Table of Contents

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 found that healthcare providers and community resources are knit together in a fragmented way. For example, many providers have no or limited process and technology ties to care management and hospital resources, which results in uneven care for patients returning to the community. At the core of the PPS's projects is recognition that the community needs an integrated delivery system that provides both healthcare and services that address the social determinants of health across the continuum, from preventive to end-of-life care. As a result of this fragmented healthcare delivery system, the PPS service area is fraught with inappropriate ED and inpatient utilization as well as a high prevalence of chronic conditions.

Utilization: In six out of eight neighborhoods, the observed rate of preventable emergency room visits (PPV) is larger than expected. In addition, rates of unplanned readmissions (PPR) are higher than the State average at all but two of the local hospitals. In three out of six neighborhoods, preventable adult hospitalizations (PQI) are higher than the risk-adjusted State average; two others are in between the State average and its goal of a 25% reduction. For the pediatric population, the largest burden of preventable hospitalizations (PDI) is asthma, particularly in the Bronx.

Chronic conditions: The top five chronic conditions—hypertension, hypercholesterolemia, low back

pain, diabetes and depression—range in prevalence from 16-35% in the NYP PPS and impact the top four out of five diagnoses for admissions and ED visits (cardiovascular disease, respiratory disease, diabetes and mental health conditions). Of the adult PPS population, 20% has 1-2 of the most common chronic conditions (COPD, seizure, CHF, renal failure, diabetes, sickle cell and asthma). Including individuals with substance abuse and/or serious mental illness along with 1-2 chronic conditions raises that figure to 32%.

In addition to the structural issue of fragmentation, cultural and social determinants of health act as barriers for patients in our population. These barriers are associated with low preventive screening, late presentation to care, lack of treatment and improper utilization of healthcare services, which in turn result in poor health outcomes and health disparities. Dr. Carrillo, NYP's VP-Community Health, has done extensive research into these barriers, resulting in a comprehensive, evidence-based understanding of how they prevent access for minority and poor communities.(2)

Indeed, the communities served by our PPS are predominantly socioeconomically disadvantaged minorities who are often linguistically isolated. The NYP PPS is 20% Black, 41% is Hispanic, 26% is foreign-born, and 61% speak a primary language other than English (mostly Spanish or an Asian language). Almost a third of the PPS population lives at or below the federal poverty line of $23,050 for a family of four (2012 figures).
The PPS is uniquely positioned to assess, prioritize and support integration of the healthcare delivery system, investing in the technology, human capital and service innovations required to achieve high-level, sustainable performance. The PPS will help all participating providers reach NCQA Level 3 2014 designation and facilitate care coordination through technology. In each project, we will implement cultural competence and health literacy training for providers across the PPS, translating materials and contracting with CBOs to integrate Community Health Workers into the care team.
This project addresses all the needs outlined in our Summary of CNA Findings, as it serves as the foundation of each project. It specifically addresses CNA1 (Integrated Delivery System) and CNA2 (Culturally Competent Providers).

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.

Transforming existing practice patterns is frequently difficult, as it requires a culture change. NYP has, however, excelled in this regard, successfully implementing the PCMH model in its clinics and working toward developing both a corss-campus Health Home and a tri-institution Medicare ACO.
The NYP-led PPS is built on the strong foundation and experience of the NYP Regional Health Collaborative (RHC), which has been expanded across all of NYP's campuses. In October 2010, NYP, in association with the Columbia University Medical Center, launched an integrated network of patient-centered medical homes that were linked to other providers and community-based resources and formed a "medical village" in Northern Manhattan. Three years later, a study of 5,852 patients who had some combination of diabetes, asthma and congestive heart failure (CHF) found that emergency department visits, hospitalizations and 30-day readmissions had been reduced by 29.7%, 28.5% and 36.7%, respectively, compared to the year before implementation of the network. Patient satisfaction scores improved across all measures. Financially, NYP experienced a short-term return on investment of

11%.

NYP has extensive experience with CBO-based Community Health Workers (CHWs), with whom we have been working for nearly a decade. One example is WIN for Health, a hospital-academic partnership model implemented in 2006 to reduce the burden of asthma in Northern Manhattan. At the center of this model are bilingual CHWs who provide culturally sensitive education and support for patients. CHWs offer comprehensive education, home visits, goal setting strategies, referrals for social services to address competing obstacles such as complications associated with housing, immigration, and employment, and ongoing support. Patient participation is associated with decreased ED visits and hospitalizations and increased confidence and knowledge. The PPS is implementing CHWs sourced from CBOs in every single of the ten DSRIP projects we have developed.

The PPS includes strong FQHC Collaborators (Harlem United, Community Healthcare Network and Charles B. Wang), each with extensive experience and history collaborating with local CBOs to improve the health of their patients. We have also leveraged common referral relationships with local pharmacies that offer bedside and home delivery of medications.

The NYP PPS will build on a strong record of using IT to support innovative care delivery models: NYP's suite of IT applications that will support DSRIP include its electronic health record (Allscripts Sunrise Clinical Manager), a care coordination platform (Allscripts Care Director), a suite of data analytics tools (that provide registry functions and quality reports) and a personal health record (PHR) application.

In NYP's Medicaid Health Home initiative, NYP extended its care coordination platform to seven care management agencies and established the relevant privacy and legal infrastructure to support data sharing.

For DSRIP, NYP will be able to bring IT capabilities that were developed to support its Patient Centered Medical Home (PCMH) activities. NYP provides registries, data reporting capabilities, dashboards and a personal health record for the over 150 physicians across six clinics who are certified at Level 3 PCMH.

NYP has extensive experience building innovative care models with its RHIO, Healthix. NYP is an active member of Healthix, both contributing data as well as using data in care. NYP has active representation on the Healthix Privacy Committee and the Healthix Clinical Committee.

NYP has extensive experience with Meaningful Use that will be relevant to DSRIP. The hospital attested to Stage 2 compliance in November of 2014. In addition, over 150 physicians are compliant with Stage 1 and are scheduled to attest to Stage 2 in early 2015.

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.

While the NYP PPS focuses on a population that is well known to it, the delivery of medical and social services is still fragmented. The PPS will work with each Collaborator to identify its patient entry and exit points, i.e., where/how beneficiaries get referred into and are transitioned out of its care model. This process will include identifying the relevant information needed to ensure a "warm handoff" across care settings is a primary component of many of the DSRIP projects we have chosen.

One of the largest implementation challenges will be IT connectivity across the PPS Collaborators each with different software platforms or limited IT capabilities. NYP PPS plans to invest a significant portion of its IT budget to developing that connectivity across the PPS, using our care management systems and the RHIO. In addition, coordinating and sharing patient information in a timely manner with other PPSs will be another significant challenge that our commitment to connecting Collaborators to the RHIO is intended to meet.

We anticipate an increase in demand for NYP and our Collaborators' services, both of which are already stressed in some service delivery areas. The PPS intends to meet this excess demand by expanding our primary care and care coordination capacity through increased staffing levels, expanded practice hours and, in some instances, redesigned, more efficient space. A few projects require a very specialized workforce who may be difficult to find immediately. For example, we will be looking for pediatric psychiatric NPs (Project 2.b.i) and palliative care specialists (Project 3.g.i). In addition, we will be competing with other PPSs for CHWs and other community-based talent. Our Workforce Strategy (Organizational Application - Section 5) outlines our proactive approach to recruitment, both for us and our Collaborators.

The PPS serves a culturally diverse patient population which presents a challenge. NYP has a robust cultural competency program (Organizational Application - Section 7), which we will expand to our Collaborators. NYP/LM is a new partner in the NYP system with a predominantly Chinese patient population. Collaboration with long-standing leaders in the community such as Charles B Wang Community Health Center will allow us to effectively engage this specific population.

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.

There are three primary PPSs that overlap with ours: Mount Sinai PPS, New York City's Health and Hospital Corporation's PPS (HHC) and Advocate Community Partners (ACP). The Mount Sinai and NYP PPSs overlap on Integrated Delivery System (Project 2.a.i), Care Transitions to Reduce 30-Day Readmissions (Project 2.b.iv) and Integration of Behavioral Health and Primary Care (Project 3.a.i). The HHC and NYP PPSs overlap on Ambulatory ICU (Project 2.b.i), Behavioral Health Crisis Stabilization (3.a.ii) and HIV Center of Excellence (3.e.i). During the Design Grant phase we met with both Mount Sinai and HHC about potential project overlap and collaborations. In both instances it was agreed that

starting in January 2015 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols for those projects where we have overlap, shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. In addition, we have met with Advocate Community Partners to understand their PPS and describe our projects/vision for the PPS, particularly with respect to the Lower Manhattan service area. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

For Tobacco Cessation (Project 4.b.i), we have joined with the NYC Department of Health and Mental Hygiene, in the project coordination role, to implement media campaigns and technical training. The other PPSs in this collaboration include: Advocate Community Partners, Lutheran Hospital and North Shore Hospital System.

Though no overlapping PPSs in the NYP PPS service area are undertaking Decrease HIV Morbidity (Project 4.c.i), a few in NYC are tackling Project 4.c.ii, "Increase early access to, and retention in, HIV care." We will work to coordinate efforts with existing and ongoing initiatives in our service area, including the NYSDOH AIDS Institute NYLinks project and the End of AIDS campaign.

2. <u>System Transformation Vision and Governance</u> (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 NYP PPS has a strong commitment to achieving an integrated, collaborative and accountable delivery system. The strategic vision for the PPS is multi-pronged with a focus on developing a comprehensive set of Collaborators in order to meet the community's needs, aligning with and leveraging existing population health resources, enhancing IT capability and connectivity, bolstering primary care and care management capacity and transitioning to a value-based reimbursement methodology capable of sustaining the PPS's projects and goals.

We believe that under the IDS umbrella, our specific DSRIP projects will contribute to improved health and impact rates of potentially preventable admissions and readmissions and emergency department use. We have already demonstrated success in these areas through the work of our Regional Health Collaborative, recently featured in Health Affairs, which shows that such efforts can reduce not only utilization but also per patient Medicaid expenditures.(3) As the sole acute care hospital in the PPS, with a strong demand for its services across all payers, NYP does not anticipate reducing its number of acute care beds; however, we do anticipate significant growth in our ambulatory and community-based programs in order to effectively meet the community's needs. Comprehensive set of Collaborators

The PPS includes five of NYP's six campuses and its ambulatory clinics, Federally Qualified Health Centers, community-based physicians, nursing homes, home care providers, behavioral health providers, as well as social services and community-based organizations providing services such as supportive housing and specialized meal programs. As described in Section 2, these Collaborators will be integrated into a governance structure that will be flexible and responsive to evolving DSRIP guidelines and community needs. We anticipate that membership will evolve throughout the performance period

as the PPS becomes more efficient and plans for future payment reform initiatives and environmental changes. NYP and other PPS Collaborators have significant experience in responding to environmental changes by working with/adding new Collaborators and workforce members, e.g., integrating culturally competent Community Health Workers (CHW) and Patient Navigators (PN) into care teams. The PPS anticipates expanding that example by further mobilizing CHWs and PNs as extenders of our care coordination teams in many of our DSRIP projects. (Milestone Goal: DY2)

Existing population health management systems

The NYP PPS will leverage the existing population health management tools and capabilities of NYP Regional Health Collaborative and NYP's and other Collaborators' Patient Centered Medical Homes and Health Homes to ensure that members receive the services from providers best situated to serve them. We expect to launch the Clinical/Operations Committee of the PPS in March/April 2015. The Committee will work on establishing the necessary strategies to succeed in the performance period, including defining: standard care protocols for transitions of care, standards for clinical information exchange within/across the PPS, community stakeholders and Medicaid beneficiaries, and standard performance measures and feedback mechanisms. The Clinical/Operations committee will also be responsible for coordinating the PPS's care protocol efforts with existing PCMHs, Health Homes and other population health initiatives across the system. The protocols will be disseminated across the PPS and the appropriate staff trained in their use. (Milestone Goal: DY2)

Information Technology capability

Data sharing and two-way communication will be critical to the success of our PPS. The overall goals of the IT architecture are to provide workflow support for the teams that are caring for patients in each of the projects, analytic capabilities and support for a variety of clinical and operational purposes, and IT connectivity among the PPS members. Analytic support will start with monitoring the performance of individual Collaborators on their implementation milestones to their impact on the IDS utilization/outcomes goals. These performance management mechanisms (e.g., dashboards) will allow the PPS to identify opportunities to continuously refine the projects and improve the overall performance of eh PPS' DSRIP projects. (Milestone: DY 2) The PPS will establish connectivity among its members by extending NYP's care coordination application to other PPS members and through the use of the Healthix RHIO to support inter-institutional data views, notification about key events and the use of direct messaging to support data transfer between PPS members. (Milestone Goal: DY3) In addition, NYP will establish a single web-based resource to share PPS care protocols, policies and resources. The PPS will achieve 2014 Level 3 PCMH IT standards and Meaningful Use certification for all appropriate providers. (Milestone Goal: DY3)

Expanded access to primary care and care management

The foundation of any integrated delivery system is accessible, high-quality primary care. The PPS will work with all participating safety net providers to achieve 2014 Level 3 PCMH and Meaningful Use certification. (Milestone Goal: DY3) These PCMHs will serve as the center for the PPS's population health management efforts, for example, using registries to identify and track specific patient-level outcomes and engagement. (Milestone Goal: DY3) In addition we understand that to be a truly integrated system we need to improve intra- and inter-institution care transitions. We will develop a unified care management strategy that is shared across all PPS members. One area of focus is information flow from EDs to outpatient providers. The Patient Navigation program is composed of culturally competent paraprofessionals who will ensure connectivity to outpatient care is made as well as connection to community resources that can assist in the care continuum. They will work extensively with the existing social work and care management resources within the PPS to create a multi-prong approach. Finally, we are implementing a Community Health Worker strategy across our projects to provide patients with

culturally competent, in-home support. (Milestone Goal: DY1 for PNs and CHWs)
Value-based reimbursement
NYP PPS believes that its projects will be successful, contribute to improved health and help reduce the rates of inappropriate hospital and ED utilization for our attributed population. The system savings associated with these reductions needs to be reinvested in the PPS, particularly those financially fragile safety net providers contributing to the projects' positive performance. A value-based alignment of the State, the MMCOs and the PPS that allows all three organizations to share in the savings, should yield the resources necessary to ensure that the Medicaid population has access to necessary services.
Payment transformation offers the means to fund the system's reinvestment in the integrated delivery system that DSRIP is focused on creating. We enjoy very professional and collegial relationships with all of the MMCOs serving our communities and will continue to engage with them in this transformational process through regularly held meetings and discussion. (Milestone: DY 1)
From our perspective, a logical next step would be to introduce mutually agreed element(s) of value-based, pay-for-performance terms into our payment methodology. We recognize that MMCO contracting evolves over time and contemplate we would initially pursue negotiations with one plan, perfecting the implementation and approach, before considering introducing the amended terms in Agreements with other MMCOs. (Milestone Goal: DY3) Longer term, subject to negotiating acceptable terms and conditions, we could consider alternative models. Our primary goal for any value-based payment model we pursue with our Collaborators is that it puts the patients first.

