As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

The IA recommends that the PPS create a plan to address the shortage of qualified and trained staff to engage in this project, thus improving the availability of proper care management and creating a foundation for appropriate referrals (project 2.a.iii).

PPS Action Plan Narrative:

The shortage of qualified staff is an endemic Bronx-wide issue with which Bronx Partners for Healthy Communities (BPHC) has had to wrestle from the very beginning of DSRIP. In the context of project 2.a.iii (Health Home at-Risk, HH@R), BPHC has produced significant results in addressing the challenges associated with the shortage of qualitied and trained care coordination staff through labor pool initiatives to develop the local workforce, beginning in early DY2.

BPHC has developed an extensive Care Coordination Training Series in conjunction with the Primary Care Development Corporation (PCDC), the National Council of Behavior Health, the Association of Psychiatric Rehabilitation Services, and Hostos Community College. This series has been active since spring of 2016 and includes the following courses:

1) Medical Office Assistant Refresher and National Healthcare Career Association Certification (9 full days)
2) Care Coordinator Training Program (9 full days)
3) Nurse Care Management Supervisory Training (one full day in addition to the Care Coordinator Training Program)
4) Essentials of Care Coordination (2 full days).

We have a total of 185 staff trained to date.

By expanding care coordination as part of a team-based primary care model, BPHC seeks to transform the delivery of care and the patient experience, particularly for high-risk and high-needs patients, and to ensure patients gain access to community-based services that address various social determinants of health. Beyond new employment and training, we also focus on the redeployment and retraining of existing staff, specifically for the roles of medical assistants (MAs) and care coordinators (CCs). These redeployment opportunities help to create career paths, a critical aspect of retaining the workforce.

BPHC also recognized the need to support the Human Resources Departments of our largest primary care organizations to recruit for the additional staff required for DSRIP in this difficult market. In August of 2016, BPHC deployed funds for this purpose to our largest organizations that had responsibility for recruiting and onboarding as shown below:

Recruitment and On-Boarding Support			
Organization Name	Budgeted Amount	Amount Paid	Date Paid
ACACIA (Promesa)	50,000	50,000	8/31/2016
SBH Health Systems	75,000	75,000	8/9/2016
Institute for Family Health	50,000	50,000	8/9/2016
Morris Heights Health Center	75,000	75,000	8/31/2016
Union Community Health Center	50,000	50,000	8/10/2016
Montefiore Medical Center	150,000	150,000	8/10/2016
Bronx United IPA	50,000	50,000	8/10/2016
Total	500,000	500,000	

Additionally, BPHC has undertaken various labor pool development initiatives to address the shortage of qualified staff in the local workforce. The PPS is working closely with the Phipps Neighborhoods Career Network (PNCN), which is a career development program helping to connect young adults in the Bronx to healthcare-related employment and education credentials. On March 9, 2017, the executive director of the program will be making a major presentation to the BPHC Workforce Subcommittee about linkages to participants in their Bronx-centric employment program. BPHC has also launched training and advancement programs with the New York Alliance for Careers in Healthcare providing Bronx residents with paid internships within BPHC partner organizations. As of January 2017, eight of these paid interns have been placed in our partner sites to gain DSRIP-related experience and potentially have opportunities for longer-term regular positions in the future. BPHC has also collaborated with WF1 Healthcare Career Center, an organization working with job seekers across New York City to help match qualified talent for both clinical and administrative positions.

A member of our BPHC Workforce Subcommittee, Curtis Dann Messier, who is the City University of New York (CUNY) Assistant Director of Continuing Education, has been of great help in establishing BPHC workforce programming with CUNY. Besides the Medical Office Assistant Certification program (part of the BPHC Care Coordination Series, see above) BPHC has consulted with Lehman College to help establish a credit-bearing care coordination program, which is to begin in September of 2017. Finally, the 1199 TEF Employment Center Services are being made available to all of BPHC partners to assist with recruitment and sourcing of candidates. Most recently, we have become the first PPS working with 1199 TEF to post positions on our website using an 1199 TEF recruitment tool called HWapps. This allows our partner organizations to post DSRIP positions, as well as permits both internal and external candidates to apply for specific positions. Recently, BPHC successfully piloted this TEF service

with Montefiore Medical Center (MMC)for DSRIP positions. It has now also been implemented at SBH Health System and Acacia as well as MMC, and will progress to additional partner organizations during the months of March and April, 2017. An uptick in hiring has resulted from these efforts and as of February 2017, 124 (or 78%) of the 159 DSRIP-funded jobs, made available at BPHC partner organizations to fill out the BPHC primary care team model, have been have been filled to date.

