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**New York Department of Health**  
Delivery System Reform Incentive Payment (DSRIP) Program  
Project Plan Application

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## Using this document to submit your DSRIP Project Plan Applications

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

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

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



## Domain 2 Projects

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

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

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

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

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

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



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

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

**1. 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 current delivery system does not meet the needs of medically and behaviorally complex patients. The primary strategy of the PPS is to increase the use of evidence-based practice, decrease care delivered in silos, and increase communication among providers through development of an integrated provider network and clinical system interoperability. Indeed, the Bronx has higher rates of Prevention Quality Indicators (PQI) hospitalizations when compared to the rest of New York State, with some of the highest rates found in the population that the PPS serves. In the neighborhoods of Hunts Point, Mott Haven, Highbridge-Morrisiana, and Crotona-Tremont there were more than three times the number of Observed/Expected admissions when compared to the statewide rate between 2008 and 2009.

There are many reasons for this:

Surveyed residents in these neighborhoods reported a higher rate of psychological distress, ranging from 5-8 percent. 32.9% of Medicaid beneficiaries with behavioral health related utilization had an inpatient admission for any reason and was not exclusive to behavioral health.

In 2013, the BLHC Emergency Department identified 32% of visits as potentially avoidable presenting a major opportunity to reduce costs and utilization. Qualitative CNA findings demonstrate that patients experience long wait times for primary care, medical specialty and behavioral health appointments and that appointments are scheduled on multiple dates and locations causing patients to miss work and experience financial hardship in regard to transportation costs. If services are not efficiently and



conveniently provided, patients will continue to over utilize the ER.

There are issues directly post-discharge from the hospital. During this time, patients may become lost to follow up from primary care or behavioral health services due to low health literacy, cultural and linguistic barriers, disruptions in health insurance coverage, co-occurring diagnosed or undiagnosed behavioral health disorders, unstable housing or homelessness, and financial barriers. Population health management and care coordination are needed to maintain at-risk patients in the outpatient setting for primary care and behavioral health services. The PPS's strategy includes exploring risk stratification and predictive models to identify at-risk patients and use of the Health Home model which demonstrates the effectiveness of community outreach and care management in maintaining patients in the right care at the right utilization levels. The PPS will leverage the expertise of its two Health Homes and its experience managing 95,000 beneficiaries through a full risk contract with a managed care organization. Because of this risk arrangement, the Lead Entity is investing significant resources to build the PPS's care coordination capacity across all service providers to ensure that the percentage of patients who are clinically appropriate for presentation to the ER will increase, as will the percentage of people accessing primary care for ambulatory sensitive conditions. Integrated care at the primary care and preventive level will result in less need for inpatient acute care beds. The PPS is formulating plans to redirect staff currently serving an inpatient setting to primary care, medical specialty, behavioral health services, and care management based on their degree and training. The PPS will focus on investing in clinical system interoperability and in supporting safety net providers to achieve PCMH Level 3 2014 and MU standards as a strategy to prepare for system-wide grounding in evidence-based medicine and population health management. Through implementation of PCMH concepts such as long term relationships, shared decision making, team based approach to care, and expanded access to services after hours and at other non-traditional times, the basis of the IDS is to assure that the patient is the center of care and focus of all IDS activity

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

The greatest asset the BLHC PPS has is the wide array of provider and community groups that will work together to address the social issues that drive avoidable hospitalizations. The PPS includes more than 100 organizations including hospitals, Health Plans, FQHC networks, CHCs, and is complemented by a large array of community-based organizations that provide primary, specialty, long term care services, homeless services, social services and behavioral health services. Key within this partnership is the relationship the BLHC PPS has with Urban Health Plan, a major FQHC and named as one of the top 20 community health centers in the country, with over 100 medical providers.

The PPS has a functional ACO and two Health Homes with proven processes for providing care management and managing population health for NYS most vulnerable patients. Health Home goals are to reduce high cost avoidable hospital inpatient stays and emergency room visits; improve health outcomes for individuals with mental health/substance use disorders; and improve disease related care for individuals with chronic illnesses through the utilization of best practices and improving preventative care. The PPS will expand on the expertise of its participating Health Homes while building its IT infrastructure and clinical interoperability. Many of the health providers in the PPS are already PCMH recognized and moving toward advanced recognition. As a result, the PPS providers are poised to meet the 2014 PCMH and MU standards as specified in the project deliverables. Most



medical providers, and in particular FQHCs in NYC have had an electronic health record for quite some time and have learned to conduct population health management within their own walls, which is necessary in reporting on key clinical measures. Additionally, most have started meeting with Health Plans to work towards value based payment. The IT platform selected by the entire PPS will achieve new efficiencies and economies of scale to achieve PPS system wide population health management centered on a standard set of quality indicators that are known to improve chronic illness management and reduce avoidable admissions.

The majority of resources to be repurposed are those that result in reduced acute care beds redirecting professional and non-professional staff to primary care, medical specialty, behavioral health services, and care management. The entire PPS is building its care management infrastructure to ensure patients with chronic conditions at risk for avoidable ER visits or admissions are treated continuously in the outpatient setting.

The PPS will need to develop significant infrastructure to support an effective IDS, to provide appropriate care for its approximately 134,000 attributed patients. Therefore, in order to move first to a Contracting Model and ultimately a Delegated Model able to operate in a world of value-based reimbursement, the PPS is developing an LLC and key sub committees comprised of representatives from all PPS partners to ensure a coordinated system of care. The PPS steering committee (the governing committee) will create an overarching PPS Management Office and assign leads for all selected DSRIP projects to ensure deliverables are met across the entire PPS. As part of this effort, all PPS partners will assign key leadership and support staff to IT, HR and project management to meet IDS goals.

Another important resources is the innovative Transcare Ambulance Transport Program. FDNY 911 dispatch will send patients all over the Bronx depending on a number of factors. In response, BLHC created the Transcare program for urgent, but non-emergency, transportation needs where patients are encouraged to call Transcare so they can be transported safely to BLHC and—their primary care physicians. This reduces cost because 911 can otherwise unnecessarily sends patients to the ED across town and the primary care doctor is not informed.

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

The PPS will face challenges as it moves to a delegated model as well as financial challenges as funds flow from the institutional setting to the primary care and outpatient setting. The movement from a culture of sick care to a culture of well care will require new behaviors on the part of all health care participants, provider, payers and patients. Barriers, and the manner of addressing them, include:

1. The CNA identified co-occurring primary care and behavioral health disorders as a challenge for the PPS. Currently, behavioral health services capacity does not meet demand and when present is seldom well coordinated with primary care. The PPS has decided upon a strategy that emphasizes integration, not just co-location of behavioral health services into primary care.



2. The cultural and linguistic barriers to care are significant in a community as diverse as the South Bronx; Section 7 of this application addresses processes and strategies for overcoming cultural barriers that keep people from getting the care they need and deserve. The CNA showed that patients experience a multitude of barriers to care including provider availability; changing patient flow in practices via achieving PCMH status, adoption of EHR and HIE technology, and increasing resources for primary practices will reduce some of these barriers. In addition, the IMPACT model has been singled out as ideal for use across the PPS to better serve patients.

3. Another barrier is the requirement that the PPS share health information via the RHIO-SHIN-NY interoperability and use direct message clinical alerts among all PPS providers; this places significant financial burden on the PPS, however, there is a strong commitment to invest in technology that will support the IDS as a whole.

The PPS's hospital will face challenges in reducing acute care beds as the PPS redirects patients appropriately to outpatient care. The financial management of this paradigm shift will fall on the Finance and Workforce Committees, guided by the Steering Committee. PPS partners will work within their own systems and with Health Plans to revise contracts to better focus on value- based payment. This will be a challenging endeavor, as all parties work toward agreeing to contract terms.

- 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.

BLHC PPS is dedicated to improving health in the Bronx as a whole—which means working with all of the PPSs in the Bronx. BLHC PPS has reached out to both the HHC and St. Barnabas PPS and signed a joint letter of commitment to work together collaboratively. While all three PPSs agree to work on the applications separately due to the tight timeframes, all three PPSs agreed to collaborate closely when it matters—on development of the implementation plan and on implementation.

For example, BLHC PPS also has projects in common with HHC and St. Barnabas PPS, including 2.a.iii, Health Home at-risk intervention program. The plan is to meet with these PPSs regularly, and discuss sharing of ideas and resources where possible, thereby, building alignment and economies of scale. The PPS will seek common ground on issues such as: the use of common metrics for common projects; the return of attributed patients to their primary PPS; and opportunities for collaboration across PPSs to assure continuity of patient care and collaboration implementing change “on the ground.”

Key Milestones for working together include:

- First three-way Implementation Planning Meeting: February 2
- Establish Shared Vision for the Three-Way Partnership: February 23
- Comment on Each Other's Implementation Plan: Ongoing

While the Mount Sinai PPS is not based in the Bronx, BLHC PPS has already initiated an important collaboration with the Mount Sinai PPS. This relationship is critical for successful operations as BLHC PPS and Mount Sinai will share a Project Management Office and a Management Services Office. There are also several projects that overlap with Mount Sinai, including 2.b.iv: Care transitions to reduce 30-day readmissions; 3.a.i: integration of primary care and behavioral health; and 3.c.i: evidence-based strategies for disease management in high-risk populations. The collaboration on project design, consumer outreach, provider communication and outcomes evaluation will continue moving forward.



A key element in collaboration is the creation of a Health Information Exchange (HIE) for the sharing of key patient information digitally across the entire PPS. As we advance, all existing infrastructure will be fully leveraged. When no systems or processes are in place, a platform will be implemented to support collaboration. Interoperability will be stressed as the PPS establishes a robust platform and processes for information sharing.

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

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

The state has set important DSRIP benchmarks for the reduction in unnecessary inpatient utilization. All of the projects within DSRIP are designed to help meet this important goal. The extent this can happen is part of the analysis that will encompass scale and speed.

Therefore, in this section, we offer a comprehensive strategy and action plan for reducing the unnecessary acute care and long term care beds. To lead this strategy, the Steering Committee is dedicated to achieving PPS provider collaboration as it moves toward building an effective IDS and eventually a successful ACO model. The PPS is committed to developing additional risk sharing arrangements, building on its current experience of managing clinical risk for 95,000 beneficiaries and expanding that risk to include social supports that impact the lives of the attributed population.

### Acute Bed Management

The following steps will be followed in moving forward on acute care bed management:  
Implementation Planning

1. Finish analysis of preventable admissions. This will be done through a data run of PQI, and preliminary work is already underway. There are certain parameters to consider and the BLHC PPS data team is analyzing the information currently available in order to estimate the full number of admissions that can be avoided. Preliminary analysis shows as many as 2,029 discharges that fall into the category of Potentially Preventable Admissions. Based on the January 2015 Medicaid / HMO rate and using July 2014 grouper, these cases would reduce costs by \$27.2 million.

Milestone for Updated Analysis: February 1

Assess impact of projects on preventable admissions. The DSRIP projects focus on strategies for reducing unnecessary utilization, and the Implementation Phase is an opportunity to present an analysis of the projects' potential impact. For example:

- The Health Home At-Risk project will reduce avoidable inpatient utilization by focusing care management resources on adults with uncontrolled chronic conditions who are at risk of developing



additional chronic conditions that drive avoidable hospital utilization.

- The Ambulatory ICU project will target the top 5% of super utilizers and support through them through multidisciplinary provider teams in order to avoid costly avoidable admissions.
- The Maternal and Child Health project will support pregnant women, newborns and children who are at high risk of adverse and costly outcomes.

Milestone for Updated Analysis: February 15

1.Examine ability of partners to implement changes in projects. During the implementation phase the PPS will have to conduct a fact-based assessment of what types and degree of changes partners can realistically implement under each project. Milestone for Updated Analysis: February 27

Implementation Phase

1.Track Proposals. With planning completed, it will be important for the actual impact of the project work to be tracked and analyzed over the five year DSRIP program. Implementation may not necessarily follow the work as planned, requiring mid-course adjustments to ensure that estimated changes in utilization are either happening as planned or being accounted for as they do not. This analysis will look at a tracking mechanism to monitor project performance.

Milestone for Updated Analysis: February 15

1.Follow-up steps. Once inpatient utilization changes begin to materialize, a number of changes and adjustments will be needed.

- Workforce planning changes. Beginning in Implementation Planning Phase, the Workforce Committee has been developing a comprehensive assessment of current staffing patterns, and a gaps analysis to ensure the number of primary care, specialty and behavioral health providers are adequate to meet the need. The goals to reduce wait times for these services is crucial in minimizing misuse of the ER simply because the patient cannot obtain a timely appointment with an appropriate outpatient provider. To support this effort, the Workforce Committee is developing a robust training program based on evidence-based practices that provide knowledge and skill building in needed areas such as care management

Milestone for Workforce Planning Analysis on Staffing Patterns: February 27 Milestone for Updated Analysis on Improving Operations: March 15

- Bed Closing Procedures. Currently, one floor of the main PPS hospital is unused due to low utilization. As inpatient utilization drops further, practical decisions will need to be made on how to close additional beds and the impact on workforce and the community. Given outcomes are not likely to change until several years into DSRIP, there is time to consider how best to manage this aspect of the plan.

Milestone for Updated Analysis on Improving Operations: May 1

- Close a 20-bed Unit. BLHC plans to close one bedded unit to decertify 20 medical beds on or before the end of DSRIP Year 3. Personnel, including Nurses (R.N.), will be reassigned to outpatient clinics to better educate and manage patients with chronic disease. Closing of this inpatient unit will be enabled



through greater use of BLHC's NYS Licensed Observation Unit, further reductions in average patient length of stay and expected reduction in demand for inpatient utilization by improvements in population health as planned for in this DSRIP initiative. Additional beds will be closed as analysis continues.

Milestone for Updated Analysis on Improving Operations: DSRIP Y3

BLHC PPS Finance and Workforce committee are creating a comprehensive workforce and financial management plan to ensure the financial health of the PPS as it reduces acute care beds and redirect space and professional and non-professional staff to primary care, medical specialty, behavioral health services, and care management.

All PPS partners will have the ability to provide input to the Finance and Workforce Committees regarding the PPS-wide strategy of redeploying and/or hiring more PCPs, BH providers, medical specialists, and care management staff including field workers (community health workers) who will ensure patients maintain their connection to primary care and are not lost to follow up.

Long Term Care Bed Closing

Utilization of SNF/LTC beds is fundamentally different from that concerning acute care beds. There is no statewide plan on addressing the utilization of nursing home beds, and the DSRIP projects are not designed to impact this utilization. As such, the BLHC PPS sees a reduced potential for closing nursing home beds as compared to acute care beds. To explore the opportunities for reducing nursing home beds, the following action plan will be followed.

1.Create LTC BLHC PPS Bed Analysis Work Group. We will create a workgroup of nursing home operators and key provider partners to understand the number of beds being used, their role in the community and in DSRIP projects, and the ongoing need (if any) for those beds in the community. This committee will be asked to set a vision for the role of nursing homes and their operations in the BLHC PPS over the next year. To our knowledge, this is the first time such a report will ever have been prepared in the Bronx. We will involve all the PPS partners to join us in this effort so that it can be a truly cross-cutting and collaborative effort.

Milestone for Workgroup Formation: March 1 Milestone for Issuing Interim Report: May 1 Milestone for Issuing Final Report: October 1

1.Create LTC BLHC PPS Bed Management Work Group. With the vision set in place, BLHC PPS will implement that vision. The same workgroup members will continue to meet in order to implement the vision of the new report. It will be up to the leadership of this workgroup to call meetings, understand the issues, and affect the change that is called for in the report. We anticipate the group will meet monthly.

Milestone for First Meeting: November 1

Milestone for Following Action Items: Ongoing in the Fall 2015

- b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones



indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

The PPS has a high level steering committee with representation from PPS partners:

Dr. Isaac Dapkins- Director of Ambulatory Care, Bronx Lebanon Hospital Center Rosa Gil - President & Chief Executive Officer, Comunilife  
Paloma Hernandez- President & CEO Urban Health Plan Dr. Jeffrey Levine - Medical Director, Bronx Health Home Octavio Marin- Bronx Lebanon Special Care Center Ramon Moquete – Hudson Heights IPA Aida Morales- 1199SEIU  
Neil Pessin - President, Community Care Management Partners Health Home  
Samuel Shutman - Vice President of Managed Care & Business Development, Bronx-Lebanon Hospital Center  
Brent Stackhouse- Mt. Sinai Hospital  
Kristin Woodlock - Chief Executive Officer, FEGS

The Steering Committee has tasked itself with meeting several major milestones.

- Spring 2015: the BLHC PPS will employ a Collaborative Contracting model using the expertise and fiduciary responsibility of BLHC as the Lead Entity to enter into contracts. The metrics for this milestone include the execution of contracts throughout the PPS with all participating providers.
- October 2015: The second major milestone is the Steering Committee's plan to incorporate the PPS into an LLC under a new name by Fall 2015.
- January 2016: A third milestone is set for operations to begin for the PPS under a Delegated Model (the LLC), with metrics including the alignment of financial incentives across the PPS and the ability of the PPS to delegate risk and reimbursement using alternative payment structures.

The governance structure calls for the Steering Committee to continue to serve as the governance board of the PPS. In order to evolve the PPS into a fully functioning IDS, the Steering Committee has created key subcommittees charged with developing the IDS including: Finance, IT, Workforce, Clinical Development and Implementation, Compliance, and Community Needs. The PPS also intends to develop a consumer advisory board that can offer guidance to the Steering Committee on issues of policy and program design, consumer outreach and engagement, cultural competence and health literacy, and can speak to the specific needs of certain populations including people with behavioral health needs, recently incarcerated individuals, older adults, people living with HIV/AIDS, and people with intellectual and developmental disabilities.

These committees will meet at least monthly at a minimum during the first year. They are developing detailed work plans to achieve IDS milestones and metrics including clinical system interoperability, Advanced PCMH and MU standards achievement for all providers, and payment reform for all PPS partners in collaboration with Urban Health Plan. Committee work plans will be completed by mid-year one and operationalized by the latter part of year one moving into Year Two. Also, in mid-year one the PPS will initiate a PPS Program Management Office charged with overseeing all the selected projects for the DSRIP. This office will have a full time director and support staff to ensure success with each discrete project. To ensure inclusiveness and collaboration Town Hall meetings will be scheduled quarterly for



the entire PPS supplemented with an electronic newsletter.

The PPS will also develop a Quality Committee that will ensure evidence based clinical practice is disseminated across PPS providers. This Committee will work closely with IT to develop a quality dashboard reporting on a standardized set of key clinical, HEDIS and other metrics reporting for the entire attributed population and data will also be stratified to report on sub-populations (diabetes, asthma, etc.). ER and hospitalization data for ambulatory-sensitive conditions will be a key metric for the entire PPS. This will begin in Project Year two.

**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)*

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This will include hardware, such as computers, along with start-up software costs. This is expected to be the largest capital expenditure. Capital funding will also be needed to renovate space for program staff and coalition partners to work collectively together. For example, one PPS partner has multiple storefronts that if renovated could deliver primary care, care coordination, and social supports critical to maintaining health. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers and phones for the integrated delivery system team members. In addition, capital funds will be used to purchase medical equipment for sites or to construct new clinics that will be necessary in order to implement this project.

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?

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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



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

**6. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

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

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



implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

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



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

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

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

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

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



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

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

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

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

The Bronx is one of the leading counties in New York State with poor population health outcomes. In comparison to other New York State counties, the Bronx has the highest rates of premature deaths among people aged 64 years and younger. Some leading causes of these premature deaths are preventable and manageable chronic conditions such as heart disease, AIDS, and diabetes. The Bronx also has the highest rates of potentially preventable inpatient hospitalizations (PQI) and second highest rate for potentially preventable emergency room visits (PPV), and readmissions (PPR). The distribution of preventive and primary healthcare resources in the Bronx varies across the county. Overall, the Bronx performs below average in comparison to the other 5 boroughs with regards to availability of preventative and primary care health resources. According to data collected by the Center for Health Workforce Studies Physician Re-Registration, the Bronx has the highest rate of residents living in a primary care shortage area (HPSA, primary care = 35.7%). Though the BLHC PPS service area seems to have a higher concentration of primary and preventative services, they also have higher than expected rates of potentially preventable inpatient (PQI) hospitalizations, which implies availability does not guarantee access to timely preventative care.

According to the CNA, a variety of factors prohibit access to timely preventative primary care. Some community members found it difficult to forge a continuous relationship with their PCP or care team. Providers mentioned a lack of care coordination across care settings making it difficult to access EHRs across settings or assess patient status after discharge. Community members noted that they did not feel engaged in their care and felt providers used terminology that was difficult to understand or were not willing to explain treatments or answer clarifying questions. Finally, patients and providers noted issues with scheduling patients for appointments, long wait times, and limited after hours or weekend services. High PQI hospitalization rates and relative availability of health care resources in the BLHC PPS service area gives overwhelming support for expanding the Health Home model to include individuals at-risk for Health Home services. This project will capitalize on existing Health Home programs and primary care infrastructure in the South and Central Bronx. At-risk patients will be assigned a designated care coordinator to help them better navigate and connect to preventative primary care and social services in this area.



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

This project will target the following patient populations:

Adult (18 to 64) Medicaid beneficiaries with one of the following qualifying conditions:

- Uncontrolled Diabetes
- Uncontrolled Hypertension
- Cardiovascular disease (no uncontrolled diagnosis)
- Asthma ACT score of <19 (not well-controlled asthma)
- Behavioral Health (Non-Serious Mental Illnesses as indicated by Health Home Standards)
- Substance Abuse- Alcohol Dependency, Chronic Alcohol Abuse, Cocaine Abuse, Drug Abuse (Cannibus/NOS/NEC), Substance Abuse, Opioid Abuse, and other significant Drug Abuse)

And at risk for developing another chronic condition as define by an additional diagnosis of:

- Obesity
- impairing fasting glucose
- impaired glucose tolerance level
- pre-diabetes
- elevated blood pressure without diagnosis of hypertension
- nicotine dependence

The PPS will also focus on individuals at risk for homelessness.

The list of qualifying chronic, substance abuse, and behavioral health conditions were selected to align with the qualifying conditions that make an individual eligible for Health Home services in New York State. At-risk diagnoses were chosen by identifying which diagnoses increase the risk of developing the listed qualifying conditions. This project will also include significant focus on the social determinants of hospitalization such as housing, access to food and nutrition services, Medicaid eligibility, access to transportation and home based care options. By focusing on this population, based on both their health conditions and social determinants, this project targets individuals most at-risk for developing a second chronic condition and potentially qualifying for Health Home services. These patients are the highest cost patients to the system.

- 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.



As indicated by the CNA, there is a high volume of preventive and primary care resources in the target service area including Health Homes, community health centers, FQHCs, social service organizations, transportation and safety net providers. The PPS intends to organize and coordinate these resources for this project. Towards that end, this project plans to expand the patient population served by the two lead Health Homes, the Bronx Health Home and the Community Care Management Partners Health Home, who are members of the BLHC PPS. Key within this partnership is the relationship the BLHC PPS has with Urban Health Plan, a major FQHC and named as one of the top 20 community health centers in the country, with over 100 medical providers.

The Bronx Health Home currently has 10,000 assigned patients, of which 4,657 are actively enrolled and a network of over 50 providers that coordinate comprehensive client care in the areas of primary and specialty care, substance abuse treatment, mental health treatment, housing and other supportive social services. The Community Care Management Partners Health Home (CCMP) serves more than 10,000 individuals and consists of 20 care management organizations that provide primary, specialty, HIV and behavioral health care, and substance use services. This project will expand the service population that these existing Health Homes serve. The project will use a stepped approach where patients will be stratified based on risk level: low, medium, and high. Prior to stratifying patients, the PPS will clearly define the parameters of each risk level using evidence based risk stratification methodology and determine which level of care coordination intervention is appropriate based on a given risk level.

In addition to engaging existing Health Homes to provide care management services, this project will also engage a wide range of community based healthcare and social service providers who can assist with identifying these at-risk patients. The providers engaged will include preventative and primary care providers (i.e. PCP, community health centers, FQHCs), acute care providers (i.e. emergency room, urgent care, inpatient), pharmacies, transportation and social service providers (i.e. homeless, food, workforce development). This project will develop standardized procedures and protocols that these preventative and primary care providers will implement to identify at-risk individuals and ensure referral and retention into appropriate medical attention.



- 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.

A major challenge for this project will be that providers who specialize in care management will have increased caseloads to manage. To address this challenge, the PPS has identified network providers who have FTEs available to contribute to this effort, and will implement a plan to train, redeploy, and hire care coordinators for the project.

Additional challenges are related to the identification of individuals who are most at-risk to becoming eligible for Health Home services and enrolling them into the program. To identify these at-risk individuals on a rolling basis, the project will use EHR data to identify which uncontrolled chronic conditions are driving the health home eligible population. In addition, the project will develop a screening and referral tool that healthcare and social service providers will use to identify their at-risk patients who would benefit from care coordination services.

It will be a challenge for participating providers to share EHR data to ensure continuity of care.

Currently the two participating Health Homes have established an IT infrastructure that centralizes records of patients receiving Health Home Services. The PPS plans to harness that existing structure and explore avenues to extend it to other participating preventative and primary care providers.

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

Working collaboratively with PPSs that overlap with our service area is a high priority. Our PPS will engage with all other PPSs in the NYC region through in-person meetings, webinars and/or conference calls. Through these convenings, we will work with other PPSs to share best practices, lessons learned, training materials, and other resources that are critical to the success of DSRIP. The BLHC PPS has already started building a strategic relationship with the Mount Sinai PPS to do joint planning, achieve economies of scale, and establish shared protocols. BLHC PPS is dedicated to improving health in the Bronx as a whole—which means working with all of the PPSs in the Bronx. BLHC PPS has reached out to both the HHC and St. Barnabas PPS and signed a joint letter of commitment to work together jointly.

While all three PPSs agree to work on the applications separately due to the tight timeframes, all three PPSs agreed to collaborate closely when it matters—on development of the implementation plan and on implementation. For example, BLHC PPS also has projects in common with HHC and St. Barnabas PPS, including 2.a.iii, Health Home at-risk intervention program. The plan is to meet with these PPSs regularly, and discuss sharing of ideas and resources where possible, thereby, building alignment and economies of scale. The PPS will seek common ground on issues such as: the use of common metrics for common projects; the return of attributed patients to their primary PPS; and opportunities for collaboration across PPSs to assure continuity of patient care and collaboration implementing change “on the ground.” The BLHC PPS also plans to engage with the Medicaid managed care organizations as well as the NYC DOHMH.

Key Milestones for working together include:



First three-way Implementation Planning Meeting: February 2  
 Establish Shared Vision for the Three-Way Partnership: February 23  
 Comment on Each Other’s Implementation Plan: Ongoing  
 A key part of collaboration is the creation of a Health Information Exchange (HIE) for the sharing of key information across the PPS. As the project advances, all existing infrastructure will be leveraged. When no systems or processes are in place, a platform will be implemented to support collaboration and interoperability. The BLHC PPS will also be active contributors on the MRT Innovation eXchange to share best practices.

**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)*

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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



This project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This will include hardware, such as computers, along with start-up software costs. This is expected to be the largest capital expenditure. Capital funding will also be needed to renovate space for program staff and coalition partners to work collectively together. Existing storefront offices within the community that serve to facilitate linkages to patient care will need to be renovated. In order to renovate space, the PPS must either do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to assist with screenings. In addition, capital funds will be used to purchase medical equipment for sites or new clinics that will be implementing this project.

- 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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Community Care Management Partners (CCMP), LLC	NYS Medicaid Health Home	November 2011	N/A	<p>The Health Home is a Medicaid sponsored model of service delivery that expands on the traditional medical home model. The Health Home builds linkages to other community and social supports, enhancing coordination of medical and behavioral healthcare, with the main focus on the needs of patients with multiple chronic illnesses.</p> <p>Health Homes are responsible for assuring that their members receive all necessary services, including medical, mental health, behavioral, social services (such as housing)</p>
Bronx Lebanon Hospital Center + CBC/FECS Health and Human Services System, Inc. dba Bronx Health Home	NYS Medicaid Health Home	November 2011	N/A	<p>The Health Home is a Medicaid sponsored model of service delivery that expands on the traditional medical home model. The Health Home builds linkages to other community and social supports, enhancing coordination of medical and behavioral healthcare, with the main focus on the needs of patients with multiple chronic illnesses.</p> <p>Health Homes are responsible for assuring that their members receive all necessary services, including medical, mental health, behavioral, social services (such as housing)</p>



- 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.

Currently the two Health Homes participating in this project, CCMP and Bronx Health Home, originated from the New York State Medicaid Health Home initiative. In order to be eligible for Health Home care coordination services, an individual would need to be a Medicaid beneficiary and have two chronic conditions, or one single qualifying condition (HIV/AIDS or a serious mental illness). The DSRIP Health Home at risk project will expand the population who can benefit from Health Home care coordination services, but are not eligible to receive services due to existing Health Home eligibility criteria. Specifically, this DSRIP project will provide tiered care coordination services to individuals with one chronic condition and at risk of developing another.

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.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](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.



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## 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 BLHC PPS is committed to reducing health care costs and improving care for high risk patients with multiple chronic conditions and a history of multiple potentially preventable hospitalizations or ED visits. Identified gaps in the CNA demonstrated 73% of Medicaid Potentially Preventable Emergency Visits (PPV) in the Bronx, or 253,636 cases out of 346,837, were attributed to the BLHC PPS. This high volume of health care utilization is also observed in Potentially Preventable Medicaid Hospitalizations (PQI 90) as 70% (9,535 out of 13,447) were attributed to the BLHC PPS. Additionally, NYSDOH data (2012) showed Acute Conditions Composite (PQI 91), the number of PQI Medicaid hospitalizations in the Bronx, to be 3,384 with 2,333 (68%) attributed to the BLHC PPS. The objective of this project is to reduce health care costs by 25-35% by targeting the top 5% of high risk patients for comprehensive care through Ambulatory ICU's. When successful, Ambulatory ICU's could decrease avoidable hospitalizations for the PPS as a whole by 10%.

To quantify the need for this project, four ambulatory sensitive diseases associated with preventable hospitalization rates were selected. These diseases are Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Asthma, and Diabetes. In the Bronx, CHF PQI hospitalizations were 68.4%, Respiratory Composite PQI Q3 hospitalizations covering both COPD and Asthma were 68.8%, and Diabetes PQI 01 hospitalizations were 65.5%. More than two-thirds of these hospitalization rates occurred in the BLHC PPS and were most common among high risk individuals in previous work at Bronx Lebanon Hospital Center and Urban Health Plan Inc. (UHP).

CNA data revealed 86,156 hospital admissions are projected to be followed by a readmission. Furthermore, 21.2% of Potentially Preventable Readmissions (PPR) is attributed to the BLHC PPS. In the BLHC PPS, it was found that PPRs were due to patients' difficulty adhering to medical recommendations; living in under-sourced/stressful home environments; operational challenges such as unclear communications at discharge; mismanaged handoff of patients, and patients lost to follow up. Qualitative CNA data further supports these barriers. For example, one organizational leader described how patient homelessness resulted in "the emergency room [serving as] a respite shelter of sorts." The Ambulatory ICU will address these challenges during implementation, by providing integrated expert care for high need, high cost patients.

Additionally, provider interviews presented coordinated care for behavioral health and physical health as poor due to system fragmentation and limited integration. According to data from New York State Office of Mental Health, PQI measures of preventable hospitalizations specific to behavioral health suggested over half (54.5% or 9,215/16,942) of Bronx clients with mental health conditions had one or more physical chronic health conditions. On top of these conditions, substance abuse rates were 8.5% among BLHC PPS Medicaid beneficiaries.



This project will address the gaps identified in the CNA by use of evidence-based care involving the entire multi-provider team working together simultaneously as described in the Nuka Model, along with evidence team based care models. Patients are tiered based on risk and a team consisting of primary care and specialty providers, care coordinators, behavioral health specialists, nurse managers, and housing specialists will work closely together to serve the highest risk, multi-morbid patients. The team will address the entire gamut of the patient's physical, mental, and social state. This Ambulatory ICU project will aim for true integration of medical specialists including primary care, mental health providers and social services providers by leveraging its two Health Homes to provide intensive care management services to patients with complex needs.

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

The target population for this project will be individuals who have had in the previous 12 months one or more potentially avoidable hospital admissions and/or two or more potentially avoidable ED visits.

Further eligibility criteria include:

- Ages 18 and over who have presented with one or more of the following in the last 12 months:
- One mental health condition; or,
- One substance abuse condition/addiction; and,
- One or more co-morbid chronic conditions characterized as:
- Ambulatory care sensitive conditions or
- Chronic conditions such as diabetes, cardiovascular related diseases, behavioral health, chronic renal disease and respiratory related conditions.

This target population will be categorized as within the top 5% of risk of future hospitalization based on one or more of the criteria:

- Previous hospitalizations or ED use in the previous year (as above);
- Patients scoring at 50% or more for risk for hospitalizations using an assessment tool such as Patients-At-Risk-for-Re-hospitalization; or
- By referral from the patients current health care team.

By targeting individuals with the above criteria, there is great potential to reduce health care cost by 10% overall for the BLHC PPS through this project alone.

- 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 resources exist to build this project. BLHC PPS is an award recipient from the New York State Health Foundation for identification and multidisciplinary care planning for improvement in the 100 of the



highest risk patients. Utilization by these patients increased through outpatient engagement, with decreased hospitalizations and ED utilization where an overall decrease in cost of health care was observed. Additionally, Urban Health Plan, a large FQHC in the BLHC PPS with an excellent track record of care and services, is currently piloting a team based care model for patients with out of control diabetes who have a multitude of complex medical, behavioral and social needs. Case conferences with a multi-provider team are held weekly, demonstrating a successful reduction of 40% in Hba1c of the targeted patients. These examples reflect existing efforts and assets that can be mobilized to achieve the implementation of an Ambulatory ICU.

In addition, the BLHC PPS has a large network of providers who work in behavioral health, care coordination, primary care, nutrition, rehabilitation, community based non-physician care, complex specialty care and nursing. Formation of an integrated collaborative team using the available resources will be done by:

- Ensuring clinical interoperability for all PPS partners including information exchanges through the RHIO/SHIN-NY.
- Secured messaging to ensure immediate notification of ER visits or hospital admissions to the community primary care provider permitting efficient identification of patients, and linking them to needed complex services.
- Formation of a pod layout where providers are accessible and patients see them sequentially, as reflected in the Nuka Model of care.

To add, BLHC, UHP, Community Care Management Partner (CCMP) Health Home and Martin Luther King Jr. Health Center, have experience integrating health and mental health care. BLHC and F.E.G.S. are co-leads of the Bronx Health home for which care coordination, ED diversion, and inpatient transition of care have been successful.

BLHC, along with UHP, have the capacity as well as space to develop two multi-disciplinary teams to carry out care-review and care-management to work simultaneously to ensure all Ambulatory ICU patients receive feedback from the multi-providers involved in their case. The PPSs two Health Homes and Visiting Nurse Services of New York will be leveraged to support the Ambulatory ICU project bridging the gap in care and ensuring patients remain in primary care continuously. Since all patients in the Ambulatory ICU will have entered into one of the two major health homes in the PPS, community outreach will be a major part of the care plan. Existing EHRs at BLHC, UHP and other organizations will track all patients. Sharing of community data and health home referrals will be managed by care managers in compliance to HIPAA. This includes health home referrals data and reduction in preventable admissions and ER visit data. Both BLHC and UHP are PCMH Level 3 and poised to meet PCMH 2014 and meaningful use. EHR will be used to arrange follow-ups and optimize care to move the patient into recovery.

Other needs of the targeted patients can be met in collaboration with partner organizations such as Empowerment, Assistance, and Caring (EAC) Network, the Center for Alternative Sentencing and Employment Services (CASES) and Hospice NY. Both EAC and CASES provide services to high- need and hard to reach individuals with substance abuse disorders and/or serious mental illness who have been involved in the criminal justice system. They will actively engage vulnerable populations with co-morbid conditions as care coordinators on the team in addition to providing behavioral health services. Hospice NY will ensure treatment plans & housing is available. Additionally, Hudson IPA & Bronx United IPA, supported by BLHC, will assist in community outreach and enhance the



treatment for our most hard to reach.

- 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 Ambulatory ICU will be a resource for all of the providers in the PPS; patients will not simply be those of UHP or BLHC. These agencies are well suited to provide the kind of multi-disciplinary, multi-specialty care that the Ambulatory ICU demands. Undoubtedly, there will be cultural barriers among different agencies and providers from different fields to be overcome to make this integration a reality. Additionally, other providers within the PPS may initially be reluctant to refer patients. Although this is understandable, it will be addressed at the level of the PAC and Community Meetings to bring providers together.

Challenges related to staff have been identified. Extensive time commitment and care at an estimation of two to three hours per patient during their first visit has been identified. Providers may not commit to those hours so recruitment may be a challenge. To address these challenges, aggressive recruitment will be used as well as training to invest providers in the Ambulatory ICU model. Additionally, providers who have never worked together, but are expected to integrate as a collaborative team, could produce dynamics that may not form as smoothly due to different work styles. To address this, training and team building practices will be required for all members.

Health disparities have also been identified as a challenge. High rates of poverty, homelessness, incarceration, malnutrition, language barriers, substance abuse and cultural differences are common problems. The team's knowledge of their target populations' barriers will require training on cultural sensitivity and understanding the health disparities and social determinants of health that exist.

The following strategies will address these aforementioned challenges:

- Develop a tele-conferencing system and protocol that will bring all providers together
- Build on an infrastructure of advanced EHR that are shared with all the Community Based Organizations involved
- Hire care coordinators to provide care management
- Train partners on collaboration, cultural sensitive language, cultural competency and best practices to work together at the highest level of service

Stress-test new systems and protocols with patients and patient advocates throughout the project, to enhance and ensure relevance and utilization of Ambulatory ICU services

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

While no other PPSs in the Bronx is undertaking this project, it is the intent of the BLHC PPS to talk with other PPS partners in other hospitals about the work on ambulatory ICU and see what



thoughts and insight those partners may have for working together on addressing these high-utilizers.

**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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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



The Ambulatory ICU at BLHC will require capital funding to renovate space as well as create space for multi-specialty teams who will be participating in this project. UHP currently has space that is conducive to offering team based care at most of its sites. Renovation of current space, which is existing storefront offices within the community that serve to facilitate linkages to patient care, as well as creation of new space will be necessary to provide the best care for high-risk patients by making provider access accommodating and readily available. Purchase of office equipment, computers, phones, and IT software for tele-conferencing are necessary to ensure accessibility to patient information on EHR as well as for team planning and potential interviewing of patients (i.e. provider teleconferencing). Additionally, funds will be needed for the development or purchase of HIT where intra- and cross-agency information is shared. This includes the purchase of HIT expertise to create inter-operability to allow the various providers to link their existing EHR records into the Ambulatory ICUs' shared EHR. Tablets, and telephones for care managers, as well as other team members, will be imperative to being able to collect information and to promote team collaboration to best serve patient's needs. Wireless equipment for easy data collection of patient vitals will also be needed. While not a capital expenditure, funding for hiring of staff will also be needed to allow co-location of an integrated team with addition to an increase in hiring of care coordinators.

- 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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Bronx Health Home CCMP Health Home	Health Homes	ongoing		Many agencies in PPS already are working together in Health Homes
Communilife	HCBS			Respite Housing
Bronx-Lebanon Hospital, F.E.G.S., others	HCBS			Psychosocial Rehabilitation Community Psychiatric Support and Treatment Family Support and Training Mobile Crisis Intervention Education Support Services Empowerment Services –Peer supports Pre-vocational Services



CASES	Home and Community Based Services (HCBS)	Anticipated April 1-ongoing		CASES has applied to be a designated provider of the following HCBS:  Psychosocial Rehabilitation Community Psychiatric Support and Treatment Family Support and Training Mobile Crisis Intervention Education Support Services Empowerment Services –Peer supports Pre-vocational Services Transitional Employment Intensive Supported Employment Ongoing Supported Employment
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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 focuses on high risk patients and higher integration of services. It relies on strategic alliance of the right set of providers for the organization, more multi-provider connection and doing wrap services around based on what unique providers bringing to the table. The DSRIP project is unlike the Medicaid initiative above as its objective and focus is very different.

**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



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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 regimens. 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](http://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.

11. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
12. 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.
13. Ensure required social services participate in the project.
14. 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.
15. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
16. Ensure that a 30-day transition of care period is established.
17. 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.

According to the CNA, 86,156 hospital admissions in the Bronx were projected to be followed by a readmission (at-risk admission). 6,758 of those at-risk admissions were actually followed by a potentially preventable readmission (PPR). 21.2% of these readmissions (N=1432) were in the BLHC PPS service area. The objective of this project is to reduce the number and overall rate of these 30 day readmissions within the BLHC PPS.

Though the CNA did not provide PPRs by disease category, it did provide potentially preventable hospitalizations (PQI) data for ambulatory sensitive care conditions. Making the assumption that populations with complex chronic conditions may have both high PQI hospitalization and PPR rates for similar reasons (i.e. non-compliance with numerous medications, inability to follow complex care/discharge plans), this project will use PQI hospitalizations as a proxy for identifying populations with high PPRs. One of the main ambulatory sensitive care conditions driving PQI hospitalization is patients with congestive heart failure (CHF). In 2012, the Bronx had 2,013 PQI hospitalizations among Medicaid beneficiaries for CHF of which 68.4% are in the BLHC PPS. Another driver of PQI hospitalizations is respiratory diseases specifically chronic obstructive pulmonary disease (COPD) and asthma. In 2012, there were 4,116 total respiratory related PQI hospitalizations in the Bronx, of which 68.8% were in the BLHC PPS. Finally, another main driver of PQI hospitalizations is individuals with diabetes. In 2012, there were 2,775 diabetes PQI hospitalizations in the Bronx of which 65.5% were in the BLHC PPS. By focusing on patients with complex chronic conditions, this project hopes to reduce readmission rates within the BLHC PPS.

In the CNA, providers and community members reported a variety of issues that may be linked to higher than expected readmissions. According to the CNA, most providers viewed ineffectual transitions between care settings, particularly after hospital discharge. For example, one provider noted that “the way things are happening now is [providers] often find our clients are getting out of the hospital when sometimes two, three weeks, four weeks after, and we missed that opportunity to really make sure that there’s after-care provided.” Due to this lack of communication between the hospital and the patients’ continuity provider, patient needs are not identified prior to discharge and the careful handoff between settings does not effectively take place. Other identified issues include, but are not limited to, unscheduled follow up appointments post discharge, patients’ inability to manage complex dietary issues and medication instructions, and limited access to home care and transportation.

This project will expand upon an evidence based care transition model to better transition populations at-risk for re-admission across care settings. Patients at-risk for readmission will be risk stratified and referred to appropriate level of services and/or care management to prevent further utilization of acute services. The care transitions project will pay special attention to the social determinants of hospitalization such as housing, access to food and nutrition services, Medicaid eligibility, access to transportation and home based care options.

- 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.



To identify the target population, this project will use the Length of Stay, Acuity of Admission, Comorbidities, and ED visits (LACE) Index which is a validated risk assessment tool that can identify patients who might benefit from more intense post discharge care. The target population will be individuals with a LACE score greater than 11 with special attention to:

- Children aged 18 months to 17 years of age and Adults aged 18 to 21 years of age with asthma or diabetes
- Adults aged 18 and over with
  - Diabetes Mellitus
  - Congestive Heart Failure
  - Reactive airways disease
  - Chronic obstructive lung disease
  - Psychotic or mood disorder
  - Cocaine, alcohol dependency, and/or heroin dependency

By targeting risk at patients with these conditions, this project intends to reduce 30 day readmission rates.

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

This project will implement the Care Transitions Program (CTP) which is an evidence based care transition model developed by the Care Transitions Collaborative to impact readmission rates (RA). CTP is an adaptation of other nationally recognized evidence-based programs, such as Project RED, and the Coleman Care Transitions Initiatives. Based on a NY State Health Foundation funded evaluation conducted in 2012, patients who received two/plus CTP interventions had lower RAs (9.4%) than patients who received one/plus interventions (14.9%), as well as those who received none (17.9%). Since CTP excludes patients discharged to skilled nursing facilities (SNFs), this project will incorporate the INTERACT project, an evidence based program that reduces readmission rates specifically for SNF clients.

The primary hospital system in the PPS, Bronx Lebanon Hospital Center (BLHC), has existing protocols to ensure continuity of care for discharged patients that will be expanded. Currently, BLHC's discharge protocols include calling the patient's PCP, sending the discharge summary to the continuity provider, and tracking follow up appointment compliance. For at-risk patients, BLHC has one care manager who meets with the patient prior to discharge, creates a discharge plan for them, and follows up with the patient by phone. Under this care transitions project all of these efforts will be expanded. All patients discharged from the hospital will be set up with a follow up appointment with their continuity provider and will receive transition records electronically in a timely fashion. A PPS wide technology solution will be implemented to systematically identify patients not completing plans throughout the entire BLHC PPS provider network. Finally, additional care transitions managers will be deployed to ensure patients at-risk for readmission will receive and comply with discharge plans.

Finally, this project will capitalize and build upon on a variety of community based programs and organizations within the BLHC PPS network in order to prevent hospital readmissions. For example,



Comunilife and BHLC's have a joint Respite Program that provides housing, case management and support services. Program data shows that only 15% of the patients visited the ED within 30 days, and the program prevented readmissions for 71% of their respite population. There are also a variety of social and medical providers that are pivotal players in keeping patients out of the hospital and in the community. For example, the PPS has two Health Homes and several FQHCs within the PPS network that provide medical, specialty, care management and social services which will be further expanded in DSRIP. In addition, home care providers such as Visiting Nurses of New York, JASA, NAE Edison, and First Care of New York will be able to provide home care and/or social services to support discharge planning implementation, medication adherence, and follow up appointment compliance. Finally, the PPS has a variety of organizations that can meet the complex, needs of at-risk patients such as God's Love We Deliver which provides individually-tailored meals for recently discharged patients. This integrated network of service providers within the PPS will focus special efforts on the population that is at risk for 30 day readmission ensuring each patient has a transition of care plan and an assigned care manager, their primary care provider is notified of admission, and the patient returns to their primary care provider

- 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.

A major implementation challenge for this project is addressing the social determinants underlying the health care challenges faced by patients residing in the BLHC PPS. The population suffers from high rates of poverty, homelessness, incarceration, malnutrition, low health literacy, cultural and language barriers, and substance abuse which make it challenging to navigate health or social systems, and comply with treatment or discharge instructions. To address to this challenge, the BLHC PPS will capitalize on its available social service resources such as Dominican Sisters and BronxWorks who bring significant resources to help patients achieve better health.

Another challenge is locating patients "at-risk" within the 30 day readmission window. Many patients in the BLHC PPS are difficult to locate due to unstable housing, or incarceration. To address this issue, the project will implement 48 hour follow up protocols to reestablish contact with patients, use shared EHR systems to share patient status and location across care settings, and implement a community outreach protocol staffed by home health providers and/or patient navigators.

Another challenge is managing an increased workflow for PCPs and care coordinators. The PPS will address this challenge by training and repurposing staff, redesigning work flows and having all health care team members throughout the PPS work at that top of their scopes of practice.

- 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.

Working collaboratively with PPSs that overlap with the BLHC PPS service area is a high priority. The PPS will engage with all other PPSs in the NYC region through in-person meetings, webinars and/or conference calls. Though these convening's, the PPS will work with other PPSs to share best practices,



lessons learned, training materials, and other resources that are critical to the success of DSRIP. The PPS has initiated a strategic relationship with other PPSs within the service area. For example, the previously mentioned evidence based care transitions model that the BLHC PPS plans to expand was initially created by the anchor hospitals of the BLHC, St. Barnabas and HHC. There is a three way management letter among each of hospitals committing to work together on implementation issues. Moving forward, these hospitals will work collaboratively with each other and their PPS network providers to align their respective PPS efforts and to expand this model. In addition, the BLHC PPS and the Mount Sinai PPS have already begun joint planning to achieve economies of scale, and establish shared protocols. The BLHC/Mount Sinai relationship is fundamentally different than the BLHC relationship with the other PPS in that Mount Sinai has signed a support letter to work jointly on a program management office, MSO services, and other activities. Finally, the PPS will also be active contributors on the MIX in order to share best practices and lessons learned with PPSs in the NYC region and across the state.

**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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This will include hardware, such as computers, along with start-up software costs. This is expected to be the largest capital expenditure. Capital funding will also be needed to renovate space for program staff and coalition partners to work collectively together. Existing storefront offices within the community that serve to facilitate linkages to patient care will need to be renovated. In order to renovate space, the PPS must either do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to assist with screenings. In addition capital funds will be used to purchase medical equipment for sites or new clinics that will be implementing this project.

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Selfhelp Community Services, Inc. - Medicaid Care Transitions	The New York State Balancing Incentive Program (BIP) Innovation Fund	10/1/2014	9/30/15	The BIP Innovation Fund is designed to engage New York's broad network of providers, advocates, and community leaders in developing systemic improvements that address barriers encountered when providing community-based long term supports and services (LTSS) across all populations of Medicaid beneficiaries in the State. Up to \$45 million in Innovation Fund Grants were made available. Selfhelp received a BIP Innovation Fund Grant from New York State to expand its existing care transitions program



- 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 BIP Innovation fund supports an individual community based provider's care transitions program. This DSRIP project will support a PPS wide hospital and community based effort to improve care transitions across a variety of care settings throughout the Bronx and New York City.

**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

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

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

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



## Domain 3 Projects

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

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

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

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

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

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.

Any PPS undertaking one of these projects is recommended to review the resources available at <http://www.integration.samhsa.gov/integrated-care-models>.

*A. PCMH Service Site:*

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



*B. Behavioral Health Service Site:*

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

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

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

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

**2. 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 projects selected for this section are: 1) Co-locate behavioral health services at primary care practice sites, and 2) Implementing the IMPACT Model at primary care sites.

The CNA found that the integration between behavioral health and physical health services is poor and the system is fragmented. It also identifies behavioral health services as being in high demand with lower access in comparison to primary care. Approximately 53% of CNA survey respondents reported that behavioral health services were "available," compared to 77.6% who reported primary care services were "available." Further, since 85% of survey respondents noted that they have a primary care doctor, and 53% said they went to a primary care doctor's office for usual source of care, co-location could have a high-impact on this population. Co- location will also help address low utilization of behavioral health services because of the inconvenience of seeking care at multiple locations and the stigma associated with seeking treatment at a behavioral health location.

Approximately 22% of the Medicaid population in the PPS has a mental health condition, with approximately 8% suffering from serious psychological distress. The prevalence of substance



abuse is 8.5%. Developing programs to control Medicaid costs for this population is critical as they account for 7% (45,850) of condition-related inpatient admissions for the PPS. The CNA also found high rates of traumatic events/PTSD, which are known to be associated with medical and psychological morbidity.

Access to mental health providers and services was cited as a major problem in the qualitative and quantitative CNA. The qualitative CNA found that all of the patients questioned they were most enthusiastic about the proposed projects to address mental health and HIV. Also, a provider offered the following insight: "A lot of times we'll run into people who are just newly homeless because there's a psychiatric issue that a person has that clearly hasn't been diagnosed, much less gotten to the point where they've been able to get treatment. And even when you try to get somebody treatment in the community, the services are just not there. The few places that provide mental health services, they have waiting lists. We do our best to provide for our clients ourselves, but even our resources are limited. We even find it difficult to procure a psychiatrist on a part-time basis. So for me, that's the biggest, glaring need. Hard to even find a close second for that."

A majority of the physicians participating in the BLHC survey identified access to mental health services as being a significant gap that must be addressed.

Developing and expanding programs that tie primary care to behavioral health will increase access to the full spectrum of health services offered to PPS residents. Additionally, developing a multidisciplinary, team-based approach expands the depth of understanding that patients are individuals with unique biological, psychological, social, cultural and economic experiences. With this knowledge, providers are equipped to consider the whole person and provide individualized 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.

**Target Population for PROJECT A: Co-location of BH in Primary Care Services**

All individuals who access primary care services in the PPS (age 5 and over) will be screened to identify behavioral health conditions. Particular attention will be paid to high-need populations identified below.

- 1) Young adults (ages 17-25) with/without a diagnosed behavior health condition who are formerly incarcerated with diagnoses of Hepatitis C, HIV/AIDS, and trauma/violence
- 2) Adults (over 26) with/without a diagnosed behavior health condition who have comorbidities. Individuals with comorbidities tied to depression and anxiety, such as diabetes, HIV/AIDS, and trauma/violence, will receive focus. Additionally, low-income immigrants who often experience stress due to language/cultural barriers.

**Target Population for PROJECT C: IMPACT**

The framework of the IMPACT model is a multidisciplinary team delivering integrated behavioral health care. This model allows for customization to address the unique needs of patients.



Rather than dividing patients by diagnosis, it allows the program to overlap treatment teams and services to address the full needs of patients without requiring enrollment in multiple programs.

The two target populations are:

- 1) Pediatrics (ages 5-11) and Adolescents (ages 12-17) with/without a diagnosed behavior health condition of depression, anxiety, substance abuse, trauma, and attention deficit disorder.
- 2) Adults over 17 years of age with/without a diagnosed behavior health condition of depression, anxiety, substance abuse, insomnia, and PTSD and trauma.

- 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 BLHC PPS has two hospitals (BLHC), several FQHCs such as Urban Health Plan (UHP), community clinics, behavioral health providers, and community and social services organizations, such as VIP Services and HELP/PSI, Inc. who provide both primary care and behavioral health services. The Bronx Lebanon Hospital Center (BLHC) has psychiatric providers (psychiatrists and nurse practitioners) working in seven primary care clinics (four internal medicine clinics and three family medicine clinics) throughout the South Bronx community. UHP has seven FQHCs providing primary, medical specialty and behavioral health services in the South Bronx community. Among BLHC providers there is a child psychiatrist who offers services for children and adolescents at one clinical site. The current model of care at these sites is one of co-location. The goal is to transition to a fully collaborative model. With psychiatric providers, social workers and medical providers already in place, these clinics provide a sound framework on which to develop the collaborative care model proposed. This could serve as a model within the BLHC PPS. Psychiatric providers utilize the same electronic health record as medical providers at BLHC. In addition to having full access to clinical notes there is a secure health messaging system to facilitate communication around cases. Both BLHC and UHP have the ability to utilize patient registries to track the patients served by these providers. However there is a need to incorporate and/or expand these registries into for all primary care and behavioral health providers within the PPS the existing electronic health record to facilitate tracking, accuracy and clinical monitoring.

- 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 top four challenges to achieving the goals of the project are: 1) A lack of behavioral health specialists such as psychiatrists and psychologist; 2) A the need for the current workforce to be retrained and enlisted in new work in order to meet the needs in the behavioral health arena; 3) Linking patient information between providers; and 4) Patient follow up and commitment to treatment. Additional challenges include cultural and language barriers and stigma related to a



mental health or substance abuse diagnosis and treatment.

These challenges will be met by conducting education and sensitivity training with providers, developing a workforce retraining program to address the need for behavioral professionals, and linking organizations through the use of electronic medical records. Integration of tele health and supported online evidence based treatment for the most common behavioral health disorders seen in primary care will also be considered as a way to extend provider capacity.

Additionally, continuing education programs will be developed and implemented to create culturally and linguistically appropriate environments for this population. Most importantly, care management will be actively used to retain patients in primary and behavioral health services throughout the PPS network.

- 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.

All of the PPSs serving Bronx County, including the Bronx Partners for a Healthy Community PPS (the SBH-lead PPS) and the HHC PPS, will collaborate in order to ensure maximum use of resources and to reduce duplication of services during the implementation process. There is a three-way signed letter for each of the PPSs, committing them to working together on implementation. The goal being to further align plans for collaboration in order to will ensure that all of the Bronx community-based partners and providers are working under a common set of goals, metrics and care models across all Bronx County PPSs.

As such, a joint PPS planning committee will be developed and will begin to meet in 2015 in- person, by phone and through webinars to coordinate this project through the sharing of best practices, lessons learned, and training materials. The overarching goal of these convenings will be to develop strategic partnerships and to share information in order to provide for seamless implementation of the project and to ensure that the maximum number of patients receive the care they need.

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

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

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

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

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress



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

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

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

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

Yes	No
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This is expected to be the largest capital expenditure. Funds will also be needed to renovate space for program staff and coalition partners to work collectively together. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to assist with screenings. In addition capital funds will be used to purchase computers, tablets and phones for the social workers and others who will be participating in the screening process, and those providing the interventions. In some instances, capital may be required to expand (build out) capacity to provide primary care services. Capital will be required to renovate existing storefront offices within the community that serve to facilitate linkages to patient care.



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

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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



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

5. **Domain 1 DSRIP Project Requirements Milestones & Metrics:**

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

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

- c. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.
- d. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.



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

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

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

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

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

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

##### **1. 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.



Diabetes is a major cause for morbidity and mortality in the Bronx, and is the fifth leading cause of premature death in people who are less than 65 years of age. Approximately 10% of the total Medicaid population in the BLHC PPS has diabetes, with 3% of this population experiencing condition-related utilization and hospital admissions. Approximately 69% of the Diabetes Composite (PQI S01) hospitalizations are attributed to the BLHC PPS. In 2012, there were 792 potentially avoidable hospitalizations for short-term diabetes complications (PQI 01) among Bronx Medicaid beneficiaries, of which the BLHC PPS accounts for 550 (69%). There were 1,585 potentially avoidable hospitalizations for long term diabetes complications (PQI 03) among Bronx Medicaid beneficiaries, of which the BLHC PPS accounts for 1,091 (68%). Additionally, there were 327 cases of uncontrolled diabetes (PQI 14) in the Bronx, of which 255 (77%) were attributed to the BLHC PPS. Lastly, of the 136 lower-extremity amputation among patients with diabetes (PQI 16), 71 (52%) were patients in the BLHC PPS. The CNA concluded that “Many community members see diabetes as their greatest health concern.”

According to CNA survey results and feedback gathered during focus groups, community members identify diabetes as their top health concern. Lack of food security and access to nutritious meals, and lack of safe places to exercise was another challenge noted, which negatively impacts the health outcomes and well-being of people living in the South Bronx. The survey also revealed that there is room for improved care coordination across the healthcare system. Respondents also indicated that they often have difficulty communicating with their providers, which results in poorer health outcomes. All this data provides overwhelming support for the implementation of this project and the need to improve the management of diabetes.

This project will help bridge many of the gaps identified in the CNA. Specifically:

Increase capacity of practices within the PPS to provide evidence-based, comprehensive patient centered care to patients with diabetes.

Greater emphasis on care coordination, and the inclusion of primary care, will provide more seamless access to care and needed services to maintain health and keep patients out of the hospital.

Care coordination teams will be composed of a diverse array of providers to address medical, non-medical, and cultural needs to prevent avoidable ER visits and hospitalizations Risk stratification of the population to meet the need through a “hot spotting” strategy.

Patient management program for high cost health care users.

Enhanced focus on patient centered care to promote self-management and self-efficacy.

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



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

The patient population for this project is all Medicaid beneficiaries with uncontrolled diabetes, or diabetes with any of the following comorbidities: hypertension, coronary artery disease, or mental health conditions living in the BLHC PPS.

“Uncontrolled diabetes” is defined the following way for this project:

Medicaid patients with an A1c value greater than 9%

Medicaid patients with diabetes + hypertension, coronary artery disease, or mental health conditions

The PPS will focus primarily on Medicaid beneficiaries with comorbid mental health conditions and those with multi-morbidity patterns as they are at very high risk for preventable hospitalizations and are known to be high cost health care utilizers. This project will target beneficiaries with other medical and mental health conditions because these are the people with the most complex diabetes cases, and the population that the PPS will have the greatest ability to impact by way of improving health outcomes and reducing costs. The PPS believes that this population will benefit the most from “hot spotting”, care coordination, and methods to promote patient centered 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.

Patient Centered Medical Homes (PCMH) and Health Homes (HH) will lay a critical foundation for the implementation of this project by way of care coordination expertise, disease management, dissemination of evidence based best practices, and workforce strategy. Providers within the PPS are positioned to achieve PCMH certification and advanced PCMH certification. The PPS has two HHs (BLHC HH and CCMP), which can be leveraged to provide care management services.

The PPS has several PCMH certified safety net providers and a key strategy will be ensuring that all participating providers are trained in providing evidence-based diabetes care and are prepared to employ coordinated care teams. Urban Health Plan, a network of FQHCs, has successfully piloted an interdisciplinary team approach with significant improvements in diabetes control. DSRIP will support the expansion of evidence based models of care for patients with uncontrolled diabetes. The goal of this project is to achieve transformation through full deployment of evidence based guidelines and team based care. The care coordination team framework is based upon PCMH team care principles and will include primary care providers, medical specialists, social workers, community health workers, pharmacists, and nurse coordinators.

One of the project requirements states that 80% of the PCPs in the network must be engaged in this project. The PPS is confident that the PCPs at these PCMH and HH sites, along with all other participating partners, can be mobilized to meet this requirement through extensive outreach efforts.

The PPS will leverage the Community Based and Social Services Organizations in the service area and build upon their networks. The PPS will create community care coordination teams to provide proactive



integrated care. Training of the entire staff on how to effectively work with Medicaid beneficiaries with uncontrolled diabetes is a key strategy. Training will include promoting cultural and linguistic proficiency, patient self-efficacy and diabetes self-management.

Meals on Wheels programs, transportation services, dental providers, podiatry, and optometry, and behavioral health services will be engaged. Food security, transportation to and from medical appointments, and access to dental and vision services are critical to the patient centered management of diabetes and as such, the PPS will create referral pathways to ensure that patients have access to the full continuum of services across care systems. The goal is to promote a patient centered approach, and ensure our target population has access to the necessary resources to manage their diabetes.

The use of a data sharing platform across the PPS will enhance care management and coordination as well as avoid unnecessary health care costs.

DSRIP will provide an opportunity to transform the BronxCare Diabetes Centers of Excellence. The PPS will explore partnerships with innovators such as the Joslin Diabetes Center to develop better and more cost-effective services for diabetic patients. This Center of Excellence currently provides counseling and educational services, and will be an important implementation resource.

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

One challenge relates to workforce issues, specifically shortages of PCPs and providers who specialize in care management. To address this challenge, we will recruit, incentivize, and train midlevel providers. We will also deploy “mobile teams” to increase access to care, and also implement a shared medical appointment system. Training will be provided on case coordination and management.

Addressing patient health literacy will also be a challenge. Care coordination teams will play an integral role in addressing this challenge as they will assess patients’ levels of health literacy to provide patient centered learning and navigation services to engage patients.

Interdisciplinary care coordination teams will address a number of challenges: access to nutritious meals and safe places to exercise, medication adherence resources, insurance status, and transportation. We know our target population often lacks access to these needed resources, which compromises their health. Health Homes Care coordination teams will work with patients to identify these needs and provide referrals to community partners as necessary. Shared medical appointments and use of retinal scans will help to address the burden on patients of attending multiple appointments on different days.

Current IT infrastructure & disease registries used to track patients do not support interoperability or population health management. These systems need to improve so that patient care can be properly tracked and are not lost to follow-up. DSRIP provides new opportunities to strengthen this component of implementation



- 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.

Working collaboratively with PPSs that overlap with our service area is a high priority. Our PPS will engage with all other PPSs in the NYC region through in-person meetings, webinars and/or conference calls. Though these convenings, we will work with other PPSs to share best practices, lessons learned, training materials, and other resources that are critical to the success of DSRIP. BLHC PPS has signed a letter with HHC and St. Barnabas Hospital PPS in a strategic agreement to work on implementation issues jointly. We have already started building a strategic relationship with the Mount Sinai PPS to do joint planning, achieve economies of scale, and establish shared protocols.

Once we enter the implementation phase of DSRIP, our PPS will also need to engage with other PPSs in our region who have selected project 3.c.i, so that we can all work collaboratively with one another to ensure that our efforts to implement this project are aligned to the best extent possible. The Mount Sinai PPS will be a key strategic partner in the planning and implementation phase of this project. The PPS will also engage the Medicaid managed care organizations as well as the NYC DOHMH.

We will also be active contributors on the MIX in order to share best practices and lessons learned with PPSs in the NYC region and across the state.



**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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This will include hardware, such as computers, along with start-up software costs. This is expected to be the largest capital expenditure. Capital funding will also be needed to renovate space for program staff and coalition partners to work collectively together. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to coordinate patient care. In addition capital funds will be used to purchase medical equipment for sites or new clinics that will be implementing this project.



Capital funding will also be necessary to renovate existing storefront offices within the community that serve to facilitate linkages to patient care.

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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

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

**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

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

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



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of project requirements, scale of project implementation, and patient engagement progress in the project.

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



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

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

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

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

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

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

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

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



Asthma is one of the top health concerns of people living in the Bronx, contributing to high numbers of preventable hospitalizations and morbidity, particularly among young adults and children. Among children in the Bronx who are Medicaid beneficiaries, the asthma rate of 701.47 per 100,000 is startlingly higher than the NYC overall rate of 426.91 per 100,000. Of the total 733 Asthma in Young Adults Prevention Quality Indicators (PQI) hospitalizations, 566 were attributed to BLHC PPS (77%). The Bronx Lebanon Hospital Center (BHLC) sees ~8,000 pediatric ER visits annually. About half of the children make more than one visit per year due to asthma crisis. Approximately 52.6% of asthma preventable PDI hospitalizations in 2012 were among very young children ages 2-5.

In adults, while the PQI for respiratory admissions has declined in the Bronx since 2009, it still remains high above the expected rate. In 2012, out of the 10,486 Medicaid PQI hospitalizations in NYC, 32%, or 3,383 of those PQI hospitalizations happened in the Bronx. The BLHC sees ~8,000 adult ER visits annually, and ~1,000 get admitted. Of those that are admitted, 10-15% are re-admitted within 30-days.

The CNA also highlights the impact that indoor/outdoor housing conditions and environmental factors have on triggering respiratory conditions such as asthma.

The PPS data also shows that asthma health care resources are plentiful in the services areas where rates of preventable hospitalizations are high, indicating that while the resources are available, people may not always have the means of accessing resources or have the tools to utilize services most effectively. They may also simply not know these resources exist. Additionally, the data indicates that gaps remain in access to culturally and linguistically competent providers. This project will bridge this gap by training and mobilizing Community Health Workers (CHWs) and other networks of trusted and well-established community based organizations (CBOs) in the implementation of this project. There also appears to be a correlation between serious housing violations and PQI data, further supporting the importance of home-based interventions.

Combined, this data provides overwhelming support for the implementation of this project and the need to fulfill the project requirements.

Although there are a number of environmental factors that exacerbate asthma in the Bronx, our goal is to implement an asthma home-based self-management program. Through the implementation of this project, the PPS will implement evidence based asthma management guidelines with the goal of giving Medicaid beneficiaries and their families the tools they need to minimize their exposure to asthma triggers in their home, and develop skills on how to access external resources to better manage their asthma and related symptoms.



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

The patient population for the project is all child and adult Medicaid beneficiaries with asthma living in the South Bronx. More specifically, this project will reach the following populations:

Children and adults with an asthma diagnosis

Children and adults who have used the ER or have been hospitalized at least once in the past year due to exacerbations associated with their asthma diagnosis

Children and adults who have received an oral steroid or received nebulized treatment at least once in the ER, hospital, or primary care setting

This PPS selected this patient population based on the CNA, and due to the fact that DOH has been promoting the uptake of more interventions targeted at adults. While the PPS will target Medicaid beneficiaries living in the South Bronx, the will focus on reaching those living in Mott Haven and Hunts Point as the CNA indicated that a high number of preventable hospitalizations occur in that area.

By embedding CHWs in hospital and primary care settings, education and navigation services can start immediately, providing linkages to community providers and other resources to promote enhanced self-management in their homes. The CHWs will also be trained under a comprehensive and standardized process to ensure consistency and to ensure they have the skills to work with the target population. This will include provision of care management and asthma education focused upon proper medication use, avoidance of triggers, monitoring of symptoms, and use of written asthma actions plans.

- 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.

BLHC is highly involved in asthma education efforts. Recently, they have been involved in asthma education, training, and surveillance in 60 daycare centers in the Bronx. BLHC also recently were the lead organization for South Bronx Asthma Partnership where they trained physicians, collaborated with pharmacies, and worked with CBOs, and developed educational materials.

BLHC, and our key partner BronxWorks, has multi-level expertise to build upon. Both are trusted and well-established institutions in the Bronx. BronxWorks employs dozens of case managers that provide housing court advocacy and two full-time employees that work within each housing court. This project will allow us to strengthen and expand upon this existing structure. The BronxWorks HomeBase just established an office in Community District 1 where there are over five NYCHA complexes.

A 2011 Census Bureau report revealed public housing units have four times as many roach infestations



as private apartments, and the asthma rate in public housing is up to three times higher than private apartments. The BronxWorks HomeBase is well positioned to address the needs of our target population living in public housing units, and to promote home-based self-management programs among these high-risk populations.

Urban Health Plan (UHP), an FQHC network, received an award from the EPA in 2009 for excellence in asthma management and participated in a business case for quality with the NYC DOH in which UHP's health care costs in the treatment of asthmatics were 22% less for adults and 39% less for children compared to other network providers. Both BLHC and UHP are well positioned to ensure that all providers within the PPS are trained on asthma treatment based on evidence based guidelines including ensuring that all patients receive an asthma action plan and are retained in primary care.

Another key partner, A.I.R.NYC, has a number of resources and best practices that will be expanded upon. Since 2001, A.I.R.NYC has been helping asthmatic children and their families manage this chronic disease, and their efforts have resulted in a 64% reduction in ER visits for children suffering from asthma. Additionally, A.I.R.NYC partners with the Bronx office of the Administration for Children's Services and a number of housing shelters.

As indicated in the CNA, there is a high volume of asthma health care resources in the target service area that will be mobilized for this project. The PPS will build upon the resources and expertise of these CBOs and mobilize and retrain CHWs to implement this project. These CBOs will also be critical in helping us recruit additional CHWs.

Local exterminators are also critical to this project. As the relationships build between the target population and the CHWs, and home visits start happening, cockroach infestations will likely be detected as environmental triggers, and exterminators will need to be called upon to address the environmental trigger.

The strength of the proposed intervention is that this model can be easily adopted by other CBOs with experience in child welfare and those that operate home visiting programs.

- 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.

Engaging our target population and their families will be our greatest challenge. To successfully implement this project, individuals and their families will need to be motivated to take control of their home environment, and to manage their asthma symptoms. To address this challenge, the PPS will partner with trusted, well-established community based organizations and draw upon the networks of CHWs to connect and engage with our target population. The PPS will also partner with public housing sites. The two Health Homes in the PPS and the social services organizations will be leveraged to provide care management support to patients with uncontrolled asthma. Additionally, CHWs will be placed in hospital and primary care settings to support relationship-building in a variety of places.

Another challenge revolves around workforce issues, specifically hiring and training all CHWs that are necessary to implement this project. The CHWs working on this project will undergo a comprehensive training process that's standardized to develop appropriate communication skills, cultural competency, and navigational skills. This training will also be transferable so that non-CHWs can be trained, resulting in a more diverse array of providers with these skills.

IT infrastructure, specifically a shared data sharing platform, needs to be implemented to support the flow of client information among all providers participating in this project and in the PPS. Communication between providers is critical. DSRIP provides new opportunities to strengthen this necessary component of implementation.

- 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.

Working collaboratively with PPSs that overlap with the BLHC PPS service area is a high priority. The BLHC PPS will engage with all other PPSs in the NYC region through in-person meetings, webinars and/or conference calls. Though these convening's, the BLHC PPS will work with other PPSs to share best practices, lessons learned, training materials, and other resources that are critical to the success of DSRIP. The BLHC PPS has already started building a strategic relationship with the key PPSs in the Bronx (HHC and St. Barnabas Hospital PPS) by having signed a strategic commitment letter to work together on implementation issues for DSRIP in the Bronx. In addition, the Mount Sinai PPS and BLHC PPS will do joint planning, achieve economies of scale, and establish shared protocols—this is as part of the strategic support letter with Mount Sinai.

Once we enter the implementation phase of DSRIP, the BLHC PPS will also need to engage with other PPSs in the region who have selected project 3.d.ii, so that we can all work collaboratively with one another to ensure that efforts to implement this project are aligned to the best extent possible.



The BLHC PPS will also be active contributors on the MIX in order to share best practices and lessons learned with PPSs in the NYC region and across the state.

**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)***

<b>Yes</b>	<b>No</b>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

This project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. Having a functional IT system is critical to allow various providers to



communicate with one another. This will include hardware, such as computers, along with start-up software costs. This is expected to be the largest capital expenditure with many project partners already requesting such funding. Capital funding will also be needed to renovate space for program staff and project partners to work collectively together. New space and workrooms will be necessary to help the CHWs connect with our target population. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers, and phones for the team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to assist with patient engagement and navigation services. Capital funding will also be necessary to renovate existing storefront offices within the community that serve to facilitate linkages to patient care.

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

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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

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

**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the



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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.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

**Project Objective:** To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the first two years of the child's life.

**Project Description:** High risk pregnancies do not end with the birth of the child, but can continue with high risk parenting situations. Women with high risk pregnancies due to age, social situation or concurrent medical or behavioral health conditions may need significant support beyond obstetrical care to grow a healthy child. Nuclear families and single mothers may not have access to functional parenting skill advice to assist them in the crucial first two years of a child's life.

**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.

For performing partner systems where the community assessment identifies significant high risk obstetrical/parenting cases, there are **three models** for intervention that may be utilized for this project. Systems should choose one primary project but may also choose requirements from the other two projects to add as part of their project.

*Model 1: Implementation of an evidence-based home visiting model for pregnant high risk mothers including high risk first time mothers. Potential programs include Nurse Family Partnership.*

1. Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high-risk mothers including high-risk first time mothers.
2. Develop a referral system for early identification of women who are or may be at high risk.
3. Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.
4. Use EHRs or other technical platforms to track all patients engaged in this project.

*Model 2: Establish a care/referral community network based upon a regional center of excellence for high risk pregnancies and infants.*

1. Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).
2. Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high risk mother and infant with local community obstetricians and pediatric providers.
3. Develop service MOUs between the multidisciplinary team and OB/GYN providers.
4. Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.



5. 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.
6. 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.
7. Use EHRs or other IT platforms to track all patients engaged in this project.

*Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program.*

1. Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.
2. Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.
3. Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.
4. Establish protocols for deployment of CHW.
5. Coordinate with the Medicaid Managed Care organizations serving the target population.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

### **Project Selection**

For this project, one of the following three project models can be selected. Please indicate which of the three will be chosen:

- Model 1: Implementation of Nurse-Family Partnership program model for pregnant high risk first time mothers.
- Model 2: Establish a care/referral network based upon a regional center of excellence for high risk pregnancies and infants.
- Model 3: Implementation of a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaborative (MICHC) program.

### **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 PPS will develop a Community Health Worker (CHW) program based on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program and will also utilize a Nurse-Family Partnership program to reduce avoidable poor pregnancy outcomes. Pregnancies in the South Bronx are often complicated by one or more of the social, economic, and environmental factors reported in the CNA. The project will fill gaps identified in the CNA including: 10.5% of the BLHC PPS births are to women who received late or no prenatal care and 9.7% of births are low birth weight. The BLHC PPS has a higher percentage of births between ages of 15-19 in comparison to the Bronx and NYC overall and births to teens are high risk. 82% of the births are Medicaid or self-pay compared to 75% for the Bronx overall. Racial disparities exist in the Bronx; there are 1.4 times the number of preterm births for blacks and 1.2 times for Hispanics as compared to non-Hispanic whites. In the qualitative CNA, patients agreed that programs to reduce pre-term births are critical, and they suggested additional programs to reduce teen pregnancy. The goal of the project is to develop new resources in order to improve maternal and child health outcomes; reduce preterm births; decrease the number of low birth weight babies born; reduce infant mortality and maternal mortality; increase well baby visits; and reduce the rates of avoidable hospitalizations and emergency room utilization. Targeting the most at-risk women and children will decrease preventable and costly admissions. The new resources include CHWs and an interdisciplinary care team to address the medical and psychosocial concerns of the enrolled families. The team will include NYS DOH-trained CHWs at the front-line and supervisory/coordinator level, social workers, nurses, nutritionists, mental health, primary care clinicians (obstetricians, pediatricians and family medicine practitioners) and community based and social service providers who will co-manage the high-risk families enrolled in the program through the first two years of the child's life. The team will support CHWs based at all committed provider sites in the PPS. The PPS will recruit and hire experienced CHWs who understand the cultural needs of the diverse PPS population and will deploy them in the community and in participants' homes according to protocol. When participants are members of Medicaid managed care plans the CHW and interdisciplinary care team will coordinate with the care managers at the plan. Providers participating in this project will use a common IT platform to securely share participant information and to generate the reports needed for both quality assurance and DSRIP Project Requirements Milestones and Metrics. The Nurse-Family Partnership will work hand-in-hand with the CHW program through early identification of women at high risk, cross-referral, secure sharing of relevant patient information, participation in the interdisciplinary care team, and direct provision of home-based services. Clinical protocols will determine if an intervention is appropriate for CHW- or NFP-level intervention so there is no duplication of service.

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

The patient population to be engaged includes:

- High risk pregnant women and their infants
- NICU patients and their families



- High-risk women of childbearing age residing in zip codes 10451-60, 10468, and 10472-74. These zip codes include the poorest district in the nation, the South Bronx, with approximately 40 percent of residents, roughly a quarter-million people, living below the federal poverty level.

The CNA data cited above demonstrate the significant maternal and infant health risks for this community. Social risks and high need accompany these health risks. These communities, while strong in character, struggle with major illnesses related to poverty. The CNA identified that South Bronx residents are even more likely than the average Bronx resident to be without a regular physician and to visit the emergency room for non-emergent and primary care treatable conditions. More than half of the Bronx population is uninsured or insured by Medicaid. More than a third of borough residents are foreign born and English is spoken as a second language in more than half of the Bronx households. High-risk women and children up to age two will be recruited from sources including the participating hospital's high-risk pregnancy clinic and NICU, community health centers, cross-referrals among project partners and providers, and referrals from community-based organizations.

- 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.

Current assets and resources include:

- Bronx Lebanon Hospital Center's (BLHC) home visiting services through Healthy Families and Early Head Start programs
- BLHC Level 3 Neonatal Intensive Care Unit, which served over 600 premature infants last year
- BLHC's Woman's Health Clinic
- BLHC's pediatrics department
- Visiting Nurse Service of NY's experienced, evidence-based Nurse-Family Partnership
- Urban Health Plan's FQHC network including its OB-GYN Services and its MICHC program, the only one of its kind in the Bronx, which will be expanded to reach the attributed population in DSRIP.

Combining these community resources makes for a strong model of care and service. One important resource that drives and dictates staffing for the CHW model is NYS DOH CHW program standards and the number of patients to be served is directly related to the staffing levels prescribed by NYS DOH in its CHW model. These existing community-based programs need additional resources as they have not had the benefit of an interdisciplinary care team, formalized referral structures, or data sharing mechanisms, all of which will be developed through this project. In addition, the PPS will continue to partner with a rich assortment of community-based and social services organizations serving at-risk families.



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

One organizational challenge is creating an IT network sharing and referral system. The PPS will address this by collaborating with the PPS CMIO to expand the current EMR to include referral feedback loops with community partners with a built in alert system that will indicate when a referral has been made or when a patient has missed an appointment.

According to the CNA, other barriers to care include: 1) difficulty in understanding the provider/excessive medical jargon; 2) language barriers; and, 3) inadequate time and attention from the physician. To address these issues, the PPS will: 1) train staff on how to optimally communicate with the patient population; 2) hire bi-lingual nurses, community health workers and social workers who can communicate with the patients in their own language and are familiar with patients' cultures; and, 3) hire nurses, community health workers and social workers who can act as physician extenders to explain medication adherence and compliance, necessity of appointments, and self-care, and link patients to care in the community. In addition there are multiple cultural, social, and other barriers facing women seeking prenatal care that participating providers have extensive experience addressing through existing outreach programs to at-risk women, children and families.

- 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.

Working collaboratively with PPSs that overlap with the BLHC PPS service area is a high priority. The PPS will engage with overlapping PPSs through in-person meetings, webinars and/or conference calls to share best practices, lessons learned, training materials, and other resources that are critical to the success of DSRIP. Upon entering the implementation phase, the PPS will also need to engage with other PPSs in the region who have selected project 3fi, so that all can work collaboratively with one another to ensure that efforts to implement this project are aligned. A key element in collaboration is the implementation of a Health Information Exchange (HIE) system for the sharing of key patient information digitally across the entire PPS. As the project advances, all existing infrastructure will be fully leveraged. When no systems or processes are in place, a platform will be implemented to support collaboration. Interoperability will be stressed as the PPS establishes a robust platform and processes for information sharing.



**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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The PPS will require capital funding to obtain the necessary IT to create intra- and inter-agency information sharing, and to renovate space for program staff and coalition partners. The space will serve to house all program staff together, including community based coalition members. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the coordination of outreach, the multidisciplinary team and CHW/NFP activities. The project also require capital funds to renovate existing storefront offices within the community that serve to facilitate linkages to patient care. In addition, capital funds will be used to purchase computers, tablets and phones for the outreach workers and NFP nurses who will be making home-based visits to high-risk families and will need mobile equipment to securely record and transmit patient data. Capital funding will also be required for nursing equipment such as infant scales.



- 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?

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

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

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

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

**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

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

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

- a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed



by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

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



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

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

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

**Project Requirements:** The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under “Interventions to Promote Mental Health and Prevent Substance Abuse”

([http://www.health.ny.gov/prevention/prevention\\_agenda/2013-2017/plan/mhsa/interventions.htm](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm)).

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

**Partnering with Entities Outside of the PPS for this Project**

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

Entity Name
NYC DOHMH

**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.



#### Participate in MEB health promotion and MEB disorder prevention partnerships

Approximately 22% of the Medicaid population in the PPS has a mental health condition, with approximately 8% suffering from serious psychological distress. The prevalence of substance abuse is 8.5%. Developing programs for this population is critical as they account for 7% (45,850) of condition-related inpatient admissions for the PPS. The CNA also documents that on average more than 38% of households in the PPS live below the FPL. In some neighborhoods, it is as high as 47%. The median household income is \$34,300 compared to \$51,865 in NYC. The literature supports the fact that poverty impacts mental illness both directly and indirectly. As such, this project will focus on integrating poverty services into primary care and behavioral health. Specifically, the project will focus on building infrastructure and collaboration between community based agencies whose interventions directly reduce poverty.

The CNA also documents domestic violence as a significant community concern that has received inadequate attention. 31% of survey respondents indicated that health education programs on domestic violence are needed in their communities, and a key informant indicated that 100% of children in an early childhood program had witnessed domestic violence. Further, a key informant stated “when you come from communities who have been just so devastated by war and trauma, that what was happening to the fathers and their uncles is that a lot of times they didn’t get treatment. They were totally traumatized...” In response to the pervasive problem of domestic violence, and the gap in services that exists, this project proposes to develop and expand home-visiting programs to prevent disorders among youth and strengthen families. The project will also develop trauma informed care capacity to reduce the impact of traumatic experiences.

#### Expand efforts for Collaborative Care

The CNA documents that community members marked substance use and alcohol abuse as pressing issues. This project will work toward substance abuse prevention using the collaborative care SBIRT model, which will be implemented in PPS participating primary care clinics. Additionally, peer support is widely regarded as an essential component of behavioral health care. Peers work in collaboration with integrated care teams to provide person-centered, recovery-oriented care. Expanding access to peer support services could reinforce current initiatives that aim to reduce readmissions, improve transitions of care and increase community-based recovery and healing. In addition to available face to face peer services, closely moderated online peer support programs can also provide needed social supports for maintaining physical and emotional health.

#### Provide cultural and linguistic training on MEB promotion, prevention and treatment

The CNA documents that approximately 14,000 residents (1% of the total population) migrated from abroad less than a year ago. According to US Census, there are 24 different languages spoken in homes in the Bronx, with the majority being Spanish or Spanish Creole (46.4%) and



English (43.2%). For a quarter of the PPS, they speak English “not very well.” Immigrants face higher levels of stress which impacts long-term mental and physical health and increases poor health outcomes. According to the CNA, gaps remain in the availability of culturally and linguistically competent providers. Also, in the CNA, residents identified low quality and reliability of language services offered. This project will address this gap by providing training to behavioral health providers on how to deliver culturally competent care throughout the behavioral health system, public education about MEB resources in immigrant communities, and the role of stress on mental and physical health and poor health outcomes.

The CNA documents that approximately 14,000 residents (1% of the total population) migrated from abroad less than a year ago. According to US Census, there are 24 different languages spoken in homes in the Bronx, with the majority being Spanish or Spanish Creole (46.4%) and English (43.2%). For a quarter of the PPS, they speak English “not very well.”

Immigrants face higher levels of stress which impacts long-term mental and physical health and increases poor health outcomes. According to the CNA, gaps remain in the availability of culturally and linguistically competent providers. Also, in the CNA, residents identified low quality and reliability of language services offered. This project will address this gap by providing training to behavioral health providers on how to deliver culturally competent care throughout the behavioral health system, public education about MEB resources in immigrant communities, and the role of stress on mental and physical health and poor health outcomes.

- 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 patient population expected to be engaged in the project is representative of the PPS and supported by the CNA. For the trauma informed care program, the focus will be on:

Pediatrics (2-11) and adolescents (12-17) who have experienced trauma, violence, or neglect.

Low-income parents or caretakers will also be a focus for the home visiting program, which will contain components of trauma informed care (i.e., recognizing symptoms of trauma and developing coping strategies), in order to help prevent violence, teach parents how to interact with their children, and to recognize the signs of behavioral health conditions.

Victims of domestic violence and other acts of violence will also be a focus for the trauma informed care program.

Community based organizations that serve residents in the PPS with low socio-economic status will be the focus for building the structure to integrate poverty services into primary care and behavioral health. This population will also benefit from the home visiting program as well.



All provider types in the BLHC PPS who treat a large number of immigrants will be the target for cultural/linguistic training. Additionally, providers who have not traditionally treated the behavioral health population and are being re-trained to provide such services to this population will also be a target.

Adult high risk drinkers or those who have a known substance abuse problem will be the target for the efforts to expand collaborative care using the SBIRT model, in addition to smokers as tobacco is well known as a gateway drug. Additionally, the CNA demonstrates that over half (54.4% or 9,215/16,942) of Bronx clients with mental health conditions also have one or more physical chronic health conditions. Thus, an additional focus will be those with comorbidities as this data supports the need for coordinated behavioral and physical health 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.

BLHC has extensive experience utilizing the SBIRT model and motivational interviewing, as well as co-location of services to serve this population. Currently, there is co-location of psychiatric services in several of Bronx-Lebanon's outpatient clinics. The resources that may be pooled from this group include utilizing mental health specialists to educate and train non-medical staff and for selection of clinical scales. Further there is a plan to expand the co-location model to one of collaborative care model across outpatient sites in the PPS—this plan will be developed more fully during implementation planning, to be timely submitted to the state. The experience of co-location of services is an invaluable asset to draw on in this effort.

With regard to reaching out to patients at a population level for trauma, mental health and substance use screening is the perfect complement to this model. The collaborative care infrastructure being developed in parallel throughout the PPS will provide a resource for serving the mental health needs of those patients determined to be at high risk. Thus, in addition to expanding the base of patients reached, this PPS includes the resources necessary to facilitate the next step in patient care. The collaborative care model also features a registry for tracking patients and utilizes the electronic health record which will facilitate the process for this program.

Social services are critical here. The CNA identified a wide variety of community based agencies that reside in the PPS who will be active in this project. Food pantries, financial assistance and support programs, clothing and furniture banks, employment support services, visiting nurse services, and housing advocacy agencies, to name a few. All of these agencies will serve as tools to help recruit and identify the patient population that will be engaged by implementation. The project will work with community organizations to develop the tools and models to be utilized to effectively implement this project, including poverty reduction interventions.



Several community based organizations including VIP Services, Narco Freedom Inc., Comunilife, and St. Christopher's Inn provide critical social and medical services to the target population and will be an integral partner in the successful implementation of the project. The PPS will rely extensively on its community partners in this effort—the hospital cannot do this work by itself. Community workers, trained and organized through the PPS, are going to be the most important asset in this project to helping deliver care to patients. This is where the Steering Committee and the Workforce Committee will have to organize the plans and execution of those plans.

- 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 top five challenges to achieving the goals, and the steps for addressing those challenges, of the project are:

The need for the current workforce to be retrained to handle behavioral health patients and the recruitment of more social workers, nurses, and case managers to help with the home visiting program. The Workforce Committee has been working extensively with SEIU to develop a new overall training program. Specific, technical work will be needed to help the provider groups working with this population to be trained appropriately.

Linking patient information between providers. As with all projects, there is a need to develop electronic medical records. The IT Committee is currently reviewing options for a PPS-wide EMR, and this will be a critical step.

Unfamiliarity with trauma informed care and other models of care to be used. The work under this program will be new to providers in the BLHC PPS, and again training will be required to prepare staff to help patients under this program. This will include developing a new curriculum and finding trainers experts in these issues to deliver on that curriculum.

A large population of English as a second language patients. Cultural literacy training will be needed to help promote understanding and compliance with treatment.

Patient follow up and commitment to treatment. Outreach coordinators will need to help motivate compliance with future care steps—this will require hiring and new staff training by the PPS.

Part and parcel of this work is the need to overcome mental health stigma in general. As a society, mental health stigma is something we have not been able to overcome, but training and attention to these issues are critical for successful diagnosis and treatment. Continuing education programs will be developed and implemented to create culturally and linguistically



appropriate environments for this population, and educating the population on the importance of accessing care in order to address behavioral health issues.

- 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.

All of the PPSs serving Bronx County, including the Bronx Partners for a Healthy Community PPS (the SBH-lead PPS) and the HHC PPS, will collaborate in order to ensure maximum use of resources and to reduce duplication of services during the implementation process. The goal being to further align plans for collaboration in order to will ensure that all of the Bronx community-based partners and providers are working under a common set of goals, metrics and care models across all Bronx County PPSs.

As such, a joint PPS planning committee will be developed and will begin to meet in 2015 in-person, by phone and through webinars to coordinate this project through the sharing of best practices, lessons learned, and training materials. The overarching goal of these convenings will be to develop strategic partnerships and to share information in order to provide for seamless implementation of the project and to ensure that the maximum number of patients receive the care they need. NYC DOHMH will contribute data, tools and training.

- 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 joint planning committee, which is made of representatives from overlapping PPSs, will begin to meet in January 2015 to complete the detailed Implementation Plan, which will be submitted by March 2015.

The PPS has identified a number of key milestones in this implementation planning process, including:

Convening a cross-PPS Joint Planning Committee that will meet on a monthly basis from January 1-March 31, 2015

Establishing a work plan and timeline for project implementation no later than February 27, 2015

Agree upon project commonalities and shared resources no later than February 27, 2015

Agree on shared data platform no later than February 27, 2015

## 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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The project will require capital funding to obtain the necessary IT to create intra- and cross-agency information sharing. This is expected to be the largest capital expenditure. Funds will also be needed to renovate space for program staff and coalition partners to work collectively together. In order to renovate the space, the PPS must do limited construction and purchase office equipment, computers and phones for the multidisciplinary team members. This will facilitate the multidisciplinary teams being together on site, when necessary, to assist with screenings, home visits, and development of training tools for the cultural and linguistic training. In addition capital funds will be used to purchase computers, tablets and phones for the social workers and others who will be participating in the screening process, and those providing the interventions. Renovate existing storefront offices within the community that serve to facilitate linkages to patient care will also need to occur, as will construction of additional care sites, in some cases.

- 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
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**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. 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. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its populations and successfully meet DSRIP project goals.

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

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



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

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

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

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

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

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

#### **Partnering with Entities Outside of the PPS for this Project**

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



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Entity Name
NYC DOHMH



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**Project Response and 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.

With access to proper treatment, HIV does not always progress to AIDS. Yet AIDS is the fourth leading cause of death in the Bronx. In 2012, out of the 53,901 Medicaid beneficiaries living with HIV in New York State, one of the largest number of HIV positive individuals were those living in the Bronx with 15,674 total HIV cases, which is 31% of the total NYC Medicaid beneficiaries. There were 12,677 cases of HIV/AIDS in the BLHC PPS in 2011, an increase of 4.1% since 2007. In 2012, there were 427 deaths related to HIV/AIDS in the Bronx., and 8,316 individuals living with HIV, and 35,867 newly diagnosed with HIV/AIDS.

The CNA determined that many individuals in the Bronx experience difficulties accessing and navigating New York City's complicated healthcare system as well as the social services that support it. In addition, HIV is a significant problem within the Bronx community and retention in care is one of the contributing factors. As a result of the difficulties in navigating the healthcare system, patients often neglect primary care and utilize the healthcare system only in times of crisis. This coupled with the complex medical/social issues of individuals living with HIV/AIDS that frequently results in unsuppressed viral loads and poor outcomes.

The PPS proposes several projects to improve outcomes for people living with HIV/AIDS in the Bronx. Peer led interventions have proven to be very successful. As a result, a peer health navigator program will be developed to assist individuals in navigating the healthcare system and social services systems. This will aim to improve access to services that improve functioning in the social determinants to health. These services include housing, transportation, behavioral health services, and entitlements. In addition, the navigators will assist the individuals with activities of daily living to improve appointment attendance, time management, and budgeting. Navigators will also conduct outreach and reengagement to those lost to care.

A project will also be established to develop peer specialists health navigation services to support early access to, and retention in, HIV care. This will include the Center for Disease Control (CDC) approved Diffusion of Effective Behavioral Interventions (DEBIs) to provide education to individuals living with HIV on how to improve their healthcare and to assist with managing anxiety, fear, and ambivalence about receiving HIV care.

Finally, the PPS will conduct a social media campaign with education and information on early detection, viral load suppression, and other issues important to the population living with HIV/AIDS. This will improve access to critical information to improve the health outcomes for individuals living with HIV/AIDS.



Given the scope of the issues involved, seven PPSs in NYC are engaged in joint planning, via a non-binding charter agreed to by the collective PPSs. The BLHC PPS intends to continue this commitment through implementation planning and operations to address major gaps in access to, and retention in, HIV care as this citywide project is developed further.

- 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.*

DOHMH estimates that there are 133,635 individuals infected with HIV, 18,709 of which are unaware of their HIV status. The target populations for this project are HIV-infected individuals (undiagnosed and diagnosed) and those who have experienced a recent incident that could potentially have exposed them to HIV (i.e., individuals eligible for PEP). The populations will also consist of HIV positive individuals that are out of care, in care but have unsuppressed viral load, undiagnosed men, women, individuals ages 13-64, and Black or Latino undocumented immigrants. The PPS will focus its implementation on programming that targets the patients' needs and to create prevention programs that include services for the following patient categories:

Co-infected/co-morbidity

Sexual Orientation (gay, lesbian, transgender, straight, MSM)

High Risk negative population

Behavior health issues including addiction, mental health needs and serious mental illness

- 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 PPS has a strong HIV medical case management component already in place and will utilize this asset throughout the project. Many PPS providers have existing HIV Medical Case Management such as BronxWorks, BLHC, Dominican Sisters Family Health Service, Inc., AIDS Service Center, Harlem United, BOOM!Health, and Communilife, to name a few. The integration of Medical Case Management will assist in assessing patient needs and to also be able to engage and retain patients in medical care, mental health care, behavioral and substance abuse treatment. Through a partnership with Amidacare, a Medicaid managed care Special Needs Plan, the BLHC PPS will collaborate on many HIV initiatives including coordination of care through direct and timely exchange of clinical information.

The PPS will support PrEP for HIV High Risk individuals, as well as support an education, credentialing and supported employment program for peers to provide health navigation services in hospital or community-based health settings to support early access to, and retention in, HIV care. The PPS aims to create a program where peers, utilizing their lived experience with HIV, will be trained to help other HIV positive consumers to navigate the healthcare



environment either as part of the care coordination team, health navigators, outreach or retention to care workers. The PPS, working with other PPSs including this project in their approach, will identify a contractor to develop the program curriculum. Most Community Based Organizations (CBOs) have been operating Peer-led interventions as part of their programming. As such, they will build from existing models developed by the Primary Care Development Corporation, Cicatelli & Associates, Community Access, VIP Community Services, Argus, AIDS Service Center, BOOM! Health, New York, Harlem United, Housing Works and others to develop, implement and perform these interventions. Peer Navigators will work with organizations like Comunilife, Inc., who provides housing in the Bronx for persons living with HIV/AIDS, to decrease the impact of social determinants of HIV/AIDS on receiving health care. Interventions will include service navigation, training in activities of daily living, modeling effective self-advocacy and other supports and skills, which will improve adherence and health outcomes. In addition, the CBOs in the PPS have significant strength in engaging the most difficult to reach populations and navigating the healthcare, entitlements, and social service systems. In addition, the PPS is part of the Bronx Knows, a steering committee to improve access to knowledge of HIV status as well as critical services to improve health outcomes. Such collaborations are critical to the widespread success of this project and will also include collaboration and coordination with other DSRIP Projects 3a.i., 4.a.iii, and 2.a.iii. Resources and assets that need to be developed will include a shared electronic platform. In order for this project to have the maximum success, all providers must be able to share information. As such, a shared electronic record or platform will be developed to allow all providers to view information on the client (within all applicable laws and regulations). Many CBOs who are critical to this project do not have the infrastructure to combine electronic resources or to connect into a larger system. The PPS will work in parallel with CBOs to find a solution to interoperability challenges.

- 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 nature of the disease is a challenge. HIV is a chronic, incurable disease that disproportionately impacts ethnic/racial and gender minorities. HIV patients have a high prevalence of substance use disorder, homelessness, behavioral health diagnoses as well as other chronic co-morbid conditions such as diabetes and heart disease. Given the complex nature of this patient population there will need to be strong coordination with DSRIP Domain 2 and 3 projects. A multi-faced approach is key in ensuring that client care is coordinated. This collaborative work has already begun within the PPS, and as PPS groups continue to work together on this common 4cii project, effort will be taken to maximize resources and impact. Additional barriers include competition with other initiatives that are delivering similar services and lack of collaboration between the various organizations; as well as, ensuring that marketing ideas and campaigns are universally appropriate for the population. The Bronx is a very diverse community with various ethnics groups. Therefore, culturally and linguistically competent staff is



essential in implementing the project services. Lack of access to services resulting from factors such as no car fare or no access to telephone or computer can also pose some challenges in engaging patients into care.

Anticipated challenges for the peer project include integrating peer specialists into workplace settings. Technical assistance and training will be provided. The other major challenge is long-term sustainability once DSRIP funding ends.

A steering committee will be developed who will design and implement standard operating procedures including caseload size, staffing qualifications, quality indicators, and supervision. In addition, the steering committee will develop a system to monitor providers and partners for conformance to the PPS 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.

This project is a citywide initiative with all boroughs participating with NYC DOHMH. Coordination will occur across the boroughs on this project to ensure maximum use of resources and reduce duplication. There are currently seven PPSs affirmed to join a HIV Collaborative in NYC. As such, a joint PPS planning committee will be developed. These PPSs are committed to this collaborative via a non-binding charter, and are dedicated to working together through implementation of the project.

In addition, all 4cii projects will need to be a part of the Bronx Knows steering committee where progress and outcomes will also be measured. As part of this process, the BLCH PPS will be sharing resources as well as processes with other PPSs to ensure a seamless collaboration.

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

Consistent with the application requirements, the joint planning group consisting of seven PPS groups will continue to meet in early 2015 to complete the detailed Implementation Plan, which will be submitted by March 2015. We have identified a number of key milestones in this implementation planning process, including:

- Convening a cross-PPS Joint Planning Committee
- Establishing a work plan and timeline for project implementation
- Developing agreed upon milestones for project implementation
- Agree upon project commonalities and shared resources
- Shared data platform



**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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

The project participants will require capital funding to support IT/health information technology, construction or renovation costs, and equipment costs. Funds will be needed for health information sharing across the PPS. Equipment will need to be purchased to support the project such as tablets, computers/laptops, phones, printers for medical care coordinators and other staff to be able to provide home and clinic based services to patients in the project.

- 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
<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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
Cabrini of Westchester	Participate in a bundled payment Medicare initiative	in progress		Program delivered to a Medicaid population
Cabrini of Westchester	Care Transitions Training using Eric Coleman' s care Transition Program			Training provided by Cardinal Health Partners IPA
Bronx Lebanon Hospital Center	Ryan White Act funding	2002		Counseling and testing, therapy, and adherence for people with HIV
Community Healthcare Network Inc.	FQHC (Medicaid Expansion Program under ACA): CABS Health Center, Caribbean House Health Center			Adherence coaching across the board to enhance health and undetectable projects, such as: viral load suppression to keep people healthy. Provides the ability to bill for several types of services/u nits on the same date rather than make different appointments. Aims to enhance Mental/Behavioral Health availability. Increase open access appointments and access to nPEP/PrEP for partners on serodiscordant couples
Community Healthcare Network Inc.	Health Homes Care Coordination: Community Healthcare Network HH lead in Brooklyn, Co-lead in Manhattan			Enhance transportation rather than utilizing local transportations because many patients miss their appointment due to long waits/travel for city- based cars. Modified DOT: train and license staff to provide Direct Observation Therapy (mDOT) at patient's homes to monitor adherence to ARV's. Also, provide automate d calls to remind patients



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Catholic Guardian Services (Children's Collaborative)	BIP application			BIP funding is targeted for the transformation of the OPWDD system
The PAC Program of Brooklyn, the Bronx, Queens, and Manhattan	Increase early access to, and retention in, HIV care			This initiative will expand on existing program offers
West Midtown Medical Group	We participate in ADAP and accept ADAP Plus patients			This is coverage for uninsured patients and will allow access to more patients in need.
NADAP Inc.	Health Homes	2012 - present		Health Homes Care Coordination staff enhance the project by assisting in the meeting of project goals. Health Homes would expand upon the project description because it would increase the integration of care providers
Long Island Association for AIDS Care	Health Homes			Care Coordination/Case Management
Ridgewood Bushwick Senior Citizens Council	LCHSA - NYS Medicaid Redesign			The number of clients enrolled in Medicaid MLTC, living with HIV/AIDS,
The Center for Urban Community Services (Coordinated Behavioral Care IPA Network Member Agency)	US/New York State sponsored Health Home			The Health Home program staff utilize these services as a resource



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Housing Works	HIV Viral Load	3/1/1		We would be able to expand our
	Suppression initiative	4 - 2/28/16		Viral Load Suppression model to a greater number of clients. The Viral Load Suppression project offers a high level of care coordination as well as groups, DOT, and incentives to help clients achieve and maintain suppressed Viral Load. This is not a Medicaid initiative, it is privately funded
Cabrini of Westchester	Interact Training	Completed 2013		Bring this program to a Medicaid population
CASES (Coordinated Behavioral Care IPA Network Member Agency)	Assertive Community Treatment (ACT) teams	Nathaniel ACT team (cityw		We have two Assertive Community Treatment (ACT) teams, funded by Medicaid
HELP/PSI	SAMSHA grant to prevent substance abuse and HIV transmission among young men who have sex with other	2013-2017		The knowledge gained from this grant can help to inform educational campaigns and interventions for this subset of a high-risk population. Funds are used to provide individual and group counseling, HIV testing, and outreach in the Bronx
AIDS Service Center of Lower Manhattan Inc., dba ASCNYC	HARP 1915i (Pending)			Expand HARP 1915i to create a certification & training program for Peer Educators and Community Health Workers as well as provider trainings on the implementation of peer-delivered services



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AIDS Service Center of Lower Manhattan Inc., dba ASCNYC	Syringe Exchange (Contingent upon CMS approval)			Syringe Exchange Program- expand to integrate peer-delivered services
AIDS Service Center of Lower Manhattan Inc., dba ASCNYC	Health Home Care Management			Expand Health Home Care Management to include treatment adherence
AIDS Service Center of Lower Manhattan Inc., dba ASCNYC	OASAS 822 (Pending)			Expand OASAS 822 to co-locate medical with behavioral health

- 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.

All identified initiatives for this project will support and enhance DSRIP efforts to decrease hospitalization rates by 25% through integrated care delivery and improved coordination among hospital and community based organizations. This DSRIP project will be a collaborative effort among other city-wide PPSs, allowing for the ability to pool resources and funding so that only one borough-based contractor handles all training and site placement for the PPSs. This will decrease redundancies and costs. PPSs operating within overlapping service areas will be able to coordinate VLS efforts by working together to identify and link patients to VLS treatment.



**3. 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. 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.