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

The NYP PPS's governance structure and strategy is one that aligns well-positioned providers and Collaborators to ultimately affect the hospital and emergency department utilization of the attributed population through an integrated delivery system. These providers (FQHCs, SNFs, CBOs, individual MDs, etc.) will each have a position across a variety of committees—Executive Committee, Clinical/Operations, IT/Data Governance and Finance—to ultimately provide guidance on how the collective resources can best be 'steered' to have the most impact.
We consider the Integrated Delivery System (IDS) project the foundation upon which our nine other projects will succeed. It establishes the clinical, technical and community infrastructure necessary to coordinate the independent projects and ensure that each beneficiary receives a single standard of care across the PPS. Coordinating the nine projects' efforts and ensuring that work is complementary, with no unnecessary duplication of efforts, is key. To that end, the IDS will not be managed as a distinct project, but will be implemented and sustained as a foundational architecture supported directly by the lead project director in the PPS PMO, with the management of issues requiring PPS input being done at the PPS Executive Committee.
Building on this technical, clinical and patient-focused standardization, the NYP PPS IDS will focus on four areas of further integration: standardized care transition protocols, rapid cycle improvement, value-based program alignment and patient engagement.
Standardized care transition protocols. By DY2, the Clinical/Operations Committee will complete standardized protocols for transitioning/referring Medicaid beneficiaries across PPS collaborators,

including specific mapping of the entry and exit processes for each Collaborator. These protocols will include acute-to-non-acute, PCMH-to-CBO and methods for identifying the poorly engaged. Protocols will also be developed for widespread RHIO consent. (Milestone Goal: DY2)

Rapid Cycle Improvement. The PPS PMO (with support of the committees) will establish multiple levels of monitoring and evaluation tools, starting with monitoring the performance of individual Collaborators on their implementation milestones to their impact on the IDS utilization/outcomes goals. These performance management mechanisms (e.g., dashboards) will allow the PPS to identify opportunities to continuously refine the projects. This will also provide a common framework for monitoring the PPS's activities and the population as a whole. We anticipate these dashboards being available by the end of DY2. (Milestone Goal: DY2)

Value-Based Program Alignment. We believe that our specific DSRIP projects will contribute to improved health and impact rates of potentially preventable admissions and readmissions and emergency department use. We enjoy very professional and collegial relationships with all of the MMCOs serving our communities and will continue to engage with them in this transformational process, establishing regular meetings to explore a transition to value-based payment arrangements, discuss their population's utilization across the PPS and share resources available to patients (through the PPS or the MMCO) by DY3. All Collaborators will be invited to participate in these conversations to identify how they might possibly better align with the MMCOs by DY3. Given that the majority of the NYP PPS physicians practice in NYP clinics across Manhattan, NYP will also work to develop incentive-based components to physician compensation, mirroring the terms agreed upon with the MMCOs, by DY3. (Milestone Goal: DY3)

We and many of our network providers are in the early stages of payment reform, so any process must be flexible and allow for multi-year phasing. From our perspective, a logical next step would be to introduce mutually agreed element(s) of value-based, pay-for-performance terms into our payment methodology. We recognize that MMCOs will also need time to implement and refine methodologies that focus on increasing the quality of healthcare services, transparency and fairness. As such, NYP anticipates starting negotiations by DY4. (Milestone Goal: DY4)

Patient engagement. The PCMHs serving as the center of population health management efforts will use registries to identify and track specific patient-level outcomes and engagement. This data will serve as the basis for patient engagement strategies and efforts aimed at our high-risk, high-utilizing populations. (Milestone Goal: DY3) Culturally competent paraprofessionals— Patient Navigators and Community Health Workers—who come from the communities we serve will work with our less engaged patients to ensure connectivity to the appropriate level care as well as to community-based social service and care management resources. (Milestone Goal: DY1 for PNs and CHWs)

Building on the PPS's strong clinical and IT foundation and initiatives listed above, the PMO (through the IDS) will push the network to evolve into a truly integrated delivery system, leading to a standard, streamlined, community-focused experience for patients.

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.

To succeed, the NYP PPS must expand its service delivery capacity and enhance its IT capabilities in care management and connectivity across the care continuum. At NYP the expansion of service delivery capacity requires the addition of clinical ambulatory and care management spaces as well as the redesign/reconfiguration of existing space in order for it to operate in a more patient-friendly and efficient manner.

The PPS will also be requesting IT capital funding to support Collaborators' access to care management systems and the RHIO and the attainment of the designated Meaningful Use and PCMH standards. Several PPS Collaborators will be applying for capital funding related to IT upgrades, including but not limited to: NYP, the Center for Alternative Sentencing and Employment Services (CASES), Metropolitan Center for Mental Health, ACMH, Harlem United (FQHC) and the Visiting Nurse Service of New York.

In addition, God's Love We Deliver is doing a $30 million expansion project of their current two-story, 18,000-square-foot home in SoHo to more than double in size, allowing them to double the number of meals they can cook and deliver; Community Health Network will request $30 million to develop facilities and infrastructure for primary care, care transitions and behavioral health.

Other Collaborators will be requesting capital to fund various projects supporting the PPS's projects such as: the conversion of 40 general-purpose skilled nursing beds to an Acute Care Step-down unit capable of receiving medically complex patients being discharged from the PPS hospitals as well as direct admits from the Ambulatory ICU (Project 2.b.i) and the ED Triage for at-risk populations (Project 2.b.iii); or, the creation of 20 inpatient hospice beds at a SNF, also in support of the Ambulatory ICU (Project 2.b.i), and the ED Triage for at-risk populations (Project 2.b. III) as well as the Care Transitions to Reduce 30-Day Readmissions (Project 2.b.iv).

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
NYP	Hospital-Medical Home Initiative	10/1/12	4/30/15	A CMS-NYSDOH demonstration project helped strengthen the PCMHs and introduced medical residents into the PCMH care teams
NYP	ACO	1/1/15		NYP, Weill Cornell Medical College, and Columbia University Doctors are participating a in a jointly- led Medicare Shared Savings Program (as defined by CMS). This will start in January 2015.
NYP	Health Home Initiative	1/1/12		NYP is leading a Health Home for the appropriately attributed patient, in collaboration with several community- based organizations. This is in accordance with DOH Health Home rules and regulations.
Harlem United	NYS Medicaid Redesign Team			We have secured three grants to create new housing programs funded through MRT. This is integral part of our coordinated and integrated care model, which will be utilized in each of these projects.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Harlem United	PCMH			Fully implement and maintain PCMH status. Having PCMH 2011 Level 3 status places HU/URAM in good position to achieve PCMH 2014 Level 3 status.
Harlem United	Meaningful Use			Implementing Meaningful Use
Visiting Nurse Service of New York	Healthcare Workforce Retraining Initiative - VNSNY Home Care - NYSDOH			Provides funding to train nurses as Population Care Coordinators (PCCs)
Visiting Nurse Service of New York	Healthcare Workforce Retraining Initiative – Partners in Care – NYSDOH			Provides funding to train home health aides as specially trained Health Coaches.
God's Love We Deliver	Balancing Incentives Project – NYS			Tasked with increasing the number of referrals to MLTC in NYC and expanding our services to Westchester and Nassau Counties.
God's Love We Deliver	Demonstration Project to Integrate Care for Dually Eligible Individuals – NYS			We are participants in the Demonstration Project by aligning ourselves with the new FIDA plans and mounting a study of the efficacy of home-delivered meals for the FIDA population with the NYSDOH.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
God's Love We Deliver	HARP			Applying to be a home and community based service provider to the HARP plans
Isabella	Health Homes – NYSDOH			Participants in two health homes, NYP's and Mt. Sinai's.
Isabella	MLTCP Delegated Care Management			Provide care management services to over 700 individuals enrolled in two MLTC Plans.

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

The strategies outlined in the IDS and other Domain 2 and Domain 3 projects are significant expansions on the NYP PPS's previously funded initiative. These existing programs focus on select disease or high-cost/high-risk populations; the new programs will focus on a more expansive population and make new, highly coordinated hospitals, ambulatory, and community-based resourced available to impact utilization patterns. The PPS represents a significant expansion of the use of the RHIO and Allscripts Care Director tools as well as mapping of Collaborator's entry and exit points for resources. In addition, the ACO focuses on Medicare patients, whereas DSRIP projects target Medicaid patients.

The Collaborator initiatives listed above are helpful extensions to the DSRIP projects, but they are only pieces of the larger strategy. For example, Harlem United reaching NCQA Level 3 PCMH status fulfills but one IT requirement for one organization. Likewise, the Visiting Nurse Service's training programs are excellent complements, but by no means substitutions for the PPS's cultural competency and skills training programs.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

2.b.i Ambulatory ICUs

Project Objective: To create Ambulatory ICUs for patients with multiple co-morbidities including non-physician interventions for stabilized patients with chronic care needs.

Project Description: An Ambulatory ICU will create a multi-provider team for patients with complex medical, behavioral conditions and social complexities. An Ambulatory ICU will also include community-based non-physician care, complex specialty care (e.g., housing, rehab, etc.), for stable patients in need of additional social services. Clinical interoperability within the Ambulatory ICU will allow for efficient identification of patients and connect those patients in need of complex services by allocating levels of service only as needed.

It is expected that the applicant will implement this project at one or more sites consistent with the NukaModel which is endorsed by the Institute for Healthcare Improvement. The relationship-based Nuka System of Care is comprised of organizational strategies and processes; medical, behavioral, dental and traditional practices; and supporting infrastructure that work together - in relationship - to support wellness. Applicants should refer to the Nuka Model in developing the response:
http://www.cmcgc.com/media/handouts/29IH01/M22_NukaModel_Eby.pdf

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. Ensure Ambulatory ICU is staffed by or has access to a network of providers including medical, behavioral health, nutritional, rehabilitation and other necessary provider specialties that is sufficient to meet the needs of the target population.
2. Ensure Ambulatory ICU is integrated with all relevant Health Homes in the community.
3. Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals.
4. Establish care managers co-located at each Ambulatory ICU site.
5. Ensure that all safety net project participants 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.
6. Ensure that EHR systems used by participating providers meet Meaningful Use and PCMH Level 3 standards.
7. Implement a secure patient portal that supports patient communication and engagement as well as provides assistance for self-management.
8. Establish a multi-disciplinary, team-based care review and planning process to ensure that all Ambulatory ICU patients benefit from the input of multiple providers.
9. Deploy a provider notification/secure messaging system to alert care managers and Health Homes of important developments in patient care and utilization.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

Among adults in the service area, the conditions with the largest burden of PQIs are COPD/asthma in older adults, heart failure and diabetes. This inappropriate utilization is driven by three factors: the prevalence of complex conditions, cultural barriers and lack of access to primary care.

Adults with two or more chronic conditions face increased risks of mortality, decreased function and quality of life, unnecessary hospitalizations and more frequent use of services than others.(4) The average number of admissions per person with chronic disease range from 1.9 for diabetes to 2.7 for psychiatric conditions. About 28% of patients in the NYP/CU ACN have two or more of 18 chronic conditions. The top five chronic conditions—hypertension, hypercholesterolemia, low back pain, diabetes and depression—range in prevalence from 16- 35% and impact the top four out of five diagnoses for admissions and ED visits (cardiovascular disease, respiratory disease, diabetes and mental health conditions).

As noted in the CNA, NYP cares for a high number of Children with Special Health Care Needs (CSHCN), defined as "any child who has or is at increased risk of having a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." CSHCN comprise 15- 18% of all children in the U.S. Yet these individuals drive nearly 80% of all pediatric healthcare expenses.(5)

Cultural barriers play a big role in inappropriate utilization. Our service area has a large Hispanic population (41%). Hispanic individuals have significantly lower outcome scores for the six core Maternal & Child Health Bureau outcomes for CSHCN: they perceive receiving less coordinated care, less participation in decision-making processes related to health and less linkage with community resources, screenings and support services. Non-English speaking Hispanic families experience the greatest disparity in outcomes. Our Collaborators emphasize that language barriers and cultural factors prevent individuals from seeking care. Culturally diverse providers understand these reservations and better target patients' needs.

Finally, access to primary care is an issue. For example, only 43% of pediatricians in the NYP/WC service area accept Medicaid. East Harlem has no urgent care centers, so patients of all ages are more likely to use the ED if they don't have a PCP. As noted by our Collaborators, insufficient primary care leads people to wait for emergencies to seek care. Last, across the age continuum, patients do not have access to primary care after the hours of 5 p.m. and on weekends. The ED is often the only option.

To meet these needs, the PPS will develop 9 Ambulatory ICUs in existing PCMHs: four Adult and four Pediatric at NYP/CU and one Pediatric at NYP/WC. We will deliver comprehensive, coordinated care for complex patients using a risk-stratification methodology and a community- and practice-based interdisciplinary team. We will provide intensive case management, hiring culturally

competent RN Care Managers, Social Workers, Psychiatric NPs and CHWs, and maximizing relationships with CBOs. The programs will extend weekday hours and offer weekend hours to improve access. NYP is also committed to building capacity in all clinics to improve access (Project 2.a.i). This project addresses all six needs identified in the CNA summary table.

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 four Adult Ambulatory ICUs, located in Northern Manhattan, will target adult patients with at least two comorbid chronic conditions including diabetes, heart failure, chronic respiratory disease, renal failure or a behavioral health diagnosis. These patients are primarily poor, mostly Hispanic and immigrant residents of Northern Manhattan and the Bronx.
The five Pediatric Ambulatory ICUs will target patients under the age of 21 who meet the definition of a CSHCN. These patients will present with a variety of diseases or medical conditions that require co-management by multiple subspecialists and primary care, including patients with multi-organ system involvement or patients who are technology-dependent. Specific examples include: children with uncontrolled high-risk asthma, depressed patients who are not engaged in psychiatric care, poorly controlled Type 1 diabetic patients or patients with encephalopathy who are gastrostomy-tube dependent and at risk for aspiration pneumonia.
At NYP/CU, the four pediatric clinics see patients primarily from Northern Manhattan and the Bronx, a similar demographic to the adult clinics. At NYP/WC, though the sole resident-run pediatric PCMH is located in the middle- to upper-class Upper East Side, it serves socioeconomically disadvantaged patients who travel from other Manhattan neighborhoods, including East Harlem, and the four outer boroughs, especially Queens.

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.