Activity to track implementation progress	Frequency
Track training participation in weekly workforce staff meetings.	ongoing weekly
Get updates on 1199 TEF Employment Center recruitment activities in weekly workforce staff meetings.	ongoing weekly
Review training participation data with Workforce Subcommittee and Executive Committee.	ongoing monthly
Request monthly DSRIP hiring reports from partner organizations.	ongoing monthly

Lastly, the Care Coordination Training Program educates coordinators on how to make appropriate referrals, regardless of the organization they work for, as a basic method for effectively managing consultation requests and referrals (for both medical and social services), providing the necessary workflows to complement care coordination.

To support the work of Care Coordinators and in a continued effort to create a strong foundation for appropriate referral-making among PPS members, BPHC has initiated a process to develop a PPS-wide referral management system. This work began with the development of a BPHC Community Resources Directory, housed on the BPHC website and available beginning late March 2017. The user-friendly directory includes a detailed profile of participating PPS members and the services they offer, with an emphasis on Tier 1 community-based organizations (CBOs). Major categories of services include: Family Services, Healthcare, Legal Services, Transportation, Food and Nutrition, Housing, Finances and Employment. To prepare the directory's contents, BPHC established on-line processes for regularly collecting and refreshing organizational profiles and contact information, as well as profile management via Salesforce, and continues to assess needs, requirements and expectations for referral processes from partners including Health Homes. BPHC has also incorporated requirements for referral processes as deliverables in our contracts with CBOs and Behavioral Health agencies. By establishing a partnership with NYC Department of Health and Mental Hygiene's (DOHMH) Primary Care Information Project (PCIP) to provide hands-on Transforming Clinical Practice Initiative (TCPI) technical assistance to member organizations, BPHC has extended its work to establish effective closed-loop referrals workflows.

These efforts underpin BPHC's ongoing efforts towards the development of a PPS-wide referral management IT solution. Vendor vetting is currently underway, in collaboration with the IT Subcommittee and Executive Committee, with a decision expected by early April. The referral management system will be made available to all PPS members to make referrals among

community-based services providers, including medical, mental health, substance use, and social service providers. To achieve DSRIP goals towards smooth transitions of care, BPHC's referral management system requirements include: mobile capabilities for use in the field; specialized capabilities for both social and clinical closed-loop referrals; an interactive provider portal; ability to integrate with care coordination management system (CCMS) and/or electronic medical records (EMR); secure messaging between senders and receivers within system; ability to transfer patient health information (PHI) securely; ability to attach and send documents (i.e., consult request, consult reports, ancillary test and lab results); ability to identify pre-requisites for specialty services and diagnostic testing; provider-to-patient communication to share referral details and reminders; and customizable reports. By the end of DY3Q2, BPHC will have the ability to make hard referrals and communicate between providers via the BPHC referral management system, to conduct closed-loop tracking of referrals, and to identify gaps in the system where additional resources and partnerships are needed to enhance patient access to needed services.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

The IA recommends the PPS work with its partners in deciding on a vendor to provide IT solutions. The PPS will need to work with the vendor and network partners to address interoperability requirements that will enable the necessary data exchange for proper care management planning and documentation, as well as accurate patient engagement counts.

PPS Action Plan Narrative:

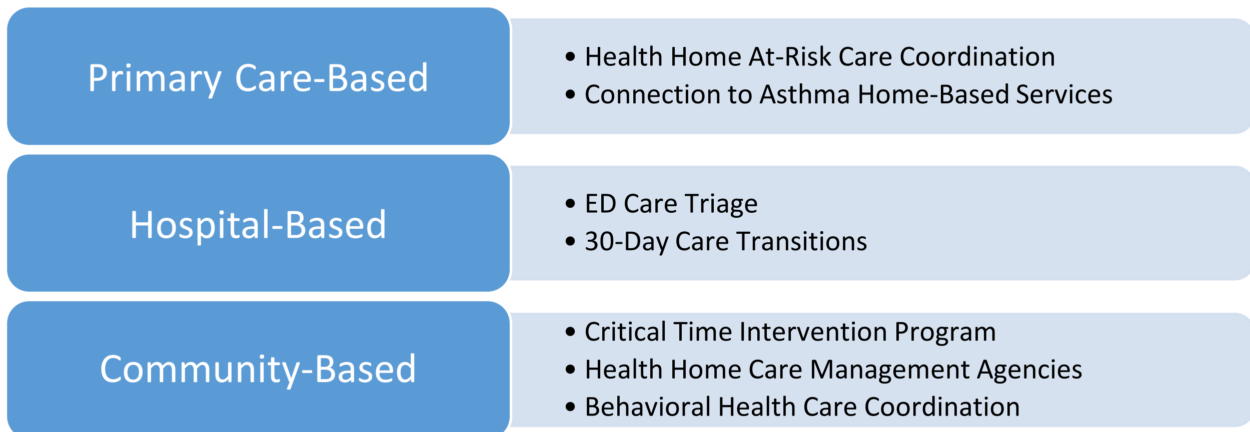
The BPHC interoperability plan, developed and approved by the BPHC IT Subcommittee, defines the need for a care coordination management system (CCMS) to support PPS efforts to meet DSRIP goals. Specifically, the CCMS can contribute to shifting utilization from episodic, reactive and hospital-based care to longitudinal (population health-based), proactive and lower cost ambulatory care and aid the PPS in responding to the following needs:

- Designing, coordinating and providing individualized care, based on patient profiling and stratification, individualized care plans for as many patients as possible and coordinated, team-based including both community-based care coordinators and more clinically focused care managers working with physicians, following the model of a Patient-Centered Medical Home (PCMH)
- Integrated behavioral health services, with specific integration interventions and protocols and provider co-location in some settings
- Avoiding hospitalization and emergency department (ED) visits by directing the patient to and treating him/her in more suitable settings
- Designing and implementing standardized and effective discharge procedures and active post-discharge coordination across the care team, geared to individual patient risk and need to support with transition from hospital and reducing the potential for readmission or complications
- Care and support services coordination and navigation that helps patients, especially those in vulnerable socioeconomic populations, in identifying and accessing appropriate health delivery and social support resources, further reducing the likelihood they will present at hospital emergency rooms with acute conditions when they become impossible to manage, not knowing where else to turn
- Appointment scheduling, reminders and other patient-centered services so that patients do not forego care or miss appointments because of long wait times, lack of coordination that requires multiple visits, transportation challenges, etc.
- Better, more complete information to guide care, including care plans.

To achieve these goals and truly transform into an integrated delivery system, PPS operations and systems must be sufficiently interoperable to serve the DSRIP patient seamlessly and to meet program objectives. In the context of care management planning and documentation across care settings, this translates into the need for BPHC to provide a CCMS to members who need one to use for care planning, clinical and social service navigation, care transition management, patient assessment, population stratification, and patient engagement. The BPHC CCMS must also have the capability to integrate with existing care management systems and leverage electronic medical record (EMR) data across the PPS.

BPHC had conducted in-depth vetting of four CCMS vendors in coordination with its stakeholder partners. In November 2016 BPHC signed a contract with GSI Health, a third-party population health management system vendor, to host the BPHC CCMS. BPHC chose GSI Health based on the breadth and depth of their experience with other DSRIP PPSs and Health Homes, current use of the system by some BPHC partners, strong customer service and ongoing technical assistance, accelerated speed to implementation, mobile capabilities, health information exchange (HIE) experience, strong operational analytic capabilities, dynamic consent capabilities, and experience with data needs for value-based payment systems.

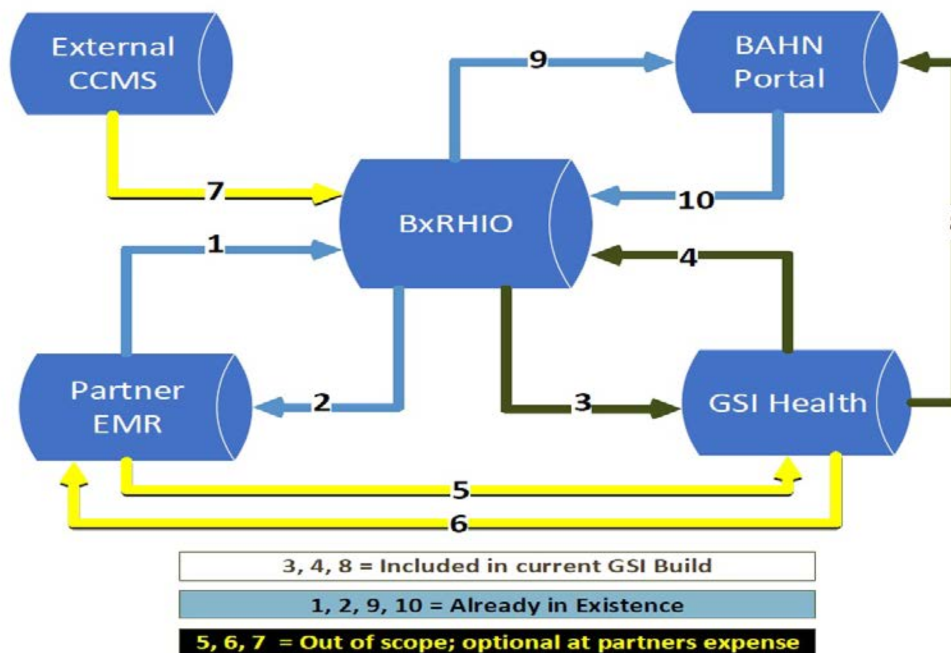
The GSI Health platform will be used by care coordination staff across organizations and care settings, working on a single care plan to promote clinical integration. The system facilitates enhanced communication and collaboration between providers, reduces duplication, and provides greater insight into the needs of patients as they navigate through the care delivery system. The GSI Health CCMS will be available to BPHC partners to conduct assessments, care planning, care plan management, operational analytics and reporting for care coordination in the following areas:



BPHC expects that in the first year of GSI Health implementation, 10,000-15,000 at-risk patients will benefit from improved care planning and care coordination services associated with these programs.

In order to facilitate interoperability, the GSI Health CCMS will integrate with the Bronx Regional Health Information Organization (RHIO), the qualified entity (QE) that serves as the

HIE for BPHC partners. As the Bronx RHIO already connects (or soon will connect, through DSRIP efforts) to partner EMRs, BPHC can create bi-directional information exchange between the EMR and CCMS via the Bronx RHIO to move clinical data, critical alerts, and care plans among the various systems used by PPS partners. Connection between the CCMS and the Montefiore Bronx Accountable Healthcare Network (BAHN) Health Home Portal will facilitate care coordination for patients enrolled in Health Home and reduce the need for care managers to conduct duplicative documentation between their own systems (for daily management) and the BAHN Portal (for billing). Discussions with both systems are ongoing. In the initial phase, the CCMS will operate as a standalone system, with system integration going-live in a second phase expected to launch in spring 2017. The following diagram demonstrates the flow of data between IT systems in use across the PPS:



In preparation for the implementation of the GSI Health platform, five workgroups were formed immediately following contract execution. These workgroups include the CCMS Steering Committee, BPHC Project Management Team, Implementation / Project Team, Technical Team and Compliance Team. These teams have contributed to decisions surrounding the legal and policy framework for system use, site configuration, operational workflows, and system integration. The progress of the workgroups and GSI Health are reported monthly to the IT Subcommittee and the Executive Committee.

Timeline for CCMS go-live across BPHC partners and programs:

Activity	Responsible Party	Dates
Contract Execution	BPHC CSO GSI Health	11/21/2016 (completed)
Configuration	Workgroups BPHC CSO GSI Health	11/22/2016 – 1/20/2017 (completed)
Platform Build	GSI Health	1/23/2017 – 2/3/2107 (completed)
User Acceptance Testing	BPHC CSO	2/6/2017 – 2/17/2017 (completed)
Initial User Training (80 users)	GSI Health BPHC CSO Parner Staff	2/21/2017 – 3/1/2017 (completed
Health Home At-Risk Go-Live	Union Community Health Center (pilot)	3/27/2017
	SBH Health System Acacia Network Bronx United IPA	4/15/2017 – 4/31/2017
	Montefiore COBRA	TBD Estimate: 5/15/2017
Critical Time Intervention Go-Live	Project Renewal SCO Family of Services Visiting Nurse Service of NY Riverdale Mental Health Association	4/1/2017
ED Care Triage / Care Transitions Go-Live	SBH Health System	TBD Estimate: 5/15/2017
Asthma Home-Based Intervention Referrals	a.i.r. bronx Union Community Health Center SBH Health System Acacia Network Bronx United IPA	TBD Estimate: 5/15/2017
Health Home Go-Live (dependent on interface functionality with BAHN Portal)	Union Community Health Center (pilot) SBH Health System Acacia Network	TBD Estimate: 5/1/2017
Community Behavioral Health Go-Live	Community-based Behavioral Health Providers	TBD Estimate: 6/1/2017

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

The IA recommends that the PPS develop a strategy to increase partner engagement across all projects, with a specific focus on Mental Health partners for Domain 3a projects.

PPS Action Plan Narrative:

This narrative specifically addresses BPHC's strategy for engaging Mental Health and Substance Use (Behavioral Health) partners to achieve DSRIP goals. A plan for engaging the full range of PPS partners across all projects has been detailed in the BPHC response to Recommendation 4, as requested by the PAOP.

Project 3.a.i – Integration of Primary Care and Behavioral Health Services ("PC/BH")

Bronx Partners for Healthy Communities (BPHC) developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational set of guidance for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from BPHC's implementation workgroups (IWGs). The COP section on PC/BH project provides guidance on policies and procedures that must be adopted in order to achieve integrated care through co-location or the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Collaborative Care Model. The COP is easily adapted to organizational and site-specific formats for documenting the policies and procedures of their respective agencies.

To support robust implementation across a diverse array of hospital-, ambulatory-, and community-based settings, BPHC has launched, in coordination with its vendor Institute for Family Health (IFH), a training and technical assistance (TA) strategy that is flexible and responsive to the varying needs of the BPHC partners. Training and Technical Assistance Needs Assessments were conducted, which addressed the providers' current rates of patient assessment, with the focus of PHQ-2 and PHQ-9 (PHQ 2/9) screens. The assessments provided details on patients and workflows, as well as technical assistance and training needs. The assessments addressed the sites' need for hiring and training staff to fulfill the Depression Care Manager (DCM) role. The role requirements were defined in collaboration with the Workforce Subcommittee and a job description was developed from the effort. Resources were identified to develop trainings for DCM's and the role has been defined in the COP.

The role of the Psychiatrist was also defined in the COP and a job description was developed, both of which were approved by the PC/BH IWG and the Quality and Care Innovations

Subcommittee. During the Training and Technical Assistance Needs Assessments, resources were provided to aid in the hiring of the psychiatrist, a key component of the IMPACT Model. IFH, in addition to conducting the trainings, provided assistance in identifying consulting Psychiatrists through a database that the organization maintains with behavioral health providers and consultants.

BPHC reached out to every mental health partner in the PPS to gauge their interest and capacity to participate in PC/BH project. Abiding by the BPHC Project Implementation Plans, the PPS began its PC/BH project work with the collaborative care model (Model 3), as the associated milestones have earlier completion dates than the milestones under the other two models.

Training and Technical Assistance Plans were developed for each organization and their respective sites to provide an overview of the topics and, when available, dates for trainings. Many sites are receiving PHQ 2/9 screening trainings, in addition to the guidance provided in the COP. To date there are 96 unique sites participating in PC/BH project, across the 3 models that BPHC supports. The BPHC DSRIP Program Directors at each of the PPS's seven largest primary care organizations, which together employ over 75% of BPHC's primary care providers (PCPs) and deliver 97% of primary care services to BPHC patients, are overseeing implementation and reporting to the Central Services Organization (CSO) when challenges arise. Trainings and the COP provide guidance on non-medical referrals to community-based providers.

Evidence-based guidelines on "stepped care" were adopted for the COP for sites implementing the IMPACT Model as required. The guidelines were obtained through the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. The PC/BH COP also outlines policies and procedures for effective implementation of PC/BH for all three models. BPHC has successfully been exceeding all patient engagement targets to date for project 3.a.i by 200%.

Community Behavioral Health Initiative

Recognizing the need to better support behavioral health providers beyond the milestone requirements described in project 3.a.i, BPHC launched a Community Behavioral Health (CBH) Initiative in DY2. The purpose of the CBH Initiative is to strengthen connectivity in the community-based BH providers and to develop standardized and sustainable processes for screening, referral, follow-up and monitoring. The Initiative provides tools, resources, training, and support for organizational learning and for making needed changes in areas such as workforce, work flows, and IT. BPHC is making GSI Health, its Care Coordination Management System (CCMS), available to all participating agencies, as well as connectivity to the Bronx RHIO.

In fall of 2016, a group of Bronx-based behavioral health agency representatives was selected to provide leadership and plan initiatives focused on key behavioral health issues affecting the community. These plans have informed and shaped the CBH Initiative. The three workgroups were created and developed integrated plans for establishing standardized processes for screening, referral, disease monitoring, and follow-up for target populations receiving behavioral health care. The Initiative, which has been built on the recommendations of the three workgroups, is designed to drive

the development, adoption and implementation of standardized practices which are the foundation of transformative collaboration and integration across systems, and improved services and outcomes for residents of the Bronx.

Community-based behavioral health providers are central to BPHC efforts to create community-driven, clinically integrated delivery systems that will be sustainable once the DSRIP program ends. The behavioral health provider community brings expert clinical and community knowledge about populations in the Bronx, the county with the poorest health outcomes in the State. Furthermore, Bronx community-based behavioral health providers have unique expertise in delivering culturally competent care in this very diverse community.

On February 17th, 2017, BPHC released an invitation to participate in the CBH Initiative. This initiative is an opportunity for our behavioral health provider partners to work with the PPS to improve health outcomes, and enhance communication capabilities and organizational capacity.

Participating agencies will work together to adopt standardized screening for all clients within a defined population of focus (such as a specific clinic or other program):

Screening: Screening all clients within a defined program using standardized tools and processes to provide universal screening for:

- Depression
- Substance Use Disorder
- Tobacco use
- Patient engagement with primary care provider
- Health Home eligibility and enrollment

Participating agencies will also be encouraged to select and address a special population of focus:

Diabetes: Screening all clients with a schizophrenia diagnosis receiving antipsychotic medication for diabetes; ensuring diabetes management for all clients with diabetes or pre-diabetes.

ADHD: For children of ages 4 – 17, providing follow up visits with the prescriber within 30 days of a prescription being written for ADHD medication; and providing at least two additional follow up visits within 244 days of the date of the prescription.

The CBH Initiative will fund twelve (12) community-based behavioral health providers and will engage three to four lead agencies to provide mentoring and facilitation support, promote collaboration, conduct training, and facilitate the use of tools and resources for participating agencies. The Initiative will provide baseline funding to support interoperability capability, and to build capacity for full implementation. It will also provide performance-based funding for achieving improvements on a defined set of performance metrics. During the course of the Initiative the proportion of funding linked to performance will increase. The Initiative will help agency teams

plan and implement their strategies and approaches, increase screening rates, develop a dedicated patient database and collect baseline data on their clients' primary care and Health Home linkages.

Community Behavioral Health Initiative Timeline:

Initiative Milestones	Target Date
Invitation to Participate Released	February 17, 2017
Agencies Submit Questions for Participant Agency Q & A Webinar	COB February 23, 2017
CBH Initiative Overview - Q & A Webinar	February 24, 2017
Proposals due	March 3, 2017
Agency / BPHC Proposal Review Calls	March 10 – 17, 2017
BPHC Issues Contracts	March 22, 2017
Collaborative Learning Session - CBH Initiative	Mid-March
Contracts Executed	April 10 – 14, 2017
Official Kick-Off - CBH Initiative	Mid-April
Project Implementation	Mid-April 2017 – Mid April 2018

Critical Time Intervention Program

To further serve the needs of mentally ill patients and more deeply engage behavioral health provider partners, BPHC initiated a Critical Time Intervention (CTI) program, as part of its DSRIP 30-day Care Transitions Intervention Program (project 2.b.iv). CTI is a nine-month, evidence-based, intensive care transitions model designed to prevent homelessness and other adverse outcomes in people with Serious Mental Illness (SMI) following discharge from hospitals and shelters. This population is frequently excluded from care transitions programs.

The intent of utilizing CTI by the PPS is to reduce potentially preventable readmissions (PPR) to the hospital and/or potentially preventable visits (PPV) to the ED by SMI patients who may be precariously-housed beginning in August 2016 and continuing through DSRIP Year 5 (March 2020). BPHC has designed its implementation of PPS CTI program to complement and leverage Health Home services already available to this population.

The target population for CTI referrals includes patients who meet all three of the following criteria:

- Patients with Serious Mental Illness (SMI).
- Patients who are eligible for New York State Health Home (HH) enrollment.
- Patients who are marginally or precariously housed (homeless or at risk for homelessness, i.e., staying with a friend or family member, couch surfing, or those with income at risk.)

An analysis of BPHC-hospital discharges meeting the target population criteria over a twelve-month period indicated that approximately 400 patients per year would qualify for CTI services.

Right sizing the estimation of this population has been challenging, as it is difficult to retrospectively identify precariously-housed patients.

The BPHC-CTI Program Model reflects a modification from the recommended nine-month fidelity model of CTI, to leverage existing services provided by Health Homes, which closely align with the services required in Phase 3 of CTI, as demonstrated in the table below:

Phase	Fidelity Model	BPHC Program Model
1 (months 1-3)	**Intense specialized support and implementation of transition plan** • CTI worker makes home/shelter visits to see client, • CTI worker accompanies clients to community providers. • CTI worker helps client create personal support network.	Identical to Fidelity.
2 (months 4-6)	**Facilitate and test client's problem-solving skills** • CTI worker observes operation of support network. • Helps to modify network as necessary.	Identical to Fidelity. In last 6 weeks of this phase, identify HH Care Manager (CM) for hand-off and that CM participates in 1-2 calls for warm hand-off.
3 (months 7-9)	**Complete CTI services with support network safely in place** • Develops and begins to set in motion plan for long-term goals (e.g., employment, education, family reunion, etc.).	Complete hand-off to traditional HH model of care.

BPHC has allotted DSRIP funds of $600,000 per year to the operation of CTI and a separate stream of funding to cover training for organizations that need it. Implementing partners were chosen through a Request for Proposal (RFP) process, which solicited proposals from organizations to enroll approximately 40 to 80 new participants in a six-month CTI program as described in the BPHC model (see table below). BPHC issued the RFP to a range of organization types, including Health Homes, Mental Health (Article 31) and Substance Abuse (Article 32) organizations that may already operate a CTI program, as well as those willing to be trained to run a new program. Organizations were selected using a weighted scoring methodology.

Four organizations were selected to each enroll approximately 80 individuals in a nine-month CTI program: Coordinated Behavioral Care IPA (CBC), Visiting Nurse Service of New York

(VNSNY), Riverdale Mental Health Association (RMHA), and SCO Family of Services (SCO). Contracts were executed and funds released in November 2016.

Following partner selection, BPHC hired the Center for Urban Community Services (CUCS)—a PPS member—to customize and provide training for CTI providers. Implementation teams for CTI were identified at BPHC hospitals and CTI providers were matched with hospitals in the following manner to ensure equitable distribution of referrals:

Hospital Site(s)	CTI Providers
SBH Health System	VNSNY – primary RMHA – back up
Montefiore Wakefield	Project Renewal (CBC) – primary VNSNY – back up
Montefiore Moses	RMHA – Primary SCO – back up
North Central Bronx, Jacobi and Bronx Lebanon (UBA patients only)	SCO

Social workers at hospitals and Health Home workers co-located at hospitals have been trained to identify and refer patients appropriate for intervention. CTI implementation partners met with hospital staff to establish referral process flows, including connecting patients to Health Home prior to discharge and allowing CTI partners to conduct in-person visits with patients prior to their discharge from the hospital.

The CTI program officially launched on January 3rd, 2017 at the hospital sites and 27 patients have been referred into the program as of March 2nd, 2017. CTI partners have developed marketing materials and are keeping records of patients enrolled in the program to submit to BPHC on a monthly basis. The hospital utilization of patients touched by the CTI program will be tracked longitudinally to gauge the long-term success of the intervention.

As a result of the Mid-Point Assessment, the Independent Assessor has developed recommendations for the PPS to address specific areas identified as deficiencies that could impact the PPS success in achieving the DSRIP goals.

For each group of recommendations under a specific organizational section or project included in the Mid-Point Assessment Report, the PPS has taken or plans to take the following corrective action(s).

Mid-Point Assessment Recommendation:

The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.

The Plan must also include a description of how the PPS will flow funds to partners so as to ensure success in DSRIP.

The PPS must also submit a detailed report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.

These reports will be reviewed and approved by the IA with feedback from the PAOP prior to April 1, 2017.

PPS Action Plan Narrative:

The only project identified in the IA's Mid-Point Assessment Report for Bronx Partners for Healthy Communities (BPHC) as having a risk score of 3 was **2.a.iii Health Home At-Risk Intervention Program**. BPHC responses to IA recommendations 1 and 2 outline PPS current activities and future plans to address the challenges identified with regard to this project.

Support for primary care has played a central role in BPHC's partner engagement and fund distribution strategies. During DY1 and DY2 the release of funds has been structured around a series of waves, reflecting PPS priorities and supporting member organizations in their implementation of DSRIP projects. These priorities include:

1) ensuring a robust primary care foundation exists across the PPS,
2) supporting patient-centered medical home (PCMH) transformation, and
3) fostering a system-wide care coordination infrastructure.

The strategically designed staged approach to distributing funds aims to align local capacity for implementation with BPHC's focus on deliverables that require early adoption in order to meet DSRIP targets, while simultaneously garnering broad participation from member organizations and ensuring support for community-based organizations.

BPHC recognizes the importance of a transparent, inclusive governance process to the success of our PPS. Through the wave-based funds flow process, the BPHC Collaborative Contracting Model was established to facilitate Partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships necessary to transition to risk-based contracting. The contractual relationships provide accountability for DSRIP program milestones, enforce Partner

obligations, and provide a basis for evaluating/tracking BPHC and Partner performance against established metrics. The engagement and funding waves are displayed in the following diagram:

BPHC Engagement & Funding Waves through DY3 Q2

Wave 1: Investing in PPS Expertise	**Wave 2:** Implementing Foundational Requirements	**Wave 3:** PCMH and Project Support	**Wave 4:** PCMH and Project Support	**Wave 5:** CBO/ CBH Support	**Wave 6:** Post-acute and Housing Support
August 2015 Funding for: - Contracts with select orgs with expertise identifying best practices to support DSRIP project implementation	*October 2015* Funding for: - DSRIP Project Managers for BPHC partner organizations. - PCMH technical support and coaching services - Workforce recruitment and training programs.	*February 2016* Funding to large PC and BH Providers for: - Team-based care - Care coordination - Connectivity - Population health	*May 2016* Funding to Independent providers for: - PCMH - Care coordination - Population health Funding to hospitals for: - ED Triage and Care Transitions	*Fall 2016/ Winter 2017* Funding for: - CBO/CBH capacity building - Inter-connectivity via RHIO - Health Literacy and community engagement - Innovative approaches to advance DSRIP goals - Depression/ substance abