, language barriers can trigger or worsen such disorders and increase ED use. The Bronx ranks last among all counties in the State with regards to social factors, making this issue particularly acute in the borough.

While the Bronx has high mental health and substance abuse utilization, only 53.3% of CNA survey respondents reported that mental health services are "available" or "very available" in their community. The Bronx has substantially lower rates of general psychiatrists (28.1 per 100,000) than the NYC rate of 49 per 100,000 (CNA Community Need 3). Gaps in care are compounded by insufficient provider training and coordination of services.

These needs inform our selection of the PC-BH Integration project. BPHC will implement all three project areas outlined in the DSRIP toolkit. Together, these projects will expand access to services and enable BPHC to better coordinate care between primary care and behavioral health (BH) providers, addressing artificial distinctions between these services and enabling providers to instead treat the whole person (CNA Community Need 4).

Specifically, BPHC will:
(1) Physically co-locate BH providers into primary care practice sites (Article 28) where feasible, considering volume, physical space, financial sustainability and regulatory barriers. These sites will implement the Collaborative Care Model (CCM) (aka IMPACT) and provide screening, medication management, and care engagement services.
(2) Physically co-locate primary care providers into BH sites (Article 31/32) where feasible to improve patient-provider engagement and expand access to medical services and medication management.
(3) Pursue virtual co-location in sites where physical co-location is not feasible through shared electronic care plans, telemedicine capabilities, and expanded medical monitoring.
(4) Expand implementation of the CCM/IMPACT to all PCMH Level 3 and Article 28 sites. BPHC will utilize this evidence-based model to screen patients for behavioral health issues using PHQ2, PHQ9, and SBIRT. In this model, care teams that include PCPs, depression care managers and consulting psychiatrists treat those with mild/moderate depression using a shared care plan, treatment-to-target and stepped care to improve outcomes. Patients with serious depression will be referred to mental health providers.

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.

This project will target all attributed patients ages 12 years and over who visit a project-participating PCP or BH professional in our PPS network. Using the definition of actively engaged patients as those who require and receive PHQ9 or SBIRT, we will estimate the population engaged by using SDOH screening targets (85% screened with PHQ2/SBIRT and of those, 15% screen positive requiring a PHQ9 screening) for the NYS Collaborative Care grant program currently underway. Montefiore, a BPHC partner, is participating in this grant program. Our proposed number of actively engaged individuals will be reflected in the January 12 scale and speed submission, which will use updated attribution data expected to be released by the State. However, analysis of SDOH Round 3 attribution data from March 2013 – February 2014 estimates more than 198,000 beneficiaries ages 12 years and over are in our

PPS, and approximately 79% of all attributed beneficiaries had a PCP visit during the data period.

We will prioritize the neighborhoods with the highest rate of attributed beneficiaries with BH issues, including Fordham-Bronx Park, Crotona-Tremont, Pelham-Throgs Neck, and High Bridge-Morrisania. According to the CNA, Pelham-Throgs Neck and South Bronx have particularly high rates of psychological distress, with 8%–9% of residents reporting it, compared to 7% of Bronx and 5.5% of NYC residents, respectively.

Our PPS's DSRIP projects 3.b.i and 3.c.i will concurrently address these populations, thus optimizing patient engagement opportunities and efforts to improve patients' health status across BPHC projects.

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

To achieve this project's goals, BPHC will expand use of the following assets and resources within our PPS:

(1) Build upon the extensive experience and expertise of PPS members who have experience implementing the three models.
Several PPS partner organizations, including Montefiore Medical Center, Morris Heights and Institute for Family Health (IFH) have implemented IMPACT/CCM and co-location models in 14 Bronx sites. Nationally recognized for its integrated care model, IFH was one of the first locations to implement IMPACT and was hired by the Advancing Integrated Mental Health Solutions (AIMS) Center to provide technical assistance and on-site training to several NYC sites. In total, IFH has trained nearly 1,000 staff and 11 sites on the model. BPHC will leverage this experience by engaging IFH to provide technical assistance to train primary care teams consisting of PCPs, care managers and psychiatrists at all PCMH and Article 28 sites on the model. This will help BPHC address care coordination needs cited in the CNA and widely reported by both primary and behavioral health care providers.

In addition, approximately 60 primary care sites and 20 behavioral health sites in the PPS have implemented some level of co-located physical and behavioral health services. Some of these sites have provided important advisement on lessons learned and best practices during the PPS planning stages and will continue to do so during implementation at new sites. They have also identified gaps and targeted areas for improvement, such as regulatory restrictions, that BPHC will address through regulatory relief, as described in other sections of this application.

(2) Leverage BPHC's existing community-based home and community based provider networks.
The Bronx has strong provider- and community-based resources that will be mobilized to achieve the strategies above. Four hundred fifty-six of the PCPs in BPHC have already attained 2008 or 2011 NCQA Level 3 PCMH recognition and will be ready to quickly implement components of this project. As part of efforts to move to 2014 NCQA standards, BPHC will work

with NYC government resources like NYC REACH who have provided technical assistance to small independent primary care practices, to help ensure PCPs meet NCQA level 3 recognition and Meaningful Use standards.

(3) Expand and strengthen the care management expertise and referral resources within our network.

Lastly, BPHC's three partner Health Homes serving the Bronx (CBC, CCMP, and BAHN) have expertise in providing care management, community supports, and referrals to individuals with mental/behavioral health issues. BPHC is collaborating with its Health Home members through project 2.a.iii to establish common practice standards and technology that will improve care management services and strengthen linkages to primary care teams.

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 BPHC has significant assets, we anticipate navigating three challenges during implementation:

(1) Provider engagement. As noted in the CNA, PCPs are generally not trained to treat mental health/behavioral health patients and thus lack the necessary knowledge and confidence to treat them effectively. They have little or no professional support on hand for consultation and care management support. The CCM/IMPACT models are specifically designed to address these issues through education and the addition of depression care managers and consulting psychiatrists. Technical assistance and provider trainings provided through nationally-recognized BPHC partner IFH will further enable BPHC to bring IMPACT/CCM to scale quickly and effectively.

(2) Provider shortages. The addition of the new CCM staff, in combination with telehealth and IT solutions that BPHC's Central Services Organization will employ, will help to address psychiatrist and social worker provider shortages described in section (a).

(3) Patient Engagement. Mentally ill individuals pose significant engagement challenges, particularly as it relates to consent to share their health information. To increase patient engagement, BPHC will work with the MHSA Workgroup, a collaboration among HHC, BPHC and Community Care of Brooklyn under project 4.a.iii, to develop new culturally-appropriate educational materials and related training programs. BPHC and its partner PPSs will also create and implement a standard consent form that will help patients better navigate and understand the consent process.

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.

BPHC and the New York City Health and Hospitals Corporation (HHC) PPS have collaborated to select the Primary Care Behavioral Health Integration project and align key interventions related to its implementation. During the January - March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues, including Bronx-Lebanon Hospital Center's PPS, to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Additionally, a critical component of the Primary Care Behavioral Health Integration project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the PPS's network. The BPHC PPS plans to discuss IT implementation and address Bronx RHIO utilization challenges with the other Bronx PPSs to address this.

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

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

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

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

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

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

4. <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.

BPHC will require capital funds for the renovation and expansion of clinics to support physical co-location of primary care into behavioral health sites and vice versa. Specifically, capital funding will be needed for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions to expand existing and create new co-located sites. BPHC will also require capital funding for development and expansion of shared HIT, telemedicine capabilities such as videoconferencing for remote consult, and medical monitoring to support virtual co-location, increase care coordination among providers, facilitate population health management, and via telemedicine, increase patient-provider contacts without sacrificing productivity.

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
Montefiore Medical Center	Bronx Behavioral Health Integration Project	2014	2016	The Bronx Behavioral Health Integration Project (B-HIP) is funded through a Center for Medicare and Medicaid Innovation Health Care Innovation Award. B-HIP is designed to provide behavioral health screening services and the Collaborative Care Model in selected Montefiore primary care practices to Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, as well as individuals covered in private health plans.
VIP Community Services	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2014	Ongoing	This SAMHSA grant, under the Federal Minority AIDS Initiative Continuum of Care Pilot, supports co-located and integrated primary care and enhanced HIV treatment and prevention.
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.
New York Harm Reduction Educators	HWRI	2015	2016	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of New York	HH	2012	Ongoing	See above for HH description.
Montefiore Medical Center	HH	2012	2014	See above for HH description.
Morris Heights Health Center	HH	2014	Ongoing	See above for HH description.
Leake and Watts Services, Inc.	HH	2016	Ongoing	See above for HH description.
The Children's Aid Society	HH	2015	Ongoing	See above for HH description.
Jewish Board of Family and Children's Services	HH			See above for HH description.
Graham Windham	HH	2015	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or

duplicate funding from the initiatives listed above.

The Bronx Behavioral Health Integration Project supports implementation of an evidence-based and age-appropriate CCM/IMPACT model at Montefiore facilities. We will build on this experience by (i) extending the model to many more sites, including those with co-located primary care and behavioral health providers; (ii) significantly expanding IT solutions to enhance care engagement and medical monitoring/management services through remote monitoring tools and a care planning platforms across participating PPS providers; and (iii) extending the model to a broader population of Medicaid patients. DSRIP funds will not be provided to this provider if doing so would supplant or duplicate CMMI funding.

The SAMHSA Minority AIDS Initiative Continuum of Care Pilot supports the integration of primary care and behavioral health. Our partner's experience with co-location will be valuable to BPHC, but DSRIP funds will not be provided to this provider if doing so would supplant or duplicate SAMHSA funding. Under this project, BPHC will also extend a co-location model to additional sites and patients.

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 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.

The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

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.

Addressing cardiovascular disease (CVD) through Project 3.b.i, Evidence-Based Strategies for Disease Management of CVD, is a high priority in the Bronx. More than one-quarter of Bronx Medicaid beneficiaries have utilized services in the past year for CVD. CVD is the leading cause of mortality in the borough among white, black, and Hispanic residents, and the Bronx age-adjusted mortality rate for diseases of the heart (225.8/100,000 residents) surpasses city (212.2) and state (198.6) rates. Community members have indicated that addressing CVD is a community need; over 40% of CNA respondents indicated that hypertension is a particularly high area of concern. Accordingly, there is substantial utilization associated with CVD in the Bronx; the hospitalization rate for CVD is 210.8 per 10,000 residents as compared to 173.6 and 159.9 per 10,000 for the city and state, respectively (CNA Community Need 10). A high number of these CVD hospitalizations are preventable; in 2012, there were 3,173 PQI admissions among Medicaid beneficiaries for circulatory conditions, representing 20% of all such hospitalizations in the state. Comparatively, the Bronx only has approximately 14% of statewide Medicaid

beneficiaries.
The Bronx is disproportionately affected by CVD in part due to primary care provider (PCP) shortages in certain neighborhoods and gaps in care. Almost one-third of Bronx residents live in one of the borough's eight HRSA-designated Health Professional Shortage Areas and four Bronx neighborhoods, Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven, fall in the CHCANYS-designated category of having the highest need for community health center expansion in the State (CNA Community Need 2). Within primary care sites, there is a lack of care management staffing to fully implement PCMH care teams, preventing PCMHs from reaching their potential.
In addition, the enormous social needs in the Bronx have hindered the borough's ability to attain good outcomes. The Bronx ranks last among all counties in the state on adverse social and economic factors, yet providers still lack the knowledge of community resources to support patients when these factors negatively impact care plan adherence.
BPHC will employ strategies from the Million Hearts initiative guide, "Hypertension Control: Action Steps for Clinicians," as a framework for CVD management, including the following:
a) Helping primary practices attain 2014 NCQA Level 3 PCMH recognition
b) Aiming to engage at least 80% of BPHC PCPs to employ evidence-based standardized hypertension and cholesterol protocols, such as the American Medical Group Foundation's Provider Toolkit and appointing a CVD clinical champion to engage and motivate providers to fully implement the protocols
c) Making blood pressure checks more available on a drop-in basis without a copay and in community-based settings, improving access
d) Training additional clinic personnel on how to take accurate blood pressure measurements
e) Deploying new technology to support providers including a patient registry and a standardized care planning tool for 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.

This project's target population is all attributed beneficiaries ages 19 and up with a CVD-related diagnosis, including hypertension (HTN), congestive heart failure (CHF), angina, and high cholesterol. We will actively engage a proportion of beneficiaries with at least one annual PCP visit. Our proposed number of actively engaged individuals will be reflected in the January 12 speed and scale submission, using updated attribution data. However, SDOH Round 3 attribution data from March 2013 – February 2014, found 37,874 attributed beneficiaries ages 19 and over with a CVD-related diagnosis. In participating PCMHs, care coordination teams will identify individuals with CVD-related diagnoses with attention to the dual eligible population that often has severe social needs. BPHC will also work with MCOs to engage patients assigned to a participating PCMH who have not received disease management services. Standardized assessments and protocols will identify opportunities to coordinate disease management services for patients with both a CVD-related diagnosis and diabetes (Project 3.c.i).
BPHC will prioritize provider outreach related to active engagement (i.e., documenting self-

management goals in the medical record) in neighborhoods with the highest number of attributed beneficiaries with CVD according to claims data: Crotona-Tremont, Fordham-Bronx Park, Pelham-Throgs Neck, High Bridge-Morrisania, and the Northeast Bronx. These neighborhoods also have the highest rates of PQI admissions for HTN and CHF in the borough, in some zip codes reaching over double the expected rate.

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 key strategy to achieving this goals of this project will be implementing a robust CVD disease management approach within these practices. This disease management approach will include the components described in section (a). BPHC will invest in primary care practices to create the care team needed to achieve Level 3 PCMH recognition and successfully implement CVD disease management. Care coordination teams will include PCPs, medical assistants, nurses, care managers, and peer educators, all of whom will be trained to educate and motivate the target CVD population and the broader community in a culturally competent manner. Our care planning tool will be able to consume discrete data from EHRs, CBOs, and claims to populate a care management plan that will guide patients, PCPs, care managers and other key providers.

We plan to address the primary care shortage for in-need Bronx neighborhoods by requesting capital dollars to build additional primary care facilities and collaborating with our Bronx PPS partners to recruit needed PCPs. In addition, we will institute a patient engagement strategy that will address the social determinants of health, such as by using peer educators in one-on-one sessions, linking patients to the YMCA's wellness program and other CBOs, and using the peer-led Stanford Self-Care group model.

BPHC has strong, diverse provider- and community-based resources that will be mobilized to achieve these strategies. Four hundred fifty-six of the PCPs in BPHC have already attained 2008 or 2011 NCQA Level 3 PCMH recognition and will be ready to quickly implement components of this project. In conjunction with CVD disease management, the IDS (2.a.i), the Health Home at-risk (2.a.iii), and diabetes disease management (3.c.i) projects will support efforts to move to 2014 NCQA standards. Care managers will be added to PCMH care teams to expand capacity to manage and support of patients with CVD who are at risk of co-morbidities. BPHC includes three Health Homes serving the Bronx that contract with agencies that have expertise in providing care management services for individuals with chronic conditions. BPHC's network will also benefit from the nationally recognized Montefiore Einstein Center for Heart and Vascular Care to offer expertise in evidence-based practices in managing patients with CVD. BPHC is fortunate to have Health People (HP), a Bronx CBO specializing in evidence-based patient education as a partner. HP has received a state grant to (1) implement the Stanford model in the Bronx; and (2) develop a system for Bronx clinicians to make referrals to CBOs with the CBOs also having capacity to report back to the physicians through the electronic system of QTAC (Quality and Technical Assistance Center), the state- and CDC-supported Center at the University of Albany that oversees implementation of evidence-based self-care and prevention courses in New York State.

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.

BPHC anticipates navigating and addressing the following challenges during implementation:
a) It will be challenging to recruit and train sufficient care management staff to serve the needs of the Bronx population. As part of our workforce strategy, BPHC will work with community colleges and CBOs to identify a pipeline of care management staff and coordinate with 1199 Job Security Fund and NYSNA to identify displaced workers who may be interested in such positions. We will contract with the 1199 Training Fund and other training organizations to ensure that these staff are adequately trained. We will also use alternative employment tactics, flexible hours, and job sharing where feasible to attract a broader pool of workers.
b) Some PCPs may find it difficult to make the changes required by this project, such as adherence to evidence-based guidelines and attaining 2014 PCMH recognition. To build consensus on guidelines and methods for engagement, Partners implementing this project will be required to participate in the Disease Management Rapid Deployment Collaborative to share best practices and institute continuous quality improvement.
c) There is a lack of patient education about long-term negative effects of HTN and unmanaged CVD, which is compounded by low educational attainment in the Bronx. High-risk neighborhoods such as High Bridge-Morrisania have ZIP codes where less than 60% of the population has a high school diploma. Projects 3.b.i, 2.a.iii and 3.c.i will enable BPHC to invest in more peer educators and care managers to educate and promote 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.

BPHC and the Health and Hospitals Corporation (HHC)-led PPS have collaborated to select the Project 3.b.i and to align key interventions related to its implementation. During the January-March 2015 implementation planning period, we intend to collaborate further with the HHC-led PPS to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized hypertension and cholesterol protocols, development of workforce strategy, recruitment and workforce training efforts, and selection of culturally competent patient education resources to support this project. Additionally, a critical component of the project is the ability to share data not only across each individual PPS but also between PPSs in order to quickly receive information on BPHC patients who may visit a clinical setting outside of the PPS's network. BPHC plans to discuss IT implementation with HHC to address how to increase both sign-up and active utilization of the Bronx RHIO.

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.

BPHC will require capital funds to develop and disseminate a care management platform, telehealth and remote monitoring tools, and patient registries, as well as enhance Bronx RHIO capabilities and EMR system licenses for partner organizations. These improvements will support population health management, cardiovascular symptom management, and via telemedicine and remote monitoring, increase patient-provider contacts without sacrificing productivity.

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
Jewish Association Serving the Aging	Balanced Incentives Program (BIP)	2014	2015	The Balancing Incentive Program (BIP) is a Federally funded State Medicaid program developed to increase access to non-institutional long-term services and supports (LTSS). This is intended to create a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children	BIP	2014	2015	See BIP description above.
Health People, Inc.	BIP	2014	2015	See BIP description above.
United Cerebral Palsy Associations of NYC	BIP	2014	2015	See BIP description above.
Project Renewal	BIP	2014	2015	See BIP description above.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
God's Love We Deliver, Inc.	BIP	2014	2015	See BIP description above.
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Healthcare Workforce Retraining (HWRI) Initiative is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH			See above for HH description.
Visiting Nurse Service of NY	HH	2012	Ongoing	See above for HH description.
Center for Urban Community Services	HH			See above for HH description.
Morris Heights Health Center	HH	2014	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives identified in Question 4b are listed in Appendix I.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified in Question 4b and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

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 BPHC can leverage participating providers' experiencing improving care for this specialty Medicaid population, BPCH will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

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 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.

The Healthcare Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

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

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

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

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

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

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

1. 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.

Addressing diabetes through Project 3.c.i, Evidence-Based Strategies for Disease Management of Diabetes, is a high priority in the Bronx (CNA Community Need 11). Fifty-four percent of CNA survey respondents indicated that diabetes is a top health concern in the community. There is high utilization associated with diabetes in the Bronx, a substantial portion of which is preventable. In 2012, there were 70,817 admissions among the 34,138 Bronx Medicaid beneficiaries with diabetes utilization. Diabetes composite PQI admissions among Medicaid beneficiaries in the borough are almost 25% higher than expected, and the rate of hospitalizations for short-term diabetes complications for this population is substantially higher than in NYC or NYS (151.22/100,000 vs. 105.03/100,000 and 110.31/100,000, respectively).
The Bronx has been disproportionately affected by diabetes because of primary care provider (PCP) shortages in certain neighborhoods and gaps in care. Almost one-third of Bronx residents live in one of the borough's eight HRSA-designated Health Professional Shortage Areas, and four Bronx neighborhoods – Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven – fall in the NYS Health Foundation-funded study's category of highest need in the state for community health center expansion (CNA Community Need 2). Within primary care sites, there is a lack of care management staffing to fully implement the medical home model's (PCMH) care teams, preventing PCMHs from reaching their potential. In addition, enormous social needs in the Bronx hinder the borough's ability to attain good outcomes. The Bronx ranks last among all counties in the state with regards to adverse social and economic factors. Providers lack the knowledge of community resources to support patients when social and economic factors negatively impact care plan adherence.
To address these gaps, BPHC will undertake a comprehensive diabetes management approach, including:
a) Help primary practices attain 2014 NCQA Level 3 PCMH recognition
b) Aim to engage at least 80% of BPHC PCPs, including those who practice in behavioral health facilities, to implement evidence-based diabetes protocols
c) Appoint a diabetes champion to oversee implementation and engage clinicians, including additional certified diabetes educators, to behavioral health facilities and community-based organizations
d) Deploy new technology to support providers, including a patient registry and a standardized care planning tool for the PPS. The care planning tool will be able to consume discrete data from EHRs, community-based organizations (CBOs), and claims to populate a care management plan that will guide patients, PCPs, care managers and other key providers
e) Institute a patient engagement strategy that will address the social determinants of health and health literacy, such as by linking patients to YMCA's wellness program and other CBOs, and using the peer-led Stanford Self-Care group model and LEAP amputation prevention

program

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.

This project's target population is attributed beneficiaries aged 19 or older with a diabetes diagnosis. We will actively engage a proportion of these beneficiaries with at least one annual PCP visit. Our proposed number of actively engaged individuals will be reflected in the January 12 scale/speed submission. Round 3 attribution data from March 2013-February 2014 found 28,624 attributed beneficiaries meeting the target population criteria. In participating PCMHs, care coordination teams will identify individuals with a diabetes diagnosis and work with MCOs to engage patients assigned to a participating PCMH who have not received disease management services. BPHC will conduct extensive provider outreach to ensure patients with diabetes receive regular care, including at least a yearly A1c test, focusing on neighborhoods with the highest number of attributed beneficiaries with diabetes: Fordham-Bronx Park, Pelham-Throgs Neck, and Crotona-Tremont. A key challenge is that about one-third of residents in the aforementioned neighborhoods are obese, and over 40% of CNA respondents report a lack of healthy foods in their neighborhoods.
We will also aim to engage patients with diabetes for whom depression and/or CVD are co-occurring disorders, using standardized assessments and protocols to identify co-occurrences and opportunities for coordinated care planning in practices implementing the IMPACT Model (Project 3.a.i). Similar protocols will address another subpopulation, diabetes patients with hypertension, who will also receive CVD disease management services (Project 3.b.i).

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 key strategy to achieving this goal of this project will be helping primary care practices attain 2014 NCQA Level 3 PCMH recognition and implementing a robust diabetes disease management approach within these practices. BPHC will invest in primary care practices to create the care team needed to achieve Level 3 PCMH recognition and successfully implement diabetes disease management. Care coordination teams will include PCPs, medical assistants, nurses, care managers, peer educators, and certified diabetes educators (CDEs), all of whom will be trained to serve patients with diabetes in a culturally competent manner. We plan to address the primary care shortage for in-need Bronx neighborhoods by requesting capital dollars to build additional primary care facilities and collaborating with our Bronx PPS partners to recruit needed PCPs.
The Bronx has strong, diverse provider- and community-based resources that will be expanded and mobilized to implement the strategies listed above. Four hundred fifty-six of the PCPs in BPHC have already attained 2008 or 2011 NCQA Level 3 PCMH recognition and will be ready to quickly implement components of this project. In conjunction with diabetes disease

management, the IDS (2.a.i), Health Home at-risk (2.a.iii), and CVD disease management (3.b.i) projects will support efforts to move to 2014 NCQA standards. BPHC includes three Health Homes serving the entire Bronx that contract with agencies that have expertise in outreaching and providing care management services to chronic patients that along with health education establish the basis for successful long-term self-management of their conditions. Many of the BPHC provider partners, including SBH, Montefiore, and FQHCs, already use CDEs as part of their care teams. BPHC's network will also benefit from Montefiore being one of four diabetes Centers of Excellence in the state, and several BPHC partners are accredited by the American Association of Diabetes Educators as a diabetes education program.
BPHC is also fortunate to have Health People (HP), a Bronx community-based organization (CBO) specializing in evidence-based patient education as a partner. HP has received a state grant to (1) implement the Stanford patient engagement and LEAP amputation prevention models in the Bronx; and (2) develop a system for Bronx clinicians to make referrals to CBOs, with the CBOs also having capacity to report back to the physicians through the electronic system of QTAC (Quality and Technical Assistance Center), the state- and CDC-supported Center at the University of Albany that oversees implementation of evidence-based self-care and prevention courses in New York State.

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.

BPHC anticipates navigating and addressing the following challenges during implementation:
a) It will be challenging to recruit and train sufficient care management staff to serve the Bronx population's needs. BPHC will work with community colleges and CBOs to identify a pipeline of care management staff and coordinate with 1199 Job Security Fund and NYSNA to identify displaced workers who may be interested in such positions. We will contract with the 1199 Training Fund and other training organizations to ensure that these staff are adequately trained. We will also use alternative employment tactics, flexible hours, and job sharing where feasible to attract a broader pool of workers.
b) Some PCPs may find it difficult to make the changes required by this project, such as adherence to evidence-based guidelines and attaining 2014 PCMH recognition. To build consensus on guidelines and methods for engagement, Partners implementing this project will be required to participate in the Disease Management Rapid Deployment Collaborative to share best practices and institute continuous quality improvement.
c) There is a lack of patient education about the complex co-morbidities resulting from long-term uncontrolled diabetes, which is compounded by low educational attainment in the Bronx. High-risk neighborhoods (e.g., High Bridge-Morrisania) have ZIP codes where less than 60% of the population has a high school diploma. Projects 3.c.i, 2.a.iii, and 3.b.i will enable BPHC to invest in more CDEs, peer educators and care managers to be deployed to these neighborhoods.

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.

BPHC and the Bronx-Lebanon Hospital Center-led PPS have both selected Project 3.c.i. During the January-March 2015 implementation planning period, we intend to collaborate further with the Bronx-Lebanon-led PPS to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized diabetes protocols, development of workforce strategy, recruitment and workforce training efforts, and selection of culturally competent patient education resources to support this project. Additionally, a critical component of the project is the ability to share data not only across each individual PPS but also between PPSs in order to quickly receive information on BPHC patients who may visit a clinical setting outside of the PPS's network. BPHC plans to discuss IT implementation with Bronx-Lebanon and the Health and Hospitals Corporation (HHC)-led PPS to address how to increase both sign-up and active utilization of the Bronx RHIO.

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.

BPHC will require capital funds to develop and disseminate a care management platform, telehealth and remote monitoring tools, and patient registries, as well as enhance Bronx RHIO capabilities and EMR system licenses for partner organizations. These improvements will support population health management, diabetes symptom management, and via telemedicine and remote monitoring, increase patient-provider contacts without sacrificing productivity.

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
Jewish Association Serving the Aging	Balancing Incentives Program (BIP)	2014	2015	The Balancing Incentive Program (BIP) is a Federally funded State Medicaid program developed to increase access to non-institutional long-term services and supports (LTSS). This is intended to create a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children	BIP	2014	2015	See BIP description above.
Health People, Inc.	BIP	2014	2015	Se BIP description above.
United Cerebral Palsy Associations of NYC	BIP	2014	2015	See BIP description above.
Project Renewal	BIP	2014	2015	See BIP description above.
God's Love We Deliver, Inc.	BIP	2014	2015	See BIP description above.
Health People, Inc.	Small Business Innovation Research Diabetes Home Self-Care Coaching	2014	2017	The Small Business Innovation Research (SBIR) Diabetes Home-Self Care Coaching provides Federal funding to develop a web-based training for coaching patients with controlled diabetes.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Health Workforce Retraining Initiative (HWRI) is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of NY	HH	2012	Ongoing	See above for HH description.
Center for Urban Community Services	HH			See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

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 BPHC can leverage participating providers' experiencing improving care for this

specialty Medicaid population, BPCH will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

The Small Business Innovation Research Program provides funding to develop a web-based training for coaching patients with controlled diabetes. Health People's experience with this model will be valuable as BPHC implements a comprehensive diabetes management approach, but the DSRIP project will significantly expand the IT capabilities and tools for participating providers and focus on a broader population of Medicaid recipients.

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 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.

The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

1. 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.

Asthma is an urgent and escalating problem in the Bronx. For this reason, BPHC has selected Project 3.d.ii, Expansion of Asthma Home-Based Self-Management Services. As of 2013, 130 of every 1000 Bronx Medicaid beneficiaries had asthma, the second-highest rate of any county in the state and an increase of almost 10% since 2009. The rate of asthma among Bronx children covered through Medicaid is particularly poor: 701 per 100,000 Bronx children who are Medicaid beneficiaries had asthma in 2012, 64% higher than the citywide rate and 333% higher than the statewide rate (CNA Community Need 9). The Bronx has the highest asthma mortality rate in the state, with 43.5 deaths per million residents from 2009 to 2011—almost three times the state average during that same time period. Bronx residents recognize asthma as an area ripe for intervention: almost 40% of residents who participated in the CNA indicated that asthma was a major health concern in their community.

Accordingly, there is a high level of utilization associated with asthma in the Bronx, much of which is preventable. In 2012, there were 4,116 adult respiratory PQI admissions in the borough, more than 40% higher than would be expected. The Bronx's rate of emergency department (ED) visits for asthma (260.2 per 10,000) was almost twice the city rate and nearly three times the state rate. Preventable utilization has been particularly acute among children: in 2012, there were 1,865 asthma PDI admissions among Medicaid-covered children in the Bronx, 80% higher than expected, and over half of these admissions were by children aged 2-5.

To implement this project, BPHC will be contracting with a.i.r. nyc, a community-based organization (CBO) that has provided home-based services to families with asthma since 2001 (described in more detail in Section c) for the implementation of its model. Strategies that we will employ include:

a) Instituting evidence-based asthma management protocols for primary care providers (PCPs) to help reduce asthma exacerbations

b) Conducting outreach to PCPs to ensure they are aware of and can easily refer asthma patients to the home-based visiting program

c) Establishing protocols to link asthma patients who visit the ED with PCPs and care coordination services via PCMHs or the Health Home

d) Establishing IT systems to transmit data from the CHWs back to the PCP to integrate the asthma action plan and data collected during asthma home visits into a care planning tool and the patient's medical record

e) Implementing clinical guidelines across PCMH partners modeled on the National Asthma Education and Prevention Program's guidelines. These guidelines will ensure the completion of asthma action plans that coordinate self-management between the home and external environments

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 target population for this project will be attributed beneficiaries with an asthma diagnosis. We will actively engage a proportion of patients who either have had three or more PCP visits or an ED visit or hospital discharge with asthma as the primary diagnosis in the past year. Based on a.i.r. nyc's experience over the past 10 years, approximately one-half of families will refuse a home visit. We will engage both adults and children with newly diagnosed or preexisting asthma, with a special emphasis on children. Our proposed number of actively engaged individuals will be reflected in the January 12 scale/speed submission, which will use updated attribution data expected to be released by the state. SDOH Round 3 attribution data from March 2013 – February 2014 found 30,325 patients with asthma who meet the our aforementioned criteria for active engagement. BPHC will focus provider outreach efforts on PCMHs, schools and CBOs located in hotspots with the highest number of attributed beneficiaries with asthma according to claims data: Crotona-Tremont, Fordham-Bronx Park, High Bridge-Morrisania, and Pelham-Throgs Neck.
Asthma is linked to poor environmental conditions, such as housing issues and pollution. Accordingly, neighborhoods with high rates of serious housing violations and rat sightings, including High-Bridge Morrisania, Crotona-Tremont, and Fordham-Bronx Park, overlap with areas of high asthma-related service utilization, respiratory PQI and PDI admissions, and also with the Cross Bronx Expressway and bus terminals, major sources of pollution in the borough.

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.

Given that this project is home-based, our strongest assets are in the community. A key informant noted that currently in the Bronx, "We give care to people who come in walking through the door, we don't even do a history of them first. We just treat them in the asthma room, and then we discharge them… They go back home and they have the same triggers and they get worse." a.i.r. nyc will address this problem by taking a holistic approach to managing asthma, in which it: sends trained community health workers (CHWs) who reside in the community and speak the families' language into homes affected by asthma to provide education; conducts a home environmental assessment to identify asthma triggers; demonstrates medication delivery devices and discusses medication use; promotes asthma self-monitoring; follows up on ED visits or admissions; and links patients back to their PCP. a.i.r. nyc also identifies interventions to mitigate asthma exacerbations factors by providing: connections to integrated pest management services or pro bono legal services that can assist with housing-related issues; referrals to social service organizations and smoking cessation supports; and assistance with developing an asthma action plan.
a.i.r. nyc's approach has shown impressive results, including an over 40% decrease in ED visits,

hospitalizations and missed school days after 12 months in the program. In addition, nearly 80% of households served by the program reported reduction in mold.

Through this project, we will work with a.i.r. nyc to expand: (1) its reach to adults as well as children, and (2) connections with care managers added to PCMH care teams via Project 2.a.iii to address the needs of chronically ill patients who are at risk of further complications. a.i.r. nyc already has robust data collection systems, and BPHC will integrate the data collected with the PPS's care planning tool.
Another strong asset of this project is that a.i.r. nyc recruits its CHWs from the community served, and they thereby know the culture and speak the languages of targeted families. We will work with a.i.r. nyc, CUNY and other CBOs to educate, train, and recruit community members from different cultural and ethnic groups to serve as CHWs.
In addition, improving Bronx housing conditions is critical to lowering the burden of asthma in the borough. To enhance the stock of housing free of asthma exacerbation factors, SBH is requesting capital to build a multiuse development that includes 360 units of affordable housing. Finally, we intend to partner on this project with the New York City Department of Health and Mental Hygiene, which is offering technical assistance on implementation.

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.

BPHC anticipates navigating the following challenges during implementation:
a) Parents and caregivers are unaware of symptoms that can lead to exacerbations and do not act fast enough to prevent an incident resulting in an ED visit. During home visits, CHWs will emphasize the importance of consistent medication use to control asthma and will demonstrate use of medication delivery devices.
b) Medicaid beneficiaries switch plans frequently, which often requires that they switch controller medications because of different formularies across plans. BPHC will work with MCOs to institute policy changes that will promote standard formularies and appropriate use of controller medications.
c) Most providers do not have asthma registries or electronic care plan tools and do not participate in the RHIO to permit information sharing across providers. BPHC's centralized services organization will address these issues by adding new IT capabilities, including a care planning and management platform and patient registries, and promoting RHIO participation.
d) Recruiting and training the staff required to implement the project at the scale needed by the Bronx population will be difficult, but ultimately achievable. a.i.r. nyc plans to recruit 17 additional CHWs in the Bronx and to add 4 supervisors and other support staff using professional recruiters. BPHC will also work with a.i.r. nyc, CUNY, 1199, and other workforce sources to scale up recruitment and training capacity.

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.

BPHC and the Health and Hospitals Corporation (HHC)-led PPS have collaborated to select the Asthma Home-Based Self-Management project and align key interventions related to its implementation. During the January–March 2015 implementation planning period, we intend to collaborate further with our PPS colleagues, including Bronx-Lebanon Hospital Center's PPS, to ensure: a) Alignment and coordination of standardized PCP, ED, and CHW protocols b) Development of a workforce strategy to recruit and train CHWs who will conduct home visits c) Selection of culturally competent patient education resources to support this project d) Development common risk assessment methodologies e) Adoption of common core partner contracting vehicles Additionally, a critical component of the project is the ability to share data not only across each individual PPS but also between PPSs in order to quickly receive information on BPHC patients who may visit a clinical setting outside of the PPS's network. BPHC plans to discuss IT implementation and address Bronx RHIO utilization and uptake challenges with HHC and Bronx-Lebanon to address how to increase both sign-up and active utilization of the Bronx RHIO.

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.

BPHC will require capital funds to develop and disseminate a care management platform, telehealth and remote monitoring tools, and patient registries, as well as enhance Bronx RHIO capabilities and EMR system licenses for partner organizations. The IT care planning tool is critical to providing care management services as well as enabling community health workers to assist patients and caregivers in completing asthma plans at home and sharing with PCPs in real time.

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

Yes	No
☒	☐

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

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Jewish Association Serving the Aging	Balancing Incentives Program (BIP)	2014	2015	The Balancing Incentive Program (BIP) is a Federally funded State Medicaid program developed to increase access to non-institutional long-term services and supports (LTSS). This is intended to create a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children	BIP	2014	2015	See BIP description above.
Health People, Inc.	BIP	2014	2015	See BIP description above.
United Cerebral Palsy Associations of NYC	BIP	2014	2015	See BIP description above.
Project Renewal	BIP	2014	2015	See BIP description above.
God's Love We Deliver, Inc.	BIP	2014	2015	See BIP description above.
Health People, Inc.	Small Business Innovation Research Asthma Home Self-Care Coaching	2014	2017	The Small Business Innovation Research (SBIR) Asthma Home-Self Care Coaching provides Federal funding to develop and pilot test a telemonitoring system that allows for early identification and treatment of at-risk populations.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Health Workforce Retraining Initiative (HWRI) is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of NY	HH	2012	Ongoing	See above for HH description.
Center for Urban Community Services	HH			See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

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 BPHC can leverage participating providers' experiencing improving care for this specialty

Medicaid population, BPCH will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

The Small Business Innovation Research Program provides funding to develop and test smartphone technologies that, in the case of Health People, enable peer-health coaching between mothers who have children with asthma. Health People's experience with this model will be valuable as BPHC expands asthma home-based self-management services. The DSRIP project will differ from the SBIR program by significantly expanding the IT capabilities and tools for participating providers, focusing on a broader population of Medicaid recipients, and incorporating home visits to detect asthma triggers.

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. Our projects 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.

The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 4 Projects

4.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
BPHC has a number of non-provider, community-based resources as participants with strengths and expertise addressing the diverse needs of patients with MHSA needs. Through our robust collaboration with HHC and Community Care of Brooklyn (CCB), our PPS also has access to a wide net of providers and community-based resources across New York City, who we look forward to working with as we begin implementation. The partnering PPSs have agreed through their joint planning, and via the Workgroup activities described in the project narrative below, to closely review these resources in

Q1/Q2 of DY1 and determine which ones to formally engage moving forward. The PPSs will also closely collaborate with relevant city and state agencies, including the New York City Department of Health and Mental Hygiene (DOHMH).

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.

As the CNA data reflect, there is a significant need to strengthen the mental health and substance abuse infrastructure (Project 4.a.iii) across the Bronx (CNA Community Need 12). High rates of substance use, addiction, poor mental health, serious psychological distress and suicide contribute to high, and often preventable, health system costs. In the Bronx overall, a higher proportion of Bronx residents (7.1%) report experiencing serious psychological distress than in NYC (5.5%) as a whole. Substance abuse is also a significant health challenge and was the second-most-cited health concern in Bronx CNA survey responses, and 18.5% of Bronx adults reported binge drinking in the past month.

The Bronx CNA data also show high levels of utilization of mental health and substance use (MHSA) services, together with high emergency department visits and inpatient admissions for MHSA issues. While mental, emotional, and behavioral (MEB) health needs affect all communities, areas with lower-income residents such as Hunts Point-Mott Haven have particularly high condition-specific service utilization rates.

The Bronx CNA highlighted shortages in mental health services. There are 391 general psychiatrists and approximately 1,900 social workers in the Bronx, resulting in almost half the per-population rate in the Bronx (28.1 psychiatrists per 100,000) than citywide (CNA Community Need 3). Also, the supply of mental health resources in the southernmost section of the Bronx, such as Hunts Point-Mott Haven and the Southeast Bronx, is very limited. Substance abuse resources appear to align better with geographic need across the borough and are clustered in south/central areas of the Bronx. Despite these resources, however, a majority of CNA survey respondents did not indicate that substance abuse resources are "readily available," highlighting a gap in awareness and ability to access such resources.

In addition to the lack of providers, resources, and awareness, gaps are compounded by silos between provider types that prevent coordination. According to providers, the system is highly fragmented and fails to adequately target adolescents, a high-priority population for prevention

and early intervention services.

To close these gaps, BPHC, together with the HHC-led PPS and Community Care of Brooklyn (CCB), has committed via a charter to a citywide MHSA Workgroup that will bring together a cross section of MHSA providers to develop appropriate infrastructure, resources, and programs to transform MHSA services across the city and develop a methodology to assess programs' impact on MHSA service utilization and care. BPHC will undertake a paradigm shift through three sectors selected from the DSRIP application by:
1. Leading MEB health promotion and disorder prevention partnerships
2. Expanding efforts with DOH and OMH to implement "Collaborative Care" in primary care settings
3. Providing cultural and linguistic training on MEB health promotion, prevention and treatment.

BPHC will also coordinate its activities with work under Project 3.a.i., Integration of Primary Care and Behavioral Health services.

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

This project will target all attributed patients aged 12 and above with mental, emotional, and behavioral (MEB) health diagnoses or substance use disorders, as well as those at high risk for developing mental health or substance abuse disorders and who have other health and social factors linked to risky substance use and MEB needs.

Based on preliminary analyses of New York SDOH-released claims data, we estimate that approximately 20% of BPHC's attributed population has a behavioral health condition. We expect to actively engage a population with conditions ranging from moderate depression and anxiety disorders to those with serious mental illness and substance abuse. We will also target engaging beneficiaries with co-occurring mental illness and substance abuse disorders, who have need for integrated mental health and primary care services and for care management services. 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 and few receive evidence-based treatment for depression. In the Bronx, 44% of Medicaid beneficiaries are aged 0-19, and experts report significant gaps in MHSA care in the Bronx for this adolescent group.

BPHC will also engage the criminal justice reentry population, who have dramatically heightened MHSA needs upon release and are a focal population of Mayor DeBlasio's administration (with DeBlasio dedicating $130 million over the next four years to address this population's health needs).

Lastly, BPHC expects to engage 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 focus group data, including Fordham-Bronx Park, Crotona-Tremont, and Hunts Point-Mott

Haven, where barriers to access include immigration status and low education achievement. For example, in Crotona-Tremont, 23.8% of residents are non-U.S. citizens, 38.7% of people over 25 years old have less than a high school education, and 32.2% speak English "less than well." Accordingly, BPHC has selected enhancing cultural and linguistic training as a project intervention to ensure that every program meets the needs of all ethnic groups within the population.

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.

BPHC and the other collaborating PPSs will build upon current MHSA assets and social service agencies across the Bronx, such as Acacia Network, the Puerto Rican Family Institute, Fordham-Tremont Community Mental Health Center and Montefiore, which all bring particular sets of expertise to the initiative. There are also 155 mental health residential programs and over 63 outpatient programs, including a New York City Department of Health and Mental Hygiene-administered Single Point of Access (SPOA) and an SPOA Housing Project staffed by the Center for Urban Community Services. The Bronx has 71 mental health programs that specifically target youth, including 32 outpatient programs and 32 support programs such as Home and Community-Based Services waiver programs. The three Health Homes that are part of our PPS also target this population to provide much needed care management services. There are approximately 107 alcohol and drug use programs of which 33 are inpatient programs that include medically managed detoxification programs and community residential programs.

However, as documented in the CNA and focus group interviews, MHSA providers have operated in silos, and there has been no central citywide leadership to promote needed MHSA reforms. Through the Workgroup, BPHC will work to bring together key leaders across provider-types to address the three sector requirements outlined above. Sectors 1 and 3 will be addressed by the group as it develops and disseminates key resources such as training materials and educational programs, particularly those targeting adolescents, and means of assessing progress. These materials will inform adolescents about the nature of and risk factors for MHSA diseases; that diseases frequently co-occur and begin during adolescence; and early warning signs. All activities and programs will consider cultural and linguistic factors, including: cultural differences 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.

The resources and program that the Workgroup develops will be shared with borough-level MHSA coordinating councils who will adapt to local needs. CBOs will play a large role in workgroups and councils to guide development of materials and the adaption of interventions to address the specific needs of sub-populations. Examples of CBOs targeting adolescents upon which the PPS can build include the New York Children's Health Project (NYCHP), Health People's Adolescent Peer Mentoring Program, and school-based health curricula that will expand to more robustly address MHSA prevention and early intervention. Odyssey House and the Acacia Network have both received SAMHSA awards for adolescent substance use

disorders and community re-integration. In developing educational models for adolescents and adults (e.g., parents, teachers) on MHSA needs, BPHC will support partnerships among CBOs, health professionals, and/or middle- and high-schools that have strong experience in this arena, including the aforementioned programs.

BPHC's MHSA project activities will also address Sector Project 2 project components by enhancing existing and new sites implementing the CCM/IMPACT model under Project 3.a.i. As implemented in NYC, the CCM model almost exclusively targets adults, with less demonstrated efficacy in treating adolescents, and does not include use of SBIRT. BPHC, in collaboration with partner PPSs and stakeholders, will explore opportunities to pilot adolescent-targeted adaptations of the CCM model using developmentally sensitive materials and structured involvement of adolescents and parents in education and treatment (e.g., the ROAD model).

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.

Language barriers, low health literacy, stigma, and insufficient social support are major challenges confronting BPHC and its partners in efforts to improve the health of the target population. In certain communities, parents may be reluctant to actively engage in MEB health promotion efforts due to their own biases or illness. MEB health programs will address this by producing and promoting training programs geared to parents, teachers, care coordinators and mental health professionals that address cultural-acuity, particularly for ethnic minorities and immigrant populations. BPHC will link with community health educators like Health People that have resonance and efficacy in local communities to address these concerns, and look to peer advocates, faith-based and other leaders, to engage whole communities as well as individuals in breaking down socio-cultural 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 the adolescent group. Thus, in developing adolescent-specific adaptations of the CCM model, the PPSs will evaluate practices that have reported success in reaching adolescents with similar demographics and needs as those in the Bronx's communities. And in evaluating and modifying existing adolescent training materials to be used in a school-based or other setting, the PPSs will consider evidence-based models such as peer-mentor programs and programs that leverage social media outlets to disseminate messages.

Further, as MHSA care is often siloed among providers due to separate licensures, regulations and billing across provider types, we anticipate certain challenges in coordinating and integrating care through active prevention efforts, routine screenings to assess all co-occurring conditions, and development of comprehensive treatment plans. Through the Workgroup, and in collaboration with state agencies, BPHC will identify particular obstacles to care coordination and then work to remedy those deficits, such as seeking waivers to support rapid integration of

care.

Lastly, there is a lack of robust data to measure progress in meeting MHSA needs and improving outcomes. BPHC's CSO will enhance data and analytic capabilities at the provider and population levels; and BPHC will also depend upon State-level data to evaluate progress.

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.

Since Fall 2014, BPHC has participated in various MHSA joint-planning sessions with HHC and BPHC to achieve consensus on the selected Sector Projects 1 3, as well as interventions within each Sector Project that will address identified gaps. 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, these PPSs will bring together a diverse cross-section of MHSA leaders in the citywide Workgroup to develop programs and resources under Sector Projects 1 3 that can more comprehensively address MHSA needs. 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, the PPSs will also collaborate to review and expand upon existing CCM trainings to more appropriately address adolescent groups. And, consistent with Sector Project 3, all resources and programs will be designed with sensitivity to cultural acuity for the unique demographics in the Bronx.

During the 2015 implementation planning period, we intend to collaborate further 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.

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.

Implementation milestones are as follows:

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

Gap Analysis: Review existing programs and CBOs to identify gaps and strengths to build on via DSRIP (Q1/Q2 DY1).

Adolescent Programs: Review evidence-based models for adapting CC model to adolescents (Q3/Q4 DY1); develop curriculum (Q3/Q4 DY2); share curriculum with PPSs to integrate into CC model (Q1/Q2 DY3). Identify Department of Education contact; develop/implement curriculum (Q1/Q2 DY3).

Adult 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. 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 PPS currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

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

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.
Counseling Services of New York	Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recovery Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Health Workforce Retraining Initiative (HWRI) is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.
Graham Windham	HWRI			See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York Harm Reduction Educators	HWRI	2015	2016	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of NY	HH	2012	Ongoing	See above for HH description.
Center for Urban Community Services	HH			See above for HH description.
Morris Heights Health Center	HH	2014	Ongoing	See above for HH description.
Leake and Watts Services, Inc.	HH	2016	Ongoing	See above for HH description.
The Children's Aid Society	HH	2015	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

FIDA serves dual eligible individuals through managed long term care plans. FIDA enrollees are likely to participate in this project given that it targets individuals with high needs. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.

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.

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. Our projects 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.

The Health Workforce Retraining Initiative trains and retrains healthcare workers to gain additional skills and training needed to meet the demands of today's workforce. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

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
BPHC has a number of non-provider, community-based resources as Participants, including AmidaCare and Housing Works, with strengths and expertise addressing the diverse needs of the HIV/AIDS population. Through our robust collaboration with the other PPSs, including HHC, Community Care of Brooklyn, Lutheran Medical Center, Bronx Lebanon Hospital Center, New York Hospital of Queens, and Mount Sinai Hospitals Group, our PPS also has access to a wide net of providers and community-based resources across New York City, who we look forward to working with as we begin implementation. The partnering PPSs have agreed through their joint planning, and via the Workgroup activities described in the project narrative below, to closely review these resources in Q1/Q2 of DY1 and determine which ones to formally engage moving forward. The PPSs will also closely collaborate with relevant city and state agencies, including the New York City Department of Health and Mental Hygiene (DOHMH).

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 CNA identified HIV/AIDS as a significant health issue and as the fourth leading cause of death in the Bronx (CNA Community Need 13). This project 4.c.ii will increase access and retention in HIV care, through the interventions described below, chosen for their proven ability to impact the objectives, improve the quality of care and address identified gaps.

Performance across HIV-related indicators throughout the city show positive advancements in HIV care. Among Medicaid Managed Care Beneficiaries in the Bronx who are HIV positive or have an AIDS diagnosis, 91% are engaged in care and 69% receive appropriate viral load monitoring. New infections amongst intravenous drug users have dropped significantly, and those who have HIV/AIDS have a 60.19% rate of viral load suppression, an indicator of decreased HIV transmission risk.

Although transmissions have decreased and treatment has improved overall in recent years, the Bronx still experienced a higher rate of new HIV diagnoses at 43.1 per 100,000 people than the city-wide rate of 33.5 per 100,000 people overall between 2010-2012 (CNA Community Need 13). Bronx neighborhoods with the highest numbers of people living with HIV/AIDS are Fordham-Bronx Park, Crotona-Tremont and High Bridge-Morrisania. These neighborhoods, plus

Hunts Point-Mott Haven, have the highest rates of HIV infection among the Bronx neighborhoods, experiencing rates up to 71 per 100,000. Most Bronx neighborhoods have higher prevalence rates than the city overall and experience pronounced racial/ethnic disparities in HIV infection. The rate of new HIV diagnoses among Black/African American Bronx residents is four times that of White residents, while Latinos are infected at a rate double that of White residents.

To address the HIV project, BPHC and six other NYC PPSs engaged in joint planning efforts to address major gaps in access to, and retention in, HIV care. Together, we have identified the following common sectors from the project requirements:
1. (Sector 1) Decrease HIV/STD morbidity and disparities; increase early access to and retention in HIV care
2. (Sector 2) Increase peer-led interventions around HIV care navigation, testing and other services
3. (Sector 3) Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations
4. (Sector 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. (Sector 5) Assure cultural competency training for providers, including gender identity and disability issues
6. (Sector 7) Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care
7. (Sector 9) Promote interventions directed at high-risk individual patients, such as therapy for depression

Within these sectors, BPHC's interventions include implementing: a viral load suppression initiative that includes behavioral health support (Sectors 1,2,4,5,7,9); the ARTAS (Antiretroviral Treatment Access Study) model at sites with high volumes of infected individuals (Sector 1); evidence-based community HIV education campaigns using the successful model of Health People, a Bronx CBO described below (Sector 3); standardized screenings for behavioral health and substance abuse problems (Sectors 4, 9); a multi-layered cultural competency campaign, with emphasis on LGBTQ communities (Sector 5); embedded CASACs (Credentialed Alcoholism and Substance Abuse Counselors) HIV care delivery sites (Sectors 1, 4, 9); evidence-based point-of-care EHR tools, e.g., clinical decision support, connections to medication fill history and patient registries (Sectors 1, 4, 9); case management for patients who have fallen out of care (Sectors 1, 4, 9), and standardized support groups and peer navigation program trainings and protocols across the Bronx (Sector 2).

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

The target population for this project is HIV-infected individuals, particularly those with new diagnoses, those who have been diagnosed but have fallen out of treatment and those at high risk of becoming infected (i.e., individuals eligible for PrEP). Based on preliminary analysis of

claims data from the New York State Department of Health, we estimate that approximately 3.5% of BPHC's attributed population has an HIV/AIDS diagnosis. Of these diagnosed beneficiaries, we expect to engage a proportion of those who have had an annual primary care visit, marking locations and opportunities to engage these patients in project 4.c.ii interventions. Attributed beneficiaries who have not had an annual PCP visit will be harder to engage, and may have fallen out of care completely. Additionally, the target population is inclusive of persons with co-occurring diagnoses, such as those with mental health or substance abuse conditions, as well as social factors like previous incarceration or homelessness, which play a significant role in their ability to access care and maintain care routines. This diversity and the level of cofactors and comorbidities within the target population lend to the complexity of this Project, and are a central organizing point for collaborative efforts within BPHC, as well as with the PPS HIV Collaborative overall. Our target population also includes several subpopulations, including Black/African American and Latino populations that face the significant health disparities as discussed above. There will be a particular focus on those living in Fordham-Tremont Bronx Park, Crotona-Tremont, High Bridge-Morrisania and Hunts Point-Mott Haven, as these are areas with high rates of HIV infection.

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.

The HIV/AIDS Resource map in the CNA suggests a geographic alignment between the locations where high numbers of Medicaid beneficiaries with HIV/AIDS service utilization reside and areas where HIV/AIDS resources are available. The existing healthcare infrastructure around HIV/AIDS will provide a strong foundation for the implementation of this project.

BPHC includes some of the largest HIV providers among its partners including Montefiore, SBH Health System, Institute for Family Health, Acacia Network and others. For example, Montefiore's CICERO program uses a comprehensive model of medical, supportive and mental health services across 10 community health centers. Core teams at these sites include HIV care coordinators, clinical pharmacists with expertise in HIV and substance abuse treatment, psychiatrists, psychologists, patient navigators, administrators and data entry clerks. In addition, the CNA describes an array of community-based organizations in the Bronx offering a broad spectrum of services for beneficiaries with HIV/AIDS. These CBOs provide resources such as housing (Boom! Health), community outreach and reentry services (The Osborne Association) for HIV-positive criminal justice offenders. Another organization, Health People: Community Preventive Health Institute, addresses various health challenges in the South Bronx. Peer educators at this organization, who are HIV positive themselves or have family members burdened by the disease, are trained to use evidence-based education practices in their outreach—a model that has proven successful across the country for the HIV/AIDS population. Health People has been involved in BPHC's clinical planning efforts, and we plan to leverage their expertise and expand upon other existing resources as we implement this project. Finally, BPHC and other collaborating PPSs will collaborate with HIV Special Needs Plans (SNPs) such as AmidaCare, which provides Medicaid coverage for beneficiaries in the Bronx, Manhattan and Brooklyn.

However, despite the improved treatments and resource infrastructure described above, key informants suggested that HIV funding goes primarily towards medical management services, with fewer resources becoming available for supportive services that address the psychosocial impact of being infected with HIV. This finding suggests that BPHC should focus on increasing, standardizing and raising awareness for such support services within Bronx communities, and our support group, peer navigation and case management interventions will address these needs and linkages. An aging population of Bronx residents living with both HIV/AIDS and other common chronic conditions indicate a need for the integration of HIV care and other medical services. The level of care coordination needed to help this population will be addressed by many of the interventions BPHC has chosen, including those described in projects 2.a.i, 3.a.i, 3b.i, 3.c.i and some more specific to this project, including the introduction of EHR tools at provider sites, such as HIV registries, and the introduction of substance abuse counselors at HIV care sites.

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.

HIV/AIDS is a chronic, incurable disease that disproportionately impacts ethnic and racial minorities. Given the social and economic factors affecting this patient population and BPHC's broad list of providers and collaborating partners, there will need to be close coordination of project activities with DSRIP Domain 2 and 3 projects, multiple partners and programs. PPS-aligned partners across the city and in the Bronx have agreed to form a Work Group with a common charter, and are actively planning together and will implement HIV programs collaboratively.

One of the challenges and issues anticipated in implementing this project is effectively addressing social cofactors that constrain successful access and retention in care, including cultural perceptions and stigma around certain diseases. With its PPS partners, BPHC will implement a cultural competency campaign to more effectively identify needs, work with an array of nonmedical service providers to address different needs, and create and standardize peer support and evidence-based education programs.

Another identified challenge will be the effective pooling of resources across the PPS collaborative—particularly knowledge, experiences, perspectives and funding—to address needs of subpopulations to improve project design and implementation. To address this challenge, BPHC will work closely with the other PPSs and the NYC DOHMH to ensure effective allocation of DSRIP funding and establish regular and ongoing communication. These collaborative efforts will take place during the planning and implementation phases of DSRIP.

Finally, another critical challenge will be keeping patients engaged in care, which is a central project objective. In response, BPHC will implement interventions across our PPS partners that

focus on peer outreach, links to Health Homes for care management services, Primary care and Behavioral Health integration (project 3.a.i), RHIO use and technology to link providers and CBOs for referrals, care coordination through patient registries, case management models and peer support programs.

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

The seven PPSs in the HIV Collaborative, committed to via a charter, have engaged in joint planning for this project and are dedicated to working together through implementation. While the combination of sectors and interventions will vary 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 established to address issues related to operations planning, intervention implementation, performance measures and data sharing.

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

Consistent with application requirements, the PPS HIV Collaborative will continue to meet in early 2015 to complete 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:

- Convening a PPS HIV Collaborative Planning Committee (Q2, DY1)
- Establishing a work plan and timeline for project implementation (Q3/4, DY1)
- Developing agreed-upon milestones for project implementation (Q3/4, DY1)
- Agree upon project commonalities and shared resources (Q3/Q4, DY1)
- Agree upon a data-sharing system to address reporting and implementation needs (Q3/Q4, DY2)

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

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

Yes	No
☐	☒

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

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
VIP Community Services	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2014	Ongoing	This SAMHSA grant, under the Federal Minority AIDS Initiative Continuum of Care Pilot, supports co-located and integrated primary care and enhanced HIV treatment and prevention.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Montefiore Medical Center	NYS DOHMH HIV/AIDS-Related Grant	2013	2015	The Montefiore Medical Center grant is provided by the NYC Department of Health and Mental Hygiene to increase HIV testing through patient and provider engagement and increased testing capacity.
Acacia Network	Fully Integrated Duals Advantage (FIDA)	2015	2018	The New York and CMS Fully Integrated Duals Advantage (FIDA) initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans. FIDA offers a person-centered, integrated care model to improve the care experience and provide a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Metropolitan Jewish Health System	FIDA	2015	2018	See above for FIDA description. NOTE: Other entities participating in FIDA are listed in Appendix I.
Counseling Services of New York	Health and Recovery Plans (HARP)	2015	Ongoing	New York State's Health and Recover Plans (HARP) program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
Montefiore Medical Center	HARP	2015	Ongoing	See above for HARP description. NOTE: Other entities participating in HARP are listed in Appendix I.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
SBH Health System	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2012	Ongoing	New York State's Health Home (HH) program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and some children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Acacia Network	HH	2012	Ongoing	See above for HH description. NOTE: Other entities participating in HH are listed in Appendix I.
Regional Aide for Interim Need, Inc.	Health Workforce Retraining Initiative (HWRI)	2015	2016	The Health Workforce Retraining Initiative (HWRI) is a jointly funded program of the New York State Department of Health and Department of Labor. The initiative is designed to train and retrain healthcare workers of all levels to meet the demands of changing models of care, including patient-centered and team-based models, as well as integrated care management.
Visiting Nurse Service of New York	HWRI			See above for HWRI description.
CenterLight Health System	HWRI	2014	2016	See above for HWRI description.
Institute for Family Health	HWRI	2007	2015	See above for HWRI description.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Graham Windham	HWRI			See above for HWRI description.
New York Harm Reduction Educators	HWRI	2015	2018	See above for HWRI description.
The Salvation Army	Health Homes (HH) for Medicaid Enrollees with Chronic Conditions and for Children	2015	Ongoing	See above for HH description.
Institute for Community Living, Inc.	HH	2012	Ongoing	See above for HH description.
The Osborne Association	HH	2015	Ongoing	See above for HH description.
Visiting Nurse Service of NY	HH	2012	Ongoing	See above for HH description.
SBH Health System	HIV Rapid Testing Program	2012	2014	The HIV Rapid Testing Program is funded by the New York State Department of Health and supports HIV testing for uninsured populations.
SBH Health System	Targeted Capacity Expansion Program: Substance Abuse Treatment for Racial/Ethnic Minority Population	2013	2016	The Targeted Capacity Expansion Program is a Federally funded program that supports behavioral health services and HIV testing and treatment services for individuals at high risk for or living with substance use, mental health, and HIV/AIDS conditions. In addition, the grant supports infrastructure and capacity improvements designed to increase access to care and services for these populations.

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.

Additional partners participating in the initiatives above are listed in Appendix I attached to this application.

While our BPHC partners' experiences will help inform the development and implementation of clinical projects, the partners identified above and in Appendix I participate in Medicaid initiatives and/or other non-DSRIP delivery reform initiatives that differ from this project's goals and activities. DSRIP funds will not be provided to partners if doing so would supplant or duplicate funding from the initiatives listed above.

SAMHSA Minority AIDS Initiative Continuum of Care Pilot. VIP Community Service's experience with enhancing HIV treatment and prevention will be valuable to inform this DSRIP project, but DSRIP funds will not be provided if doing so would supplant or duplicate SAMHSA funding.

Montefiore Medical Center NYS DOHMH HIV/AIDS-Related Grant. We will build on this experience by increasing access to and retention in care for a broader population of Medicaid patients and high-risk individuals beyond Montefiore facilities.

FIDA. This DSRIP project will extend FIDA services to all of our actively engaged population, not just those enrolled in FIDA.

HARP. This DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

NYS Health Home program. Our projects 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.

The Health Workforce Retraining Initiative. Our partners' experience with this model will be valuable as BPHC expands our care coordination and integrated care models, but DSRIP funds will not be provided if doing so would supplant or duplicate CMS funding.

HIV Rapid Testing Program. SBH Health System's experience implementing this program will be valuable to inform this DSRIP project, but DSRIP funds will be used to support different project purposes and a broader and insured Medicaid population. As such, this project will not duplicate NYSDOH funding.

The Targeted Capacity Expansion Program (TCE-HIV). In the case of SBH Health System, the grant is primarily used to conduct HIV prevention and education for women and minority populations. SBH's experience with TCE-HIV will be valuable to inform this DSRIP project, but DSRIP funds will be used for a more expansive scope of HIV and other healthcare services and for a broader Medicaid population. As such, this project will not duplicate SAMHSA funding.

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.