These programs have been designed upon the collective impact and cultural competency principles of the NYP Regional Health Collaborative (RHC) and in alignment with the relationship-based Nuka System, which requires care to be longitudinal, coordinated and include personal coaching. In October 2010, NYP, in association with the Columbia University Medical Center, launched an integrated network of patient-centered medical homes that were linked to other providers and community-based resources and formed a “medical village” in Northern Manhattan. Three years later, a study of 5,852 patients who had some combination of diabetes, asthma and CHF found that emergency department visits, hospitalizations and 30-day readmissions had been reduced by 29.7%, 28.5% and 36.7%, respectively, compared to the year before implementation of the network.
We will hire seven RN Care Managers and three behavioral health providers, who will complement existing clinic staff, to manage these complex patients. For the highest-risk patients, we will hire

nine CHWs through our Collaborator CBOs and dispatch them to provide culturally appropriate, diagnosis-specific education and support in the home. Depending on location, these CHWs will be cross-trained in pediatric care, adult chronic conditions and palliative care (for Project 3.g.i).
Existing relationships with community providers (e.g., pediatrics: St. Mary's Hospital for Children, NY Center for Child Development; adult: Isabella, Rogosin Institute) will be deepened through care management protocols and technology. New relationships will be developed where service and continuity gaps exist. Areas for improvement already identified include population-specific pharmacy needs (e.g., CityDrug & Surgical) and medically-appropriate meals (e.g., God's Love We Deliver).
Interdisciplinary team meetings will be key in managing the complex health needs of this population. The IDT is co-led by a PCP and an RN Care Manager who facilitates panel management, tracks electronic disease registries and provides care management. The combination of IT, coordinated teamwork and culturally competent providers will help us meet the documented needs of our community.
Staff, CHWs and Collaborators will use NYP's existing care coordination platform, Allscripts Care Director, to coordinate care across the continuum. In addition, there will be a connection to the Healthix RHIO to track patients' utilization at other hospitals. All patients will have access to a secure patient portal via myNYP (www.myNYP.org), which will support patient communication and allow for self-management or for families to manage their children's issues.
Our teams are experienced and well positioned to succeed with this initiative. All eight NYP/CU primary care practices are Level 3 NCQA-certified PCMHs; the NYP/WC clinic will become Level 3 in 1Q15. Nurse Care Managers in our PCMHs demonstrated success with this population in the NYP Regional Health Collaborative. In three years, 5,852 adult patients with diabetes, asthma or CHF saw ED visits, hospitalizations and readmissions reduced by 29%, 28% and 37% respectively.(6) Also in fall 2010, the NYP/CU pediatric team launched the PCMH model for pediatric asthma (WIN for Asthma), which today serves a population of 3,500 children and demonstrated a 60% decline ED visits and hospitalizations from 2009-2012. The NYP/WC pediatric team has a Special Needs team that has been coordinating care for these medically complex patients for over ten years.

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

The project will require significant IT investment to support the new staffing model and resources available to multi-comorbid patients. At NYP/WC (pediatrics only), the clinic uses a different EHR than the rest of NYP and many Colllaborators. A significant challenge will be interfacing the Allscripts Care Director care coordination platform and the existing Amalga population health analytics tools (registries, etc.) at NYP/WC and to our Collaborators as appropriate. To address this challenge, NYP will invest early (DY1-2) in establishing the necessary data-linking and EHR modifications to support integration of ACD (Project 2.a.i).
In addition to infrastructure challenges, we anticipate the Ambulatory ICU target population having difficulty accessing new tools made available via the internet, smartphones and tablets (and hosted by the PPS). To address this challenge, the PPS's CHWs will be trained to provide basic "technical support" to patients, enabling them to use basic web and app-browsing, text messaging and email

to gather additional information on their condition, communicate with their providers and identify resources across the PPS network.
Capacity in the NYP Ambulatory Care Network is constrained, both space and provider availability. NYP is committed to investing capital to increase capacity (Project 2.a.i). In the short term, the nine Ambulatory ICUs will extend weekday hours and adding weekend hours.
Hiring pediatric psychiatric NPs is difficult due to the relative scarcity of such professionals. We will begin recruiting for this position in early January but understand that a delay in hiring will delay the pediatric project's overall implementation. See also Workforce Strategy (Section 5) for our recruitment strategy.
This project requires a regulatory waiver to the extent that discounting, packaging, combining or other reduction or denial of payment is required for multiple procedures and/or medical services provided to patients on the same date of service. A major goal of this project is to employ a multi-disciplinary care team to treat a patient for multiple medical and/or behavioral conditions during a single visit to the project site. We need claims for multiple services provided to a patient on the same day to be paid at the full fee-for-service amount in order to ensure financial feasibility. See also Section 1, Regulatory Relief.

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 no overlapping PPSs in the NYP PPS service area are undertaking Project 2.b.i, no coordination activities were planned for this project. However, implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among overlapping PPSs.

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

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

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

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

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

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

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

a. Will this 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.

As part of NYP's capital expansion project planned for the Ambulatory Care Network, we will be adding some equipment for this project. For Pediatrics, we need (1) two examination tables that have side rails to assist in caring for older children, who are more difficult to manage while on the table, and (2) four scales for wheelchairs.
In addition, Blythedale Hospital will be requesting capital for increased capacity of its pediatric long-term care unit.

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
St. Mary's Healthcare System for Children	Balancing Incentive Program, Innovation Fund			Funding for remote patient monitoring of medically complex pediatric home care patients via interactive voice response system to identify changes in condition, lapses in medication adherence, etc. and to prevent avoidable ED visits and admissions.

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.

St. Mary's serves a different patient population than that of the NYP Ambulatory Care Clinic. These patients are in home care as opposed to outpatient clinic care. There is no overlap between these two patient populations.

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

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

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

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

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

2.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.

The largest numbers of PPVs for the PPS are in the NYP/CU service area: Southwest Bronx (156,274) & Northern Manhattan (67,645). In addition, the observed PPV rate was larger than expected for Southwest Bronx (156,274 observed vs. 150,561 expected); Lower Manhattan (5,705 vs. 3,615), East Harlem (35,244 vs. 25,568) and the Upper East Side (3,264 vs. 2,894). Northern Manhattan was slightly lower than expected but still above the State's goal.

There are several reasons for this inappropriate utilization: ambulatory care sensitive conditions that are prevalent in our community, gaps in access and education as well as cultural barriers.

People who have ambulatory care sensitive conditions—such as CHF, hypertension, asthma and diabetes—use the ED when they are not well connected to care. Cardiovascular disease, for example, has the highest prevalence rate among adults in the PPS's service area, with 35% of the attributed population affected. Diabetes affects 19%. In the NYP/CU service area, 20% of Medicaid recipients have chronic hypertension and 10% have diabetes. In the NYP/WC service area, 21% of Medicaid recipients have chronic hypertension and 12% have diabetes. In the NYP/LM service area, 30% of Medicaid recipients have chronic hypertension or heart disease and 12% have diabetes. For children, the clear outlier is asthma, which has a 16% prevalence rate in the PPS service area (about 5,700 children). Patients with these conditions need to be redirected to the outpatient setting and connected with regular care.

Access to care is an issue. In 2013, for people who had two or more visits to the NYP/CU EDs, 20% were for primary care diagnoses such as influenza. That's because there is limited availability of key services, such as appointments with primary care and specialty physicians, and poor care continuity leads people to wait until emergencies to seek care. For example, in the NYP/WC service area, there are few local services for Medicaid patients, making it more likely that they utilize the ED in a pinch. Less than half of general physicians, pediatricians and OB/GYN providers accept Medicaid; East Harlem has no urgent care center. Finally, the NYP has recognized capacity constraints in space and provider availability in its clinics.

Another issue for our PPS—in which 41% of the population is Hispanic, 26% is foreign-born and 61% speak a primary language other than English—is culture. Language barriers and cultural factors may prevent some individuals from seeking appropriate care. Finally, education about how to best use the U.S. healthcare system and what insurance plans cover is critical.

To meet gaps in access and chronic disease care, the NYP PPS is committed to building capacity (space, hours and providers) in its clinics (Project 2.a.i) and developing Ambulatory ICUs to manage complex patients (Project 2.b.i). To address the educational and cultural drivers of utilization, the PPS will implement an ED Care Triage Team in five EDs, consisting of culturally competent, 24/7 Patient Navigators (PN). The PN will meet with high-risk patients to understand issues with access

to care and also to educate regarding resources in the community. They will schedule patients for primary care/specialty medical appointments through open access scheduling; link them to financial assistance or other social services; and connect to them to community-based resources such as home care. PNs will also offer appointment reminders and post-appointment follow-up calls. For patients without regular primary care access, PNs will attempt to match patients with a local NCQA Level 3 PCMHs within the PPS. The ED PN program will also interface with the new psych triage team, assisting with warm-handoffs between triage and the LCSW in Urgent Care (Project 3.a.ii). In addition to CNA1 (Integrated Delivery System) and CNA2 (Culturally Competent Providers), this project addresses CNA4 (Sustainable connections to community-based primary care).

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

We will engage Medicaid patients (adults and children) who have presented twice to one of NYP's five EDs for non-emergent care, i.e., eligible for a non-admission disposition if appropriate outpatient services can be procured. In triage, we will screen for patients without access to a primary care provider; those with certain ambulatory-care sensitive conditions, especially cardiovascular and pulmonary disease but not excluding other conditions that could benefit, like HIV (see Project 3.e.i) and sickle cell disease; and those who are frequent utilizers of the ED, particularly behavioral health. We will work with the embedded Psych Triage team (Project 3.a.ii) on frequent ED utilizers with mental illness or substance abuse issues.

When a patient presents to the ED and initial provider triage is complete, a list of high-risk patients will be generated via an algorithm in the EHR for on-site patient navigators (PN). The algorithm will include the following inputs: Medicaid insurance; Emergency Severity Index (ESI) of 3, 4 or 5 (i.e., not expected to be admitted); ≥ 3 ED visits in the past 12 months; Ambulatory care sensitive conditions prevalent in local patient population (CHF, COPD/asthma, diabetes); mental health diagnosis (associated with 30% of the frequent utilizing population); and lack of PCP/specialist connectivity.

This initial list will allow for earlier intervention by PNs who can discuss with patients the reasons for ED presentation, overutilization of outpatient care and current PCP/specialist connectivity. Over the patient's ED course, the care team may also electronically consult the PN for patients who were not picked up by initial algorithm but who could benefit from navigation.

These patients are predominantly socioeconomically disadvantaged, ethnic and racial minorities across the PPS: 45% white, 20% Black, 10% Asian and 24% other; 41% Hispanic, 26% foreign- born and 61% speak a primary language other than English. Of note is the Asian-American population in the NYP/LM service area, which is a new patient population for NYP. Residents are 60% white and 25% Asian (75% of Chinese origin). In addition, 20% speak an Asian language, of which 65% speak English less than "very well." Our proposal will hire and train PNs from the community who have the cultural and linguistic competency to engage in ED patients.

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

We will leverage the successful Patient Navigation program at NYP/CU (not Medicaid-focused), which began in 2009 and will now be significantly expanded. In 2013, we initiated an IRB- approved Patient Navigator evaluation project to determine the impact of the Patient Navigator Program on patient utilization. The study comprised of a cohort of 5,154 patients who were registered in the ED for a treat-and-release visit during the time period July 1, 2010 through June 30, 2011 and qualified for Patient Navigator services. In order to determine impact of such services, data was gathered reflecting ED and Ambulatory Care Network (clinic) utilization for the 12 months pre- and 12 months post- Navigator intervention. Preliminary results showed that ED utilization decreased and clinic utilization increased in the 12 months following Navigator interaction. For example, ED utilization declined from 3.67 to 1.99 for those using the ED 3-5 times ($n=535$, $p<0.001$) and 7.27 to 3.93 for those using the ED 6-11 times ($n=119$, $p<0.001$). Clinic visits increased from 1.64 to 2.96 visits per adult ($n=1,262$, $p<0.001$) and 2.42 to
3.26 visits per child ($n=363$, $p<0.001$).

We will also build upon the foundation of the NYP Regional Health Collaborative, which decreased ED utilization 30% over a three-year period for CHF and diabetes patients by connecting them with appropriate outpatient care and intensive case management.

Some of the existing 18 PNs will be redeployed to the DSRIP program (i.e., focus on Medicaid patients and the high-risk registry developed at triage) and an additional 17 PNs will be hired to allow for 24/7 coverage with surge capacity based on patient volume in the five EDs. The additional members of the ED care triage team will come from existing care coordination resources in the ED (social workers, care managers, nursing home liaisons) so that new hires in these areas not needed. In addition, the Visiting Nurse Service of New York already has a presence in our EDs; these representatives are called in to speak with patients who may benefit from home healthcare services.

Enhanced relationships and technology connections with community providers (e.g., Charles B. Wang Community Health Center, Community Healthcare Network) will support the timely referral of patients in Lower Manhattan to primary and specialty care. Improved technology will support both notification and appointment-making with community providers (e.g., Inwood Diagnostic and Treatment Center).

At NYP/WC, we will also hire an on-site NP. Because there are few safety net or urgent care providers in the service area, patients would be more likely to return to the ED after being treated and released without the NP's additional clinical support to ensure safe handoff to primary care and to address clinical issues post-discharge (such as callback access for further symptoms or pharmacy related prescription issues).

The care triage team will document each patient interaction in the existing EHR. Data will include the number of patients screened; the number of and reasons for interventions; disposition details (e.g., discharge, sub-acute rehab, etc.); and involvement of non-physician healthcare, social or pharmacy services. They will also document follow-up calls and after-care. We will use access to existing IT resources, including the care coordination platform, Allscripts Care Director, and the Healthix RHIO, to track patients as they move from the ED to our clinics.

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.

To address the capacity issue in NYP's clinics, the PPS is committed to expanding access via space, time and human resource investments. This will be critical, as one of the main goals of this project is linking patients to regular primary care.
The project will face the IT challenge of ensuring open access scheduling both within the existing NYP Ambulatory Care Network of clinics (ACN) as well with Collaborators. At NYP/CU, there is open access scheduling for our primary care practices and many of our specialty practices. This is not the case at NYP/WC and NYP/LM, and the infrastructure will have to be built. The PPS has a plan in place with NYP's IT department to implement this infrastructure by DY3.
As this program is being implemented in five EDs across the diversity of the NYP PPS, we will need to hire PNs with a variety of cultural and linguistic backgrounds. NYP has a robust cultural competency training program (Section 7), which we will expand to our clinics, PNs and Collaborators. We will also work with Collaborators such as Charles B Wang Community Center in Lower Manhattan to help us find and train PNs who speak Mandarin and understand the needs of the Chinese and Chinese-American population.

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

The only overlapping PPS working on this project is New York City's Health and Hospital Corporation (HHC). During the Design Grant phase we met with HHC about potential project overlap and collaborations. In both instances it was agreed that starting in January 2015 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols for those projects where we have overlap, shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. In addition, we have met with Advocate Community Partners to understand their PPS and describe our projects/vision for the PPS, particularly with respect to the Lower Manhattan service area, which is integral to the ED Care Triage Project. Implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among overlapping PPSs. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):
DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of

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

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

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

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

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

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

a. Will this proj

Yes	No
☒	☐

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

Isabella is developing ICU beds capable of supporting avoidance of ED visits and direct admission, i.e., vent weaning, LVAD and other complex care. These patients have complex conditions but rarely need an inpatient level of care. However, once they arrive at the ED, they are usually admitted due to the complexity of the patient. Building capacity to receive such patients without going through the ED will help decant the ED of patients with these ambulatory sensitive conditions.

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	Project End	Description of Initiatives
NYP/CU	Patient Navigator Program	1/1/09	Current	Philanthropic donation lead to creation of navigation program in 2009 to target patients in ED with no PCP or insurance coverage and help connect them with the healthcare system

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

While the existing Patient Navigator program at NYP is not Medicaid-specific, this successful initiative is being used as a model to start building the PN components of the DSRIP ED high-risk patient triage program. However, we are expanding the staffing and scope of the PNs. The navigators who will be hired for the DSRIP project will be trained in the same model but also have additional training around clinics/resources accessible to the Medicaid patient population. Additionally, they will see patients earlier in the care continuum based on a DSRIP-specific algorithm that is more expansive than the triage criteria for existing PN program. One specific example of this is that the existing navigation program excluded all patients with behavioral health diagnoses. However, as internal analysis of our Medicaid patients reveals that 30% of the patients with ≥ 3 visits per year have a behavioral health diagnosis, the DSRIP PN program will also now work with behavioral health patients (in conjunction with the Psych ED Triage Program, Project 3.a.ii). In line with the DSRIP goals of increasing PCMH and open-access scheduling, the PN will now focus on triaging patients to level 3 PCMH where possible. Furthermore, as the program is now expanding to new geographic locations, we will be collaborating with community organizations that can enhance our cultural competency training, e.g., with the Chinese American population in lower Manhattan.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

successfully meet DSRIP project goals.

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

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

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

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

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

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

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

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

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

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

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

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

A survey of our Collaborators demonstrates how social determinants of health play an important part in readmission rates. Insufficient access to primary or specialty medical care and cultural/educational barriers are two big factors. Collaborators said that language barriers and cultural factors may prevent some individuals from seeking appropriate care. Culturally diverse providers of care (including community health workers) have been show to better understand the reservations of particular populations to seek care and target their needs.(7) In addition, several populations would benefit from education about 1) healthier living choices, 2) how to best use the U.S. healthcare system, and 3) how to obtain sufficient health insurance. Such education would be particularly helpful for elderly patients, newcomers to the health system, and individuals with multiple appointments and complex care. One respondent explained the system's complexity as the "inability of community residents to navigate the healthcare system."

An analysis of data from HANYS shows the leading causes of 30-day readmissions among Medicaid patients of all ages at NYP include the following chronic medical conditions: COPD, CHF, stroke, renal failure, sickle cell/red blood cell disorders, asthma, diabetes and alcohol abuse. A review of our internal data showed that, in 2013, the crude unplanned readmission rate for adults with these conditions was 12% at NYP/CU-Allen Hospital, 15% at NYP/CU-Milstein and 13% at NYP/WC for a total of nearly 1,200 readmissions.

Indeed, the top five chronic conditions in adults attributed to our PPS—hypertension, hypercholesterolemia, low back pain, diabetes and depression—range in prevalence from 16- 35% and are conditions that impact the top diagnoses for readmissions including CHF, COPD, stroke and diabetes. There is also a high percentage of adults with comorbid chronic conditions. Looking at eight diseases of interest (sickle cell, COPD, seizures/epilepsy, CHF, renal failure, diabetes, stroke and asthma), we found that 13% of the NYP/CU attributed population has two or more of these conditions. That figure is 23% for NYP/WC and 29% for patients attributed to our Collaborators.

Given this backdrop, NYP unsurprisingly has more potentially preventable readmissions (PPR) than the State's goal of a 25% reduction from the expected rate. The PPS will strengthen continuity of care between the hospital and outpatient settings to address PPR rates at four campuses: NYP/CU-Milstein, NYP/CU-Allen, NYP/WC and NYP/LM. Project plans include modifying the Transitions of Care protocol among PPS collaborators, implementing RN Transitions Care Managers for the highest risk cases and integrating Community Health Workers into the transition phase. The RN Transitions Care Managers will be trained to act as culturally competent "coaches," teaching patients (and caregivers) self-management skills during the inpatient stay and for 30 days following discharge via home visits and telephonic follow-up. We base our model on the Care Transitions Program developed by Eric Coleman, MD. According to the Care Transitions Program, patients "are significantly less likely to be readmitted to the hospital" and "more likely to achieve personal goals around symptom management and functional recovery." In addition to CNA1 (Integrated Delivery System) and CNA2 (Culturally Competent Providers), this project addresses CNA4 (Sustainable connections to community- based primary care) and CNA5 (Intensive care management for people with multiple comorbid conditions

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

Our target population is all adult Medicaid patients who touch our inpatient units, excluding healthy moms and babies, who have their own discharge protocols. For all these patients, we will provide a simplified Care Transition Plan at discharge. In addition, we are developing a more in-depth model for patients at higher risk for readmission, specifically adults with one or more of the following seven chronic conditions: CHF, COPD, kidney failure, diabetes, asthma, stroke and sickle cell/red blood cell disorders.

As we have seen in the CNA, most Medicaid patients in our PPS are predominantly socioeconomically disadvantaged, linguistically isolated and suffering from psychosocial stressors in addition to medical ones. They come from all over the city—Manhattan, Brooklyn, Bronx and Queens—for inpatient care at our hospitals. Those with the chronic health conditions listed above are prime candidates to benefit from the higher-touch approach (RN "coaches," Community Health Workers, in-home interventions) that we propose below.

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

We will build on existing Meaningful Use work to simplify and enhance discharge instructions by transforming them into a Care Transitions Record. Each patient will receive a discharge summary, in language that is culturally appropriate and health-literacy accessible, containing details related to the hospital visit and follow-up care.

For high-risk patients, we will implement a higher-touch model based on the proven results of the NYP PCMH-based Care Management Program (NYP Regional Health Collaborative, RHC) and the NYP/CU-Allen Hospital's Care Transition Program for CHF. After implementation of the RHC, a study of 5,852 patients with some combination of diabetes, asthma and CHF who received primary care through the ACN demonstrated a 36.7% reduction in 30-day readmission rates over a three-year period.(8)

We also piloted this for CHF at NYP/CU-Allen Hospital. Every day the TCM reviews admissions for appropriate high-risk CHF cases, visits each high-risk patient, introduces herself and the care transitions program, and assesses what the patient understands about his/her admission and disease. The TCM develops a care transition plan with the patient and coaches the patient through it for 30 days post-discharge. During the first half of 2014 the TCM engaged 171 high- risk or recently readmitted CHF inpatients in transitional care follow-up services. Only 16 patients (9.4%) were readmitted. Our calculated Readmissions Rate using CMS methodology for the same period at the Allen Hospital is 25.4%.

We will hire eight RN Transitions Care Managers (TCM) who will lead the intervention, providing education on disease self-management for patients/caregivers and collaborating with the care team (including medical and social work) regarding post-discharge needs, including appointments; two pharmacists to provide bedside counseling and medication reconciliation; and six CHWs to

provide in-home support for patients after discharge.
The PPS will mobilize resources in our clinics and the community to provide such post-discharge care as timely primary or specialty care appointments (e.g., community MDs, Harlem United, Community Healthcare Network); connections to outpatient palliative care (e.g., VNS, MJHS; see Project 3.g.i); medically tailored home meals (e.g., God's Love We Deliver); home care (e.g., Hebrew Home); behavioral health management (e.g., The Bridge); and community support (e.g., Riverstone Senior Life Services). For patients who lack home support, we will introduce CBO- sourced CHWs who will provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. They will also assess non-medical causes of readmission, such as lack of transportation or food insecurity.
An automated readmission risk scoring tool is currently under development. It will be integrated into the inpatient assessment, flagging Medicaid patients who are at a high risk for readmission due to social determinants of health and their derivative healthcare access barriers (clinical, functional, cognitive/behavioral and social) and meet one of the identified chronic conditions. All providers—from the TCM to Collaborators—will be responsible for documenting these patients' care in Allscripts Care Director from day one of admission until day 31 after discharge.
There are several linkages with other DSRIP projects. Patients already known to the Ambulatory ICU intensive care management program (Project 2.b.i), will be referred to their assigned care manager. Candidates for palliative care will be referred to either inpatient Palliative Care Services and/or the Palliative Care Manager (Project 3.g.i). Patients who present to the ED after discharge despite our efforts will be flagged at triage and made a priority for Patient Navigators (Project 2.b.iii) if their visit is not medically necessary.
{Refs avail on last page of CNA.}

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.

As a result of our new transitions of care protocol, we anticipate an increase in demand for NYP's Ambulatory Care Network (CAN) and our Collaborators' services, both of which are already stressed. THE NYP PPS is committed to expanding our primary and specialty care capacity (staffing, hours, and space) as well as building IT capacity with our collaborators, allowing them to manage their volume more effectively. There are a number of overlapping and nearby PPS groups working on Project 2.b.iv. Coordinating and sharing patient visit information in a timely way across this large network will prove challenging in the absence of systems interoperability/RHIO/SHIN-NY. See below for how NYP has a robust cultural competency program (Section 7), which we will use to train all new hires. NYP/LM is a new partner in the NYP system with a predominantly Chinese patient population. Collaboration with long-standing leaders in the community such as Charles B Wang Community Health Center will allow us to effectively engage the population. Finally, regarding Requirement 2, NYP has is in active negotiations with Medicaid MCOs to modify contracts so that we will be able to provide coverage for these services. We will also work with MMCOs to modify transitions of care protocols to meet our new standards.

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.

Both Mt. Sinai and NYC's HHC are engaged in Project 2.b.iv. During the Design Grant phase we met with both Mount Sinai and HHC about potential project overlap and collaborations. In both instances it was agreed that starting in January 2015 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols (including for follow-up when 30-day intervention periods overlap), shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. In addition, we have met with Advocate Community Partners to understand their PPS and describe our projects/vision for the PPS, particularly with respect to the Lower Manhattan service area, which is integral to the success of the Care Transitions project. Implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among overlapping PPSs. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

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 w

funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

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

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

a. Will this proj

Yes	No
☒	☐

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

Hebrew Home will request funds to create an annex gym for sub-acute rehab program with dedicated rehabilitation locations to treat patients in a condition-specific manner; expand its pilot for video teleconferencing to provide a mechanism for patients to experience virtual medical visits without a need to travel or leave the nursing home setting; and renovate 64 patient rooms to create a more home-like experience, make seamless transitions between levels of care and reduce falls. Amsterdam Nursing Home will request funds to develop an enclosed area to expand services for our attributed population. Isabella is requesting funds to developing ICU beds capable of supporting avoidance of direct admission, i.e., vent weaning, LVAD and other complex care; and implement the IHRT Care Transitions Program, including space acquisition, renovation and outfitting. Methodist SNF will develop an acute step-down unit. MJHS is developing a hospice residence/inpatient unit at Isabella Geriatric Center. It will include hospice- and hospital- levels of care and serve as a hospital alternative to reduce readmission. These assets will help reduce readmissions by expanding post-acute care options for our patients.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start	Project End	Description of Initiatives
ArchCare	IMPACT			Project is designed to reduce readmissions of post-acute care patients utilizing greater communication between the sending hospital and the receiving SNF (and vice versa). The focus is on process, data transfer, MD to MD communications, hospital discharge planning and IT innovation.
ArchCare	New York Reducing Avoidable Hospitalization (NYRAH) – CMS			CMS quality improvement project that utilizes proven, evidence- based methodology INTERACT; promotion of evidence-based care paths; training program of early interventions; and improved discussions of goals of care and palliative care referrals where appropriate.

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

The Improve Processes and Care Transitions (IMPACT) to Reduce Readmissions Collaborative is a hospital/nursing home program supported by non-government provider associations in New York State designed to improve cross-provider communication and care coordination. IMPACT provides important information and resources for DSRIP, but its focus is more limited to standardized communication and relationship building. The DSRIP Care Transitions project is distinct from IMPACT in two key ways: IMPACT is limited in size and does not incorporate all of the PPS's Care Transition providers, and the PPS model will go further than communications and disrupt current hospital discharge practices through embedding new nurse care coordinators into the hospital setting. The New York-Reducing Avoidable Hospitalizations (NY-RAH) project employs the Interventions to Reduce Acute Care Transfers (INTERACT) tool to reduce avoidable hospitalizations from nursing facility residents, improve care transitions between hospitals and nursing homes, and strengthen palliative care. INTERACT is a quality improvement program coordinated by non-government provider associations in New York State focused on the changing status of residents at nursing homes. Although NY-RAH funds the placement of nurse care coordinators onside at nursing facilities, not all of the PPS's project providers are participating in this program. In addition, the PPS model will embed new nurse care coordinators in the hospital setting to manage the discharge process.

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

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

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

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

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

Domain 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.

People with chronic mental illnesses lose 10-25 years of life expectancy due to medical illnesses.(9) Patients with severe mental illness (SMI) don't make it to PCPs for routine medical care. For example, in the NYP/CU service area, the rate of diabetes monitoring for schizophrenic patients was only 68% in 2013, down from 71% in 2012. Mentally ill ethnic minorities also receive poorer healthcare for major comorbid medical illnesses such as hypertension, diabetes and dyslipidemias.(10,28) Mental illness compounds the deleterious effect of social & cultural barriers to healthcare access.
OMH PSYCKES data shows that 25% of people in two clinics at the New York State Psychiatric Institute (NYSPI) have not visited a primary care doctor in the last year, but an internal audit indicates that 65% of this population has a medical condition requiring such care. In addition, 18% of patients who received behavioral health services at NYP have had three or more medical inpatient or ED visits in the last year.

Service area residents are socioeconomically disadvantaged and linguistically isolated minorities (31% Black, 61% Hispanic). Focus groups conducted with Hispanics with SMI in Northern Manhattan by the Center for Cultural Competence at NYSPI indicate that perceived stigma and discrimination, lack of culturally adapted care (such as personalismo, a warm and personal caregiver relationship) and

language barriers prevent primary care visits.(11)

To meet these needs, we will embed primary care within five existing Behavioral Health (BH) clinics: one stationary and one mobile at NYP; two stationary at NYSPI and one stationary at Casa Washington Heights, which is owned by AIDS Service Center of New York City (ASCNYC). The clinics will hire culturally competent providers to conduct preventive care screenings (medical and behavioral), improve health literacy, improve indices of care for metabolic conditions and use evidence-based standards of care to monitor patients' medical conditions. For appropriate patients, connecting with community PCPs will be the ultimate goal. We will co- locate some of PCPs with our Mobile Crisis Team to facilitate engagement. Receiving primary care in their regular behavioral health clinic will increase patients' access to and comfort with PCP engagement and should reduce unnecessary ED and inpatient use. In addition to CNA1 (IDS) and CNA2 (Culturally Competent Providers), this project addresses CNA3 (Accessible behavioral health care) and CNA4 (Sustainable connections to community-based primary care).
{Refs avail on last page of CNA}

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

Our target are diverse, poor and immigrant adult Medicaid patients from Northern Manhattan and the Southwest Bronx. Targeted patients all carry a primary psychiatric diagnosis of chronic mental illness and co-morbid medical illness. Specifically, qualifying patients will carry psychiatric diagnoses for Schizophrenia/Schizoaffective Disorder; Bipolar Disorder; Major Depression, recurrent; or Post-Traumatic Stress Disorder in combination with any of the following medical diagnoses: Diabetes; Coronary Artery Disease, Hypertension or Congestive Heart Failure; Hyperlipidemia; or Obesity. We will prioritize care to the cohort who has not accessed traditional community primary care services and/or has had three or more medical emergency room visits or inpatient admissions in the last year.

Patients already in treatment in our clinics but not receiving primary care will be flagged from their first visit so that we can begin to monitor them to determine if they need the integrated primary care proposed. If they continue to demonstrate need (through increasing use of ED services for medicine, we will get them actively engaged with our embedded PCP as well as CBO PCPs). Treating psychiatrists may also refer to us directly if their patients identify significant barriers to accessing primary care in the community and have not seen by a primary care provider over the last 12 months.

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

In each of the four BH sites, we will hire, train and embed a PCP, NP and Licensed Clinical Social Workers (LCSWs) who will act as Outreach Coordinators. Primary care services will be available during all practice hours and will receive the same standard of care as in NYP's Ambulatory Care Network (ACN) sites. We will also hire a Health Educator, who will act as a peer-patient navigator, and a Spanish/English interpreter-translator, to be shared with Project 3.a.ii. When patients need home-based services, we will employ specially trained, culturally competent Community Health Workers (CHWs) to provide in-home support and education. We will also develop value-based relationships with pharmacies for home delivery of medications or blister packs and have initiated discussions with Melbran Pharmacy and CityDrug & Surgical.

Clinicians will have access to NYP's existing care coordination platform, Allscripts Care Director, to flag appropriate patients for the embedded primary care service as well as document care and track service utilization. The system will contain real-time information of all patient services. Staff will attend the weekly meetings at the BH sites. All contact with patients will be maintained on a shared EHR.

All four BH clinics already exist in the NYP Network and work closely with the Comprehensive Psychiatric Emergency Program (CPEP). We have a double-Boarded physician in internal medicine and psychiatry, Dr. Laura Kent, who will act as a consultant for this project. Note: High utilizers who are disconnected completely from primary care will be captured through our ED psych triage program (Project 3.a.ii).

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.

IT challenges include: 1) enabling meaningful use/review of inter-specialty notes, 2) developing registries across Collaborators, and 3) developing protocols for new disciplines. To address these challenges, the PPS will work with the existing behavioral health team and newly hired/trained primary care staff to design and develop EHR workflows; develop a common care plan within EHRs and across ACD; leverage the RHIO and SHIN-NY to develop registries that can pool patients from the five integrated sites; and build upon existing primary care flowsheets for the clinics.
NYP has a robust cultural competency training program. In addition, we will address language barriers by hiring a Spanish/English interpreter/translator (shared with Project 3.a.ii).
This project requires a regulatory waiver to 10 NYCRR 8.6-8. A major goal of this project is to treat patients for mental illness and comorbid medical conditions during a single visit. These claims must be paid at the full fee-for-service amount to ensure financial feasibility. See Section 1.

We also need regulatory relief to ensure success. We believe the State can enact these changes through the issuance of policy clarifications and sub-regulatory guidance. We will raise these issues during the implementation plan phase:
-Increasing the % of people who can receive primary care in Art. 31 clinics to include regular primary care visits
-Provision of >120 services/year across sites
-Provision of >30 visits/year and to exceed the maximum of 50 allocated for clinic level of care
-Offsite billing for home visits

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.

Both Mt. Sinai and NYC's HHC are engaged in Project 3.a.i. During the Design Grant phase we met with both Mount Sinai and HHC about potential project overlap and collaborations. In both instances it was agreed that starting in January 2015 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols, shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. Implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among overlapping PPSs. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

NYP must construct an exam room in one of the clinics, Eye-6 Adult Psychiatry, as well as further equip the other existing spaces. In addition, the Mobile Crisis Team is off-site, removed from the hospital by 13 blocks. Closer proximity (601 W. 168th Street, across from the NYP/CU adult ED) and co-location of the crisis (CTI) team (Project 3.a.ii) would facilitate all aspects of these proposals because referrals will flow more seamlessly and the providers can share resources. These two programs will also share a van.

A Collaborator, the Center for Alternative Sentencing and Employment Services (CASES), anticipates opening a satellite of its Article 31 outpatient mental health clinic in Brooklyn, and integrating primary care services into both the proposed Brooklyn site and the main Harlem site. Funding would be used to purchase necessary medical equipment, design and construct renovations and for consultants and legal advice to structure the partnership terms and agreements. Fountain House is requesting funds to develop an integrated Article 28/31 clinic and a model recovery center. BOOM! Health is requesting funds to renovate its wellness center with integrated medical and behavioral health services. Harlem United is requesting funds to renovate the clinics which will serve as the point of integration of primary and behavioral care services. (See Initiatives table below.) These programs are necessary because they will create capacity in the community for behavioral health patients who are seen in our clinics.

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	Project End	Description of Initiatives
Harlem United	Behavioral Health Integration - HRSA			Funding to integrate Behavioral Health into a Primary Care setting. This includes hiring a Behavioral Health Social Worker, developing a screening template in EHR, and is currently putting systems in place to better coordinate care to identify mental health issues and monitor health outcomes. Substance use and mental health issues are some of the most prevalent issues that prohibit adherence to medical treatment for patients with HIV.

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

The Harlem United project is operating under Model 1, i.e., integrating behavioral health into primary care as opposed to our project, which tackles Model 1, i.e., integrating primary care into behavioral health clinics. However, these two project complement one another and will both serve patients who require medical and mental health services. In addition, it allows the opportunity for sharing of best practices across the PPS.

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.a.ii Behavioral Health Community Crisis Stabilization Services

Project Objective: To provide readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis.

Project Description: Routine emergency departments and community behavioral health providers are often unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. This project entails providing readily accessible behavioral health crisis services that will allow access to appropriate level of service and providers, supporting a rapid de-escalation of the crisis. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.

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 a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.
2. Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.
3. Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.
4. Develop written treatment protocols with consensus from participating providers and facilities.
5. Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.
6. Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).
7. Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
8. Ensure that all PPS safety net providers are actively connected 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.
9. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
10. Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.
11. 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.

The NYP/CU service area has a prevalence rate of 17.1% for depression and 2.6% for bipolar disorder, both of which are on par with national rates, but a prevalence rate of 3.3% for schizophrenia, three times the national rate of 1%. Yet there is a critical lack of access to behavioral healthcare. There are only 20 accessible behavioral health centers in Northern Manhattan and the Southwest Bronx. Clinics report wait lists. In addition, less than half of psychiatrists use EHRs.

Data from the OMH PSYCKES database on 11/28/2014 shows that 20% of safety net patients (about 9,600) who received behavioral health services at NYP have had four or more emergency room or inpatient admissions in the last year. This is close to double the regional average. About 3.6% of these admissions (1,700) at NYP are for behavioral health alone, about two-and-a-half times greater than the regional average. In addition, the 30-day readmission rate for all behavioral health patients at NYP is 32%, compared to 24% regionally. (Note that these patients will also be addressed by Project 2.b.iv).

State quality metrics reinforce the difficulty of keeping these patients in care. Although the NYP/CU service area performs better than State average for the percentage of Medicaid recipients who were seen on an ambulatory basis within 7 days of discharge, by 30 days the service area performs worse than State average.

These patients are among the most disenfranchised in the system. Though well known to clinicians in our CPEP, they travel between various emergency rooms as a result of homelessness, lack of resources and mental illness, seeking routine care. Crisis interventions are needed to identify and divert non-emergent psychiatric patients from the medical and psychiatric EDs while linking them rapidly to nearby ambulatory medical, social, psychiatric and safety net providers.

Two interventions will address these needs. Intervention #1 will embed a Psychiatric NP within ED Triage to collaborate with CPEP psychiatrists to provide a Brief Assessment, identifying non-emergent patients and diverting them to a new LCSW Outreach Coordinator in Urgent Care, who will provide linkage with services including CTI (see below). This triage team will coordinate with ED Patient Navigators (Project 2.b.iii) to ensure warm hand-offs between triage and the

LCSW.

Intervention #2 will implement a community-based, mobile Critical Time Intervention (CTI) team, linked to inpatient, outpatient and ED providers. The evidence-based CTI team is comprised of a psychiatrist, Licensed Clinical Social Worker (LCSW), RN and Peer Health Educator and will target high emergency room and inpatient utilizers. The CTI team meets patients at the point of greatest need, eliminating gaps in care. The four-person team maintains a 10:1 Patient-to-Staff ratio and works with patients from three to nine months with the goal of linking patients to services underpinning unmet need, including mental health and substance abuse; appointments management, prescriptions adherence; connectivity to housing providers and primary care; and addressing barriers, e.g., lack of insurance.

Like 3.a.i, Project 3.a.ii addresses CNA1-4.

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 NYP/CU Adult ED sees primary behavioral health Medicaid patients from the poor, minority communities of Northern Manhattan and the Southwest Bronx. The two crisis interventions proposed will target individuals who have previously received behavioral health services at NYP and who have had four or more medical emergency room or inpatient admissions at NYP in the last 12 months. We have also included room for organic growth as we expect to see an increase of 5% per year based on internal data. These patients will carry one of the following primary psychiatric diagnoses: Major Depression, recurrent, severe; Bipolar Disorder; Schizophrenia; Schizoaffective Disorder; Post-Traumatic Stress Disorder; and Comorbid Substance Abuse Disorder.

Note that there is a difference between these patients and those impacted by Project 3.a.i. The latter are patients who are already in care for their behavioral health conditions but need attention to their comorbid medical conditions. The patients targeted by Project 3.a.ii are out of care, and we are attempting to link them with appropriate, regular care to improve their health outcomes and keep them from inappropriately using hospital services (ED and inpatient).

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.

For these two interventions, we will hire four physicians (plus use an existing psychiatrist resource on our mobile crisis team), nine Psychiatric NPs, an LCSW and 3 CHWs. A Credentialed

Alcoholism and Substance Abuse Counselor (CASAC) from a Collaborator will be a floating member of the CTI team, providing services and linkage to patients whose primary concerns are substance-use related. A CASAC will work with the triage team, BH clinics and inpatient units.

The existing Comprehensive Psychiatric Emergency Program (CPEP) at the NYP/CU adult ED will be an important resource to these teams, particularly the Psychiatric NP leading the ED triage team. A psychiatrist from CPEP will be available for consultation on these patients at all times.

PPS members in this field and geography have established relationships. NYP has been working with Collaborators like The Bridge, Project Renewal and ACMH, three not-for-profit organizations that offer mental health and housing solutions for New Yorkers. ASCNYC (Casa Washington Heights) has demonstrated success with treatment adherence which may be further explored for this population. Service Program for Older People (SPOP) can provide specialty services for older beneficiaries in the NYP PPS. CASES provides specialized mental health, substance abuse and support services targeted to the population at risk for, or with recent experience with, the criminal justice system.

We have engaged Dr. Dan Herman and his team to provide training in CTI for the PPS. We also hope to expand crisis beds available to our patients through our PPS. Our PPS is looking forward to participate in this needed intervention, as there is no similar service in Northern Manhattan. Providers are poised to accommodate a potential increase in patient volume with the support of our CTI team. We currently have a robust EHR (AllScripts and Care Director), which, with some modifications, will meet project requirements.

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

We anticipate increased demand for NYP's clinics. The NYP PPS is committed to expanding primary and specialty care capacity (staffing, hours and space).

We need electronic alerts to identify and track patient cohorts, and extend IT access to Collaborators. To address these challenges, NYP IT will establish alerts to notify key providers (within the EHR and via secure messaging/email) when a patient is determined eligible. Once patients are RHIO-consented, the PPS will use existing Healthix technology to facilitate real-time notification of patient utilization. We will expand access to ACD to key Collaborators to support care coordination (Project 2.a.i)

We need regulatory relief to be sustainable. We believe the State can enact these changes not by waiving existing regulatory requirements, but through the issuance of policy clarifications and sub-regulatory guidance. We will raise these issues with the State during the implementation plan phase, including: offsite billing for home visits, reimbursement for care management of

non-health home clients, exemption for CPEP Brief Assessments resulting in diversion to the LCSW in Urgent Care from counting as ED visits, increased number of interim visits by the Mobile Crisis team beyond the current allocation of five, flexible use of residential beds for crisis-bed utilization.

NYP has a robust cultural competency training program and will also address language barriers by hiring a Spanish/English translator (shared w/ Proj 3.a.i).

NYP is in active negotiations with MMCOs to modify contracts to provide coverage for these services.

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.

Since no overlapping PPSs in the NYP PPS service area are undertaking Project 3.a.ii, no coordination activities were planned for this project. However, implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among overlapping PPSs.

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

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

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

3. <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.

We plan to co-locate the CTI and Mobile Crisis Teams (Project 3.a.i) to within closer proximity (601 W. 168th Street, across from the NYP/CU adult ED). This will facilitate all aspects of these proposals including but not limited to ease of referrals and use of resources such as a van for transportation. In addition, ASCNYC is developing a peer training center to conduct peer certification training programs to deliver services that will lead to long-term stability, increased access to medical care, enhanced social connections and improved health outcomes. Construction, renovation, infrastructure development and a mobile medical van will cost $850,000. This will be a resource to which the NYP PPS CTI team can connect patients during their intervention.

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
The Bridge	MRT Supportive Housing Initiative			25 new housing units

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.

This project speaks to community capacity to absorb patients after they have interacted with our crisis teams. We hope to link people with more stable support systems, and housing is a fundamental component of such stability. We anticipate that the additional housing units created by the MRT for The Bridge has the potential to diminish unmet need and enhance the services available to our providers looking to solve problems for patients in need of housing.

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.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission to Reduce Avoidable Hospitalizations—Development of Center of Excellence for Management of HIV/AIDS

Project Objective: To work towards reducing transmission of AIDS and ending the AIDS epidemic in New York State by the end of 2024.

Project Description: There are effective strategies to manage viral loads of HIV, slow progression of the disease and reduce transmission. These strategies need to be available to all persons currently infected with HIV and all persons at risk for HIV infection. HCV infection can also be addressed in this scenario.

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. A performing provider system that has identified HIV/AIDS as a significant issue within their community may choose to implement one of the two models below.

Model 1: Early Access to and Retention in HIV and HCV Care -Scatter Model

1. Develop a consulting/referral/educational relation with a Center of Excellence (COE) for management of HIV/AIDS that ensures early access to and retention in HIV and HCV Care – Scatter Model; ensure medical and behavioral health consultation expertise are available.
2. Identify primary care providers who have significant case loads of patients infected with HIV.
3. Implement training for primary care providers which will include consultation resources from the center of excellence.
4. Develop coordination of care services with behavioral health and social services within or linking with the primary care providers' offices.
5. Ensure systems are in place that address patient linkage to care, ensure follow-up and retention in care, and promote adherence to medication management, monitoring and other requirements of evidence based practice for management of HIV/AIDS.
6. Institute a system to monitor quality of care with educational services where gaps are identified.
7. Use EHRs or other technical platforms to track all patients engaged in this project.

Model 2: Center of Excellence Management for HIV/AIDS (including HCV)

1. Identify site location for a Center of Excellence (COE) which would provide access to the population infected with HIV (and/or HCV).
2. Co-locate at this site services generally needed for this population including primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment.
3. Co-locate care management services including Health Home care managers for those eligible for Health Homes.
4. Develop a referral process and connectivity for referrals for those persons who qualify for but are not yet in a Health Home.
5. Ensure understanding and compliance with evidence based guidelines for management of HIV/AIDS (and HCV).
6. Ensure coordination of care between all available services preferably through a single electronic

health/medical/care management record.

7. Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms 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.
8. Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.
9. Use EHRs or other IT platforms to track all patients engaged in this project.
10. Seek designation as a Center of Excellence from the New York State Department of Health.

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.

Statewide, about 20% of People Living with HIV/AIDS (PLWH) are readmitted to the hospital within 30 days. African Americans and Medicaid patients are most likely to be readmitted. Not surprisingly, then, NYC makes up 79% of the State's PLWH readmissions, and within NYC, residents from the Bronx constitute 38% and of Manhattan, 26%. Cancer, mental illness and blood diseases are the most frequent clinical reasons for readmission. Of all mental health readmissions of PLWH, 48% occur in the Bronx.(12)

Risk of HIV transmission, disease progression and death from AIDS in our service area are nearly double those of the NYC average. The 2011 rate of PLWH in the area serviced by the Comprehensive Health Program at NYP/CU (CHP)—Northern Manhattan, Southwest Bronx, Harlem—ranged from 1,200 to 4,125 per 100,000 compared to 810 per 100,000 in NYS, which has the highest state prevalence rate in the U.S.(13) In addition to HIV infection, residents of the CHP service area also suffer from disproportionately high rates of comorbid diseases including STIs, hepatitis C, diabetes, cardiovascular disease, mental illness and substance abuse. Washington Heights ranked in NYC's upper quintile for syphilis, gonorrhea and Chlamydia. In nearby Highbridge-Morrisania (Bronx), hepatitis B and C, Chlamydia, gonorrhea and tuberculosis ranked in the upper quintile.(14)

Of Center for Special Studies at NYP/WC (CSS) patients, 7% live in Chelsea and the Village, which has one of the highest prevalence rates in the country. This area's 2011 rate of PLWH ranged from over 4,000 to nearly 6,000 per 100,000, compared to 810 per 100,000 in NYS.(15)

Most concerning to our PPS, whose patients are overwhelmingly poor minorities, are the

geographic and racial disparities in the Bronx and Manhattan, which have over 2.5 times higher rates of HIV diagnosis per 100,000 (Bronx 43.1, Manhattan 48.5) than the State average (16.9). The largest racial disparity is in Manhattan, where the difference in rates between Black and White new HIV diagnoses is 76.2 per 100,000; in the Bronx it is 54.2.

To address these needs, the PPS is transforming our three HIV clinics into true Centers of Excellence via increased intensive care management/coordination, extending care beyond the clinics, behavioral health integration, transforming testing and adherence, implementing a Rapid HIV Consult Service in the ED and expanding hours for same-day appointments. In addition to CNA1 (Integrated Delivery System) and CNA2 (Culturally Competent Providers), this project addresses CNA3 (Accessible primary/specialty care) and CNA5 (Intensive care management).

{Refs available on last page of CNA.}

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 is People Living with HIV/AIDS in the PPS's three HIV clinics: one at the Comprehensive Health Program at NYP/CU (CHP) and two at Center for Special Studies at NYP/WC (CSS), Baker Clinic (Upper East Side) and Chelsea Clinic. Our PPS serves a highly vulnerable population of nearly 5,000 HIV/AIDS patients from all five boroughs. Of these, we expect to maintain 4,600 on anti-retroviral treatment, as some patients simply refuse medication although they seek other types of care at our clinics.

Patients from Northern Manhattan, Harlem and the Bronx are more likely to go to the NYP/CU clinic. Blacks and Hispanics comprise approximately 90% of that patient population, 95% of whom are insured through Medicaid or the NYS AIDS Drug Assistance Program (ADAP). Approximately 45% speak Spanish as their primary language.

Patients from the rest of Manhattan and the other boroughs utilize the NYP/WC clinics. About a third of those patients come from Manhattan. Another 60% of patients come from the Bronx, Brooklyn and Queens. About 85% of patients at both clinics speak English and 10% speak Spanish, and 85-90% of patients are insured through Medicaid or ADAP.

We also plan to target PLWH who are not currently in care. These individuals often find themselves at NYP EDs or inpatient units. For example, this year, CSS provided 70 consults to new patients who were intercepted in the ED, 10 of whom (14%) were new HIV diagnoses. We expect patients in care to increase about 10% over the four-year period, due in part to this effort as well as that of Project 4.c.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.

CHP's co-located services include primary care, infectious disease specialty care, psychiatry, nutrition, prenatal care, cancer/STD screening and smoking cessation. We have seamless connectivity to tertiary-level care, dentistry and buprenorphine maintenance providers. Seventy-five percent of our providers are bilingual in Spanish and English.

CSS's co-located services include primary care, psychiatry, Hepatitis C treatment, gynecology and prenatal care, cancer/STD screening, smoking cessation, dentistry, dermatology, partner counseling/testing, nutrition, social work and nursing case management, coordination with the pediatric program, education, adherence and polypharmacy management and PrEP for HIV-negative patients at risk. At each site there is one bilingual Spanish physician and two to three bilingual social workers and front desk staff.

We will transform these clinic operations into true Centers of Excellence via:

Intensive Care Management & Coordination: More RN care managers and two Practice Care Facilitators who will coordinate insurance, transportation, medications, reminders, etc.

Extending Care Beyond the Clinic: Trained CBO-based CHWs to meet patients in the community. For non-medical interventions such as needle exchanges, housing and legal assistance, we will coordinate care with CBOs (e.g., Washington Heights CORNER Project, Argus) (Project 4.c.i).

Behavioral Health Integration: Additional behavioral health staff at CHP and a buprenorphine maintenance program and on-site substance use services at Chelsea (OASAS license pending) as well as a CHW dedicated to the substance-using population.

Transforming Testing & Adherence: CHP will include HCV testing and Pre-Exposure Prophylaxis (PrEP) evaluation. CSS will strengthen HIV and adherence education and implement pre-pour. We will enhance existing treatment collaboration with ASCNYC's Casa Washington Heights and explore relationships with pharmacies (e.g., AIDS Healthcare Foundation, Quick RX, IslandCare).

Rapid HIV Consult Service: Because urban EDs are so busy and PLWH are so complex (medically and psychosocially), ED staff often admit them unnecessarily. CHP will develop a Rapid HIV Consult Service that ED personnel can activate upon triage. HIV specialists (NP and MD) will assess whether inpatient care or ambulatory COE care is warranted. At CSS, we will formalize ED protocols for quicker consultations with HIV staff for new patients. These initiatives will be integrated into ED patient navigation efforts (Project 2.b.iii).

Increased Access: To decrease unnecessary utilization of hospital services, we will expand walk-in capabilities and same-day appointments by both hiring and re-tasking existing staff at both sites.

NYP's HIV clinics are NYSDOH Designated AIDS Centers (DACs) and Patient Centered Medical Homes and have been working with PLWH since 1988. The two medical directors have a combined 50 years' experience working as HIV care providers and leaders in the field. Dr. Peter Gordon chairs the NYSDOH AIDS Institute Quality of Care Advisory Committee; Dr. Samuel Merrick is the Vice Chair of the Medical Criteria Committee and will become its Chair in March 2015.

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.

Challenges specific to this project include those common to the implementation of new projects in general, namely identifying and recruiting exceptional candidates for projected new HIV COE positions, changing practice patterns as part of the larger practice transformation effort (e.g., taking walk-in and same-day appointments) and measuring the impact of the new interventions. Fortunately, NYP's reputation and outstanding HR Department routinely identifies superb candidates, and CHP and CSS are also well known in the HIV provider community. As a result, awareness of the initiative and its job opportunities is likely to be robust and generate significant interest from qualified applicants.

Changing existing practice patterns is frequently difficult as it often entails a change in culture. NYP has, however, excelled in this regard in recent years as it successfully implemented the PCMH model in its ambulatory care practice sites, is currently implementing its Health Home model across all campuses and amongst its network, and is currently working with Columbia University Medical Center and Weill Cornell Medical College to implement a tri-institution Medicare ACO.

Finally, as detailed in Project 2.a.i, NYP has committed to focusing its IT Department to developing practical and innovative IT tools to ensure improved clinical and care coordination communication between PPS members and process and outcome measures for individual projects, including 3.e.i. These include ensuring that EHR systems meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.

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.

Since no overlapping PPSs in the NYP PPS service area are undertaking project 3.e.i, no specific coordination activities were planned for this project. However, our HIV Project Advisory Committee (Project 4.c.i) will work to coordinate efforts with existing and ongoing initiatives in

our service area, including the NYSDOH AIDS Institute NYLinks project and the End of AIDS campaign. Additionally, each of the overlapping PPSs (Mt. Sinai and NYC's HHC) has a steering committee, and we will plan to meet with them to attempt to coordinate efforts and avoid duplicative efforts in the same neighborhoods.

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

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

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

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

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

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

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

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

Yes	No
☐	☒

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

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in

during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Comprehensive Health Program at NYP/CU	Medical Case Management	3/1/14	2/28/15	NYC DOHMH: Complex Medical Case Management for PLWH
Comprehensive Health Program at NYP/CU	Specialized Care Center	7/1/14	6/30/15	NYS DOH: HIV care and care coordination for adolescents and young adults.
Comprehensive Health Program at NYP/CU	Youth Access Program	7/1/14	6/30/15	NYS DOH: HIV risk reduction and testing for high risk adolescents and young adults.
Comprehensive Health Program at NYP/CU	Women, Infant, Children and Youth Program	8/1/14	6/30/15	HRSA Part D: Supports non-reimbursable services for women, infants, and youth living with HIV
Comprehensive Health Program at NYP/CU	Partners for AIDS Treatment and Health	1/1/14	12/31/14	NYC DOHMH: Supports rapid HIV Testing and linkage to care.
Comprehensive Health Program at NYP/CU	HIV Testing Routinize	8/1/14	7/1/15	HRSA SPNS: Supports use of innovative IT and care paradigm changes to increase practice efficiency.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Comprehensive Health Program at NYP/CU	HOTT	3/1/14	12/31/14	NYC DOHMH: Development of an HIV Online Teaching Tool (HOTT) – HIV Prevention
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Medicaid Health Home Care Management			ASCNYC proposes to EXPAND HH care management services to include treatment adherence services, including medication adherence incentives, peer-delivered support, and treatment education by licensed professionals.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	HARP/1915i Health & Community Based Services (HCBS)			Create a Certification Training program for Peers and Community Health Workers, as well as provider trainings on managing peers in medical settings. Expand Peer Health Coaches as integrated members of care teams.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Syringe Exchange/Harm Reduction Services	7/1/15		ASCNYC harm reduction and pending syringe exchange services include peer delivered education and syringe exchange, opiate overdose prevention, HIV testing, HepC screening and vaccines, mobile outreach, linkage to care and care coordination/ navigation services result in decreased hospitalizations and ER usage, increased medication adherence, and enhanced health outcomes.
Harlem United	Expanded Medical Capacity – HRSA	7/1/14	6/30/15	Allows us to reach populations who engage in risky behaviors and do not access care in traditional healthcare settings (e.g., LGBT community), do not usually access care, and are heavy utilizers of the ER.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
VillageCare	CMS Health Care Innovations Award Round Two, Treatment Adherence through the Advanced Use of Technol			Built system to support patient engagement and adherence.

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.

As detailed in the 2012 New York State Department of Health AIDS Institute Ryan White Care Act Statewide Coordinated Statement of Need, the Northern Manhattan/South Bronx service area experiences shortages in clinical and care coordination services for people with an at risk of HIV.(16) Gaps in services include delayed HIV diagnosis and entry to care, homelessness and housing instability, and insufficient drug treatment services. These demographic realities, combined with a paucity of services to address them, delay or prevent the effective identification, engagement and retention of our target population.

Essential for system-level change are a full complement of services, care coordination and IT connectivity. CHP has funding for small, disparate pieces of this very large and complex puzzle. For example, in 2009, NYC DOHMH launched the Medical Case Management program (MCM), a citywide HIV care coordination program. NYP-CHP has been an MCM demonstration site since the program's onset and, as a result, has developed invaluable experience in the scale-up and capacity building enabled by the care coordination approach. The MCM-CHP collaboration is based on a comprehensive care engagement model utilizing community navigators, care coordinators, directly observed therapy services, and structured educational modules to ensure continuous care engagement. Yet the MCM program is limited to only 5% of CHP patients.

Likewise, the HOTT (HIV/STI Online Teaching Tool) Program utilizes an interactive on-line, and mobile technology adaptable, series of tailored vignettes and other resources to guide adolescents, young adults and women at risk for HIV and STIs through scenarios where social and sexual decisions are made, resultant activities unfold, the risk of acquiring HIV or a STI is proportional to choices made, and outcomes occur. Again, this intervention is only for a sub-set of our population.

To make an impact across our entire population (and beyond, see Project 4.c.i), we must have funding that will support care coordination, IT connectivity and a full complement of services. The projects above target a sub-set of the population, and DSRIP can offer a bigger and broader platform to effect change.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patients and families confront advanced illnesses with minimal support or coordinated care, resulting in unnecessary hospital use. The Dartmouth Atlas of Health Care found that almost a third of Americans see 10 or more physicians in the last six months of their life. The prevalence of diseases most in need of palliative care services is high in our service areas. The NYP/CU service area sees a 6% prevalence of CHF, 4% of COPD and 2% of Dementia. Those figures for NYP/WC are 6%, 5% and 2%, respectively. Also, heart diseases are the number one cause of mortality in NYC (age-adjusted rate of 188.2 deaths per 100,000 population). Cancer is #2 (age-adjusted rate of 155.1 deaths per 100,000). Three other diseases also make the list: chronic lower respiratory diseases, which includes COPD (#5), cerebrovascular disease, which can lead to stroke (#7) and essential hypertension and renal diseases, including kidney failure (#8).

In addition, patients in our service area are ethnic and racial minorities (Black and Hispanic) who often face significant psychosocial and socioeconomic stressors such as high unemployment, low income and linguistic isolation. Significant racial disparities exist both in disease prevalence and access to palliative care. For example, Black Non-Hispanic individuals die from hypertension and renal disease at a rate of 19 per 100,000 compared to 8 per 100,000 in the Hispanic population and 13 per 100,000 in the White Non-Hispanic population.

Likewise, minority patients do not have equal access to pain care, according to a July 2014 blog post from Health Affairs. This disparity is often attributed to system-related factors such as reduced access to specialty care and lack of adequate health insurance. As a result, racial/ethnic minority patients are less likely to report finding pain specialists available to them compared to non-Hispanic white patients. Even when socioeconomic status is the same, this disparity persists for structural reasons such as the fact that pharmacies located in minority neighborhoods are less likely to carry analgesic medications.

Cultural competency and education also play a role in the disparity. When providers and patients differ in culture, religion and ethnicity, Health Affairs noted that providers are less likely to explain palliative care. In addition, though physicians are often the primary source of education and referrals for patients, they often lack knowledge of the range of services provided by palliative care, causing delayed referrals.

According to the CNA, palliative care are lacking. NYP and three Collaborators are the only providers of hospice and palliative care in our service area. To address these needs, we will develop a clinical model that embeds palliative care and care coordination at two NCQA Level 3 PCMHs at NYP/CU and NYP/WC and develop a robust educational program that will bring generalist level competencies in palliative care to PCPs across the PPS. In addition to CNA1 (Integrated Delivery System) and CNA2 (Culturally Competent Providers), this project addresses CNA3 (Accessible palliative care).

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

Our program targets adults with Medicaid in the NYP/CU and NYP/WC service areas with a primary or secondary diagnosis of one of six conditions: Congestive Heart Failure (CHF), Kidney Failure, Dementia, Chronic Obstructive Pulmonary Disease (COPD), Stroke, Malignancy and Sickle Cell Anemia. These categories are the same as those found in the Salient Query Definition, with the addition of Sickle Cell. As discussed in the CNA, these patients often have multiple comorbid diseases. Such patients will be flagged for primary care physicians (via the EHR) when they present at their next visit. A sub-cohort of patients will consist of those with three or more inpatient admissions for patients below age 80 and one or more inpatient admissions for patients 80 and above. These patients will be flagged as high-risk in our EHR. The PCP will then assess palliative care needs using a new, specially designed tool based on key domains such as uncontrolled pain and need for assistance with complex decisions. Our goal is to provide these patients with palliative care services over the course of their advanced illness and not merely when they are in the terminal phase.

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 palliative care intervention will consist of a newly hired, embedded Palliative Care Service (PCS) team—comprised of a physician, NP, social worker and RN Care Manager—who will provide a palliative plan of care. The Care Manager will follow up via telephone using a new, specially designed tool for assessing factors such as pain and symptom assessment, medication issues, coping with illness or logistical issues (sooner appointments, etc.). If an identified patient presents to the ED and/or is admitted to an inpatient unit, an alert will be sent to the Care Manager. (See Projects 2.b.iii and 2.b.iv.)

We will also engage and train Community Health Workers (CHWs), who will provide home visits, patient education and linguistic support. NYP has existing relationships with CBOs who provide these CHWs, and many of them are part of our PPS. CHWs will record their outreach in Allscripts Care Director, where all providers will document care. We will develop liaisons with our PPS Collaborators to facilitate referrals to home hospice, hospice or home-based palliative care, and establish protocols regarding referral timelines, onsite availability and communication. We will establish a regularly scheduled interdisciplinary review meeting for all providers.

We will build our education program on the existing “Champion” programs at both campuses, which provide a comprehensive on-the-job training model designed to teach core competencies that enable provision of ex¬pert palliative care. Training providers—PCPs, nurses, care managers, ED clinicians, social workers, CHWs, patient navigators—will facilitate appropriate identification of patients and timely referral to Palliative Care Services. A multi-disciplinary team of trained, NYP palliative care clinicians will conduct bi-monthly seminars across all locations. Education will include: pain and symptom management, goals of care discussions, how to have difficult conversations, family support and intervention, cultural competency, when to refer and services available.

At NYP, we have well developed inpatient Palliative Care Services (infrastructure and medical

expertise); expansion to the outpatient setting is the next logical step.

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.

IT challenges include: 1) creating registries to identify potentially eligible patients for palliative care, 2) creating an effective referral mechanism (and tracking) for physicians to refer to the Palliative Care team, 3) exchanging clinical information with community-based partners. To address these challenges, the PPS will use Amalga to create dynamic registries which identify target patients as defined above. Using ACD and the EHR, the PPS will also create a referral mechanism for PCPs to refer to a palliative care team if appropriate. Finally, the PPS will spread RHIO connectivity and/or ACD to its Collaborators so the full range of palliative care interventions can be managed.

Space is an issue at NYP's PCMHs. As this intervention will be based, by design, in these PCMHs, the program will benefit from NYP's commitment to expanding space and referral capacity in the ACN.

Addressing managed care contract language is a significant implementation issue. NYP has is in active negotiations with MMCOs to modify contracts to provide coverage for these services.

NYP has a robust cultural competency program, which we will expand to our clinics and Collaborators. Equally important will be training on how to deal sensitively with patients facing advanced illnesses and their families.

Palliative care providers can be difficult to recruit. The program will depend on collaborating across PCMH sites and sharing resources as much as possible as well as a successful execution of our recruitment strategy (Section 5).

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

The only overlapping PPS working on this project is New York City's Health and Hospital Corporation (HHC). During the Design Grant phase we met with HHC about potential project overlap and collaborations. In both instances it was agreed that starting in January 2015 we would meet to explore operational and infrastructure opportunities such as the development of common clinical protocols for those projects where we have overlap, shared training resources, a common approach to leveraging the RHIO and a general "best practices" sharing. Implementation of access to the RHIO and SHIN-NY across the PPS will allow us to see patient utilization throughout Manhattan, Brooklyn and the Bronx, and foster communication among

overlapping PPSs. Finally, we plan to use the MRT Innovation eXchange (MIX) to collaborate with other PPSs and build solutions to the complex challenges we will face as we implement our DSRIP projects.

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

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

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

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☐	☒

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

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

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

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

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

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

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

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

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics.

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

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

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

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

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

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

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements. The implementation must address a specific need identified in the community assessment and address the full service area population.

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

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

Entity Name
New York City Department of Health and Mental Hygiene; Roswell Park Cancer Institute; New York City Treats Tobacco (NYCTT) at New York University (NYU) Langone Medical Center; Lutheran Medical Center; North Shore Health System; Advocate Community Partners

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

1. Project Justification, Assets, Challenges, and Needed Resources (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.

Tobacco is the number one cause of preventable disease and death in the U.S. Annually, smoking accounts for 438,000 premature deaths among smokers and an additional 38,000 deaths in non-smokers from the effects of second-hand smoking. Smoking contributes to cancer, heart disease and respiratory disease development, all of which are among the top ten causes of mortality in our PPS.

Smoking rates in NYC increased in 2013 despite strong efforts to limit tobacco use. Smoking prevalence increased from 15% to 16.1% in 2013 (ACS 2014). According to the CDC, NYC has a lower rate of smoking than the U.S. (18.1%) and NYS (16.2%). However, smoking prevalence in the low SES population served by our PPS is higher than in the overall population. According to the NYC Department of Health's 2012 Community Health Survey, three of the areas served by NYP's PPS had higher rates of current smokers than the city as a whole and one was on par. Lower Manhattan, East Harlem and Southwest Bronx smoking rates were estimated at 17.6- 23.0%, and Western Queens was estimated at 14.2-17.1%. In a survey conducted by the Harlem Prevention Research Center, 43% of respondents in Central Harlem self-identified as smokers. The prevalence of smoking amongst Chinese-American males attending the Charles B. Wang Community Center in Lower Manhattan is approximately 30%, or almost 200% above the NYC prevalence rate.

Most of the area served by the PPS is of low SES by definition. Smoking prevalence is higher in disadvantaged groups, and disadvantaged smokers face higher exposure to tobacco's ill effects. In Northern Manhattan and the Southwest Bronx, over half of the 870,000 inhabitants have Medicaid,

the unemployment rate is 15%, and the median annual household income is $20- 35,000. In East Harlem 56% have Medicaid, 13% are unemployed, and the median annual household income is $20-35,000. In Lower Manhattan, almost a third of residents have Medicaid, 7.5% are unemployed, and the median annual household income is $50-75,000.

The prevalence of behavioral health conditions in these neighborhoods is also high. Smoking rates of those with behavioral health disorders, which includes psychiatric disorders and substance abuse disorders, are higher than that of overall NYC population. The prevalence of depression is 17% for the NYP/CU service area, 19% for the NYP/WC and NYP/LM service areas combined and 13% for the rest of the PPS Collaborators. The prevalence of schizophrenia is very high, considering the national prevalence rate for schizophrenia is 1% according to the National Institute of Mental Health: 3% for NYP/CU, 6% for NYP/WC and NYP/LM and 5% for Collaborators. Likewise, bipolar disorder prevalence in the general population is 2.6% (NIMH) but it is 2.6% for NYP/CU, 4.4% for NYP/WC and NYP/LM and 7.3% for Collaborators.

To address these issues, the PPS will use the framework established by the U.S. Public Health Service (USPHS) for evidence-based tobacco cessation. The NYP Tobacco Use Cessation Program (NYP-Quits) is a comprehensive approach that will facilitate clinician adoption of tobacco cessation via modifications to the EHR. PPS providers will receive education on tobacco cessation counseling complemented by tobacco cessation clinics that will provide individual counseling by certified tobacco cessation experts. The clinics will assist “hard core” smokers and will be of particular benefit to smokers with behavioral health disorders. In addition, populations who are vulnerable to smoking such as the elderly will be targeted through partnerships with community programs to identify tobacco users and provide referrals to NYP-Quits. Our comprehensive program will result in an increase in cessation counseling available to the populations we are targeting in our PPS and a concomitant increase in successful quit attempts by our patients.

In addition to CNA1 (IDS) and CNA2 (Culturally Competent Providers), this project addresses CNA3 (Accessible Care).

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.*

Because tobacco use is more prevalent in the populations served by our PPS we plan to set in motion a the NYP Quits tobacco cessation program in each of the 47 zip codes served by the our PPS (Upper Manhattan and Southwest Bronx – NYP/CU; East Harlem, Upper East Side and Western Queens – NYP/WC; Lower Manhattan – NYP/LM). Our program will flag Medicaid and dual eligible patients in these zip codes and will pay particular attention to those of low SES and those with comorbid mental health issues such as depression.

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 strategy to promote tobacco use cessation, particularly among low socio-economic status individuals and those with mental health issues, is five-pronged: 1) Use information technology to increase use of the 5 As; with particular emphasis on setting a quit date and providing pharmacotherapeutics with referral to the New York State Quitline; 2) Establish three Tobacco Cessation Clinics for intensive counseling; 3) Educate and train providers across the PPS, including the basics of the 5 A's, cultural competency, adoption of tobacco-free outdoor policies and technical assistance on implementing the necessary IT solutions; 4) Utilize Community Health Workers (CHWs) to follow up with patients who have set a quit date; 5) Identify vulnerable seniors who are smoking by: Utilizing screenings provided by Meals-on-Wheels with referrals to Tobacco Cessation Centers and training home health aides to provide screenings; 6) Participate in a Benefit Strategy Working Group sponsored by the New York City Department of Health and Mental Hygiene (DOHMH).

NYP Quits has substantive resources to implement the comprehensive program outlined for this project. In particular, the Project Leader, Dr. David A. Albert, has been a principal investigator or a co-investigator on tobacco cessation grants and projects for over 17 years. He has implemented institutional tobacco cessation programs, developed innovative programs to train clinicians, set up tobacco cessation clinics and worked in community settings to facilitate tobacco cessation integration into community health-centers and private practices. He has experience utilizing health educators to train clinicians to adopt culturally appropriate tobacco cessation guidelines. He also serves as the director of the primary care Ambulatory Care Network geriatric practice at NYP/CU.

We will mobilize our existing relationship with City Meals-on-Wheels to develop a community-based tobacco assessment for older adults. Currently, 19,500 individuals in NYC receive home-delivered meals, an intervention designed to prevent or delay institutionalization. Meals-on-Wheels will train all city caseworkers to assess tobacco use among home-delivered meal recipients. Tobacco users will be linked to tobacco cessation services (NYP Quits tobacco cessation clinics and the NYS Smoker's Quitline) and physicians of record if needed. Targeted interventions will be developed for individuals with diabetes, heart disease, cancer and cerebrovascular disease, which will be delivered through caseworkers, nutritionists and other providers.

The NYP IT support is robust and comprehensive. NYP IT has experience with complex EHR implementation, including the integration of all meaningful use objectives and the development and implementation of computerized decision support systems.

The NYP Quits program will integrate CHWs into the tobacco cessation team. Patients who are counseled by their clinicians and agree to set a quit date will receive follow up from the CHW. The CHW will facilitate the Assisting and Arranging components of the 5 A's that were initiated by the clinicians, including facilitating the referral to the NYS Smokers' Quitline and the patients acquisition of pharmacotherapeutics from their local pharmacy. In addition, the CHW will provide culturally appropriate smoking cessation materials including those developed by NYP Quits, NYCTT, NYCDOHMH, NYS DOH and NCI.

In addition, we have at our disposal the vast resources of the NYC DOHMH, including its campaigns and experience in implementing large-scale programs. The New York City Treats Tobacco (NYCTT) at New York University Langone Medical Center further complements those resources. Dr. Albert has worked with these two resources for over ten years. He has also

worked with those programs to assist them with the development of their materials.

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.

Adoption of USPHS 5 A's in routine clinical practice has been challenging in the U.S. Asking and Advising are common to most medical encounters; however higher-level interventions, such as Assessing readiness to quit, Assisting with a pharmacotherapeutic agent and Arranging for referral to a Quitline/smoking cessation program, are poorly integrated into medical practice. In order to assure adoption of the 5 A's, NYP-Quits will foster systematic change commencing with EHR modification, with a concomitant computerized decision support (CDS) to facilitate clinician adoption. The CDS will build upon the existing Meaningful Use templates in place for Tobacco Use/Smoking History, walking providers through the 5 A's and providing a scale for clinicians to assess patient interest in quitting. Building upon existing infrastructure and making the intervention straightforward will increase adoption.

One of the biggest challenges will be crafting provider training and patient education materials appropriate for the Asian-American population in Lower Manhattan. DOHMH and NYU NYCTT will provide key technical assistance and translated materials for the Chinese-American population. Cultural competency will be an extremely important aspect of provider education, and we will customize the training based on the providers' service area. Each service areas is distinct in its ethnic character: the NYP/CU service area is 31% African American and 61% Hispanic; the NYP/WC service area is 25% Hispanic and 11% Asian; the NYP/LM service area is 16% Hispanic and 25% Asian. The cultural competency curriculum for providers will draw upon NYP's extensive experience and include 1) Breaking language barriers (effective use of interpreters); 2) Effective cross-cultural communication (understanding illness in a patient's cultural and social context and helping to develop health literacy in patients and families); and 3) Understanding healthcare disparities (social determinants of health and structural barriers to care).

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.

We will work closely with DOHMH on technical training, cultural competency and benefit strategy. Other PPSs participating in DOHMH's programs are Advocate Community Partners, Brooklyn-based Lutheran Medical Center and the North Shore Healthcare System. DOHMH will assist in technical training on IT systems for community-based providers as well as providing key technical assistance and translated materials for the Chinese-American population. DOHMH also will convene PPSs to discuss ways to enhance health insurance benefits for prescription and over-the-counter cessation medications and increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications. With DOHMH, we will agree on key recommendations and facilitate action.

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

The following milestones will be completed by DY1-Q2:
Hire Staff & Establish Tobacco Cessation Clinics at NYP/CU, NYP/WC & CBW & Provide Training and Certification for Tobacco Cessation Specialists;
Develop & Implement CDS for Electronic Health Records at NYP and CBW that Includes 5 A's;
Integrate Electronic Referral to NYS Tobacco Quitline into HER

The following milestones will be completed by DY1-Q4:
Train PPS Providers in Tobacco Cessation Counseling;
Outreach to Community Seniors for Tobacco Cessation Screening and Services/ Establish Meals on Wheels Screening and Referral Program/ Establish Screening and Referral Program with Home Health Care agencies;
Begin Participating in DOHMH Benefit Strategy Working Group;
Program Data Collection & Assessment

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.

For strongly addicted smokers and tobacco users, or those with behavioral health conditions, physician visits and medical interventions that feature the 5 A's accompanied by brief in-office counseling are not sufficient to enable a successful quit attempt. Counseling is critical to helping people quit for good. The PPS will hire and train psychologists and/or social workers and nurse practitioners to staff new smoking cessation clinics at three locations: NYP/CU, NYP/WC and NYP/LM. The NYP-LM clinic will be developed in conjunction with the Charles B. Wang Community Health Center on Canal Street in Lower Manhattan. Smoking cessation will be provided by trained staff and include both counseling and access to medications including nicotine replacement therapies (NRTs), varenicline and bupropion. The cessation specialists will receive tobacco cessation training at the Rutgers University Tobacco Dependence program.

We will need capital funding to develop these three tobacco cessation clinics. The capital funding for the project is minimal and requires only the purchase of desks and computers to support the clinicians who will be working in existing facilities. The project will also benefit from the NYP PPS's commitment to increasing capacity (including space) at all of its Ambulatory Care Network clinics (see Project 2.a.i for a more in-depth discussion of these plans).

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	Project End	Description of Initiatives
NYP/CU	NIH - Evaluation of a Decision Support System to Promote Tobacco Counseling	7/1/15	6/30/20	This proposed project will evaluate a tobacco cessation iPad interface between patients and clinicians to increase tobacco cessation activities in the office setting including the provision of pharmacotherapeutics and referral to the State Smokers' Quitline

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

The NIH program—if we receive funding—is strictly research-based. The DSRIP project is operations-based and will develop tobacco cessation clinics and modify clinician practice via on-the-ground education and modifications to the EHR.

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.i Decrease HIV morbidity (Focus Area 1; Goal #1)

Project Objective: This project is targeted at decreasing HIV morbidity.

Project Description: HIV/AIDS, sexually transmitted diseases (STDs) and hepatitis C (HCV) are significant public health concerns. New York State (NYS) remains at the epicenter of the HIV epidemic in the country, ranking first in the number of persons living with HIV/AIDS. By the end of 2010, approximately 129,000 New Yorkers were living with HIV or AIDS, with nearly 3,950 new diagnoses of HIV infection in Furthermore, 123,122 New Yorkers had STDs, representing 70% of all communicable diseases reported statewide in 2010.[2] The number or people with chronic or resolved cases of HCV in NYS exceeded 175,000 between 2001 and 2009. However, many of those with chronic HCV do not know they are infected, and recently it has been noted that more New Yorkers are dying from HCV than from HIV.

This project is targeted at reducing the newly diagnosed HIV case rate in New York by 25% to no more than 14.7 new diagnoses per 100,000 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
NYC Department of Health and Mental Hygiene; Amidacare; Highbridge Woodycrest; Midtown Center; CVS Careplus 8th Ave/16th St; JBFCS; Karen Horney Clinic; Postgraduate; GHMC; LGBT Center; ACQC; Bridging Access to Care, formerly Brooklyn AIDS Task Force; Housing Works; A Better Place; James Weldon Johnson Counseling Center of Union Settlement; H&C Chemists; Heritage House; HIV Law Project

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

1. Project Justification, Assets, Challenges, and Needed Resources

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.

NYC continues to be the epicenter of the HIV/AIDS epidemic in the U.S. As of June 30, 2013, there were an estimated 130,000 People Living with HIV/AIDS (PLWH) in NYC, more than 10% of national cases.(17) NYC has a higher rate of new HIV diagnoses (33.5) per 100,000 than does NYS (16.9) or the U.S. (15.8.). The true number of PLWH in NYC may be as high as 145,000, as one in five may be unaware of their serostatus. Undiagnosed HIV plays a large role in keeping the new infection rate unacceptably high. Black and Hispanic communities (20% and 41% of the PPS, respectively) are disproportionately affected by HIV. In 2010, 45% of NYC PLWH were Black and 33% Hispanic; 48% of new HIV diagnoses were among Blacks and 31% among Hispanics.

The HIV/AIDS Treatment Cascade depicts successive levels of care engagement and treatment, with each level revealing a startling falloff, resulting in low levels of viral suppression, the ultimate measure of treatment efficacy. A 2011 CDC report estimated that nationally only 67% of HIV-infected individuals were retained in care.(19) In NYS, only 48% received continuous care in 2012.(20) Benefits of medical advances of the last 30 years are only fully realized when individuals are engaged in care. Low engagement in care is associated with poor outcomes, including increased morbidity and mortality.

A 2012 study found that 35% of patients were lost to follow-up due to: structural barriers (housing, location of clinic, food & transportation); financial barriers (cost of care

and insurance), personal & cultural barriers (racism, language, sexism and homophobia); comorbidities such as mental illness & substance abuse; and healthcare provider attitudes.(22-27)

To decrease HIV morbidity, we must increase HIV testing, linkage to care and engagement/retention for PLWH. The NYP PPS will form an HIV Project Advisory Committee with Collaborators that touch PLWH in NYC. The Project will re-engage patients who have been lost to follow-up, test individuals who do not know their serostatus and provide prevention services for uninfected, high-risk populations. PLWH—whether or not they are in care or know their serostatus—access services such as needle exchanges, food pantries and substance abuse treatment centers. Through the Advisory Committee, leaders from such organizations will convene physically and electronically (via Allscripts Care Director & the Healthix RHIO) to track patients. We will share the Program Manager from Project 3.e.i and hire a Supervisor to oversee the 10-12 CHWs sourced from our Collaborators. When PLWH known to NYP, but lost to follow-up, present at one of these organizations, the Supervisor will be notified electronically and a CHW activated to meet patients onsite and effect care engagement.

Individuals testing positive at our Collaborator organizations—who have deep experience with testing protocols—will also be referred to CHWs for care navigation. However, we will also send CHWs into the community—to clubs, commercial sex work locations, etc.—and to Collaborators and associates of PLWH. The PPS can provide local testing, referring and navigating seropositive patients to appropriate care and providing preventive services like PrEP to uninfected individuals. Education will include health information and stress patients' right to be offered HIV testing in hospital and primary care settings. In addition to CNA1 (IDS) and CNA2 (Culturally Competent Providers), this project addresses CNA5 (Intensive care management for multiple comorbid conditions). {Refs avail on last page of CNA.}

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 patient population for this project truly includes PLWH in all five boroughs. Unlike our Center of Excellence project (3.e.i), this project is focused on PLWH who have fallen out of care and individuals who have either never been in care or do not know they are infected. NYP will work with Collaborators to target high-risk individuals, with a focus on socioeconomically disadvantaged, Black and Hispanic individuals in their local environment.

Statistics on PLWH who have fallen out of care have been fairly steady. In 2013, 431 patients at the Comprehensive Health Program at NYP/CU (CHP) were lost to follow up, despite ongoing outreach and case management efforts. This accounts for approximately 15% of that clinic's patient population and is a priority domain for systemic improvement. A survey conducted amongst participants in one of our first care management programs identified high levels of structural barriers to retention in care. Participants reported: homeless (30%); psychiatric comorbidities (~50%); crack cocaine use (45%) and alcohol abuse (50%). The two clinics at the Center for Special Studies at NYP/WC (CSS) also lose about 10% of patients to follow up every year so that despite a robust number of new patient visits each year our overall population in care remains stable. Current outreach efforts are limited by an inability to determine whether these patients are in care elsewhere, incarcerated, have moved out of state or have

died. Through this project, the PPS hopes to decrease the percentage of people who have fallen out of care and, indeed, increase the number of people we see who have never been in care.

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 project will mobilize the considerable resources of the organizations working together on the HIV Project Advisory Committee to meet the chosen project requirements. Below is a description of the significant breadth and depth of experience of some key players in the NYP PPS, who have been working in the field of HIV/AIDS since the earliest days of NYC's epidemic.

NYP's HIV clinics are NYSDOH Designated AIDS Centers (DACs) and Patient Centered Medical Homes (PCMHs) and have been working with PLWH since 1988. The two medical directors have a combined 50 years of experience working as HIV care providers, and leaders in the field. Dr. Peter Gordon chairs the NYSDOH AIDS Institute Quality of Care Advisory Committee; Dr. Samuel Merrick is the Vice Chair of the Medical Criteria Committee and will become its Chair in March 2015.

The AIDS Service Center of NYC (ASCNYC) began in 1990. Today, ASCNYC has more than 90 staff, 85 peer interns and a budget of nearly $8 million. More than 1,800 clients come to ASCNYC for services each year; another 18,000 people are reached through peer education and community outreach initiatives.

Harlem United is an FQHC and community health center founded in the early days of the NYC AIDS crisis. Harlem United provides a comprehensive suite of services for PLWH including primary care, dentistry, individual counseling, HIV & STI testing and substance abuse treatment. In 2014, Harlem United was appointed to Governor Cuomo's Task Force to End AIDS.

VillageCare has provided healthcare services to individuals residing within New York City for over 35 years and is an AIDS-specific Certified Home Health Agency. It provides a variety of HIV/AIDS services, including an adult day healthcare for Medicaid-eligible PLWH, a treatment adherence program, a nutrition and meal program and community case management including home visits.

The Washington Heights CORNER Project was founded in 2005 as an activist-run, street-based educational outreach and syringe-access program aimed at reducing the spread of blood-borne diseases among IV drug users in the Washington Heights homeless community. In 2013, it provided 123 Hepatitis C tests, over 85% of which were conducting using rapid testing. It also works in partnership with Community Healthcare Network of New York City, another PPS member, to provide free HIV testing.

St. Mary's Center is the only HIV residential facility on the Upper West Side of Manhattan. Since 1992, St. Mary's Center Skilled Nursing Facility has provided quality medical care and social services to PLWH in New York City. In 1997 it opened an Adult Day Health Care, which today offers more than 60 types of support groups and services each week. In 2013, there were 12,489 adult day care visits.

The Realization Center in Union Square provides a wide range of Addiction Treatment Services including targeted programs for the LGBT community as well as those tailored to adolescents and young adults. We also are in the final stages of obtaining OASAS approval for addiction counseling and treatment, including buprenorphine, co-located at our Chelsea clinic in partnership with The Midtown Center for Treatment and Research. Addiction services such as these will play an

important role in treatment adherence for PLWH.
Finally, NYP will apply its considerable health information technology (HIT) expertise to promote adoption of its Personal Health Record (PHR), MyNYP.org, as a powerful intervention to promote patient self-efficacy and care engagement. Specific PHR capabilities, like WeillCornellConnect, will additionally allow providers and patients to communicate electronically via a secure messaging system and is accessible with a smartphone app.

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

The primary challenge—and goal—of this project will be to reach patients in the community. Our main strategy for addressing this issue is 1) to use IT to connect agencies around the city for faster and more effective communication and patient tracking, and 2) to send CHWs into the field to provide community-based support and education as well as local, CBO-based testing.

IT will present a challenge in and of itself, as not all organizations operate with the same platform. We will need to develop IT capacity in some organizations, implementing Allscripts Care Director and access to the RHIO; in others, we will need to develop interfaces between existing software platforms and NYP. Next we will develop alerts when known patients hit various organizations across the city. CHWs will also be able to enter new patients into the system using tablets provided by the PPS. The PPS has budgeted for these IT infrastructure development costs in Project 2.a.i.

Training CHWs will also be an issue we must address. NYP has a robust cultural competency program (see Section 7), which we will expand to CHWs and Collaborators. The training will include sensitivity around language and culture, but also education on HIV as a disease, gender identity, substance abuse issues and disability issues.

This program's success will generate another issue: having staff available for same-day new patient visits. See Project 3.e.i. for our plans to staff up to accomplish this goal as demand increases.

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.

Though no overlapping PPSs in the NYP PPS service area are undertaking Project 4.c.i, a few in NYC are tackling Project 4.c.ii. The HIV Project Advisory Committee will work to coordinate efforts with existing and ongoing initiatives in our service area, including the NYSDOH AIDS

Institute NYLinks project and the End of AIDS campaign. Additionally, each of the overlapping PPSs (Mt. Sinai and NYC's HHC) has a steering committee, and we will plan to meet with them to attempt to coordinate efforts and avoid duplicative efforts in the same neighborhoods.

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.

As provided for in the application, our program will address 7 of the 13 possible requirements: 1, 2, 4, 5, 7, 8 and 13. Milestones towards our goals include:
DY1-Q1: Form the Advisory Committee as a physical entity;
DY3-Q4: Implement all IT solutions, including access to Allscripts Care Director and the RHIO across the PPS;
DY3-Q4: Increase the percentage of those whose whereabouts we can ascertain, whether or not they remain in care, to greater than 95%;
DY3-Q4: Increase the number of new patients in care at NYP's HIV clinics by 10%.

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

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

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

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

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

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.
b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in the application. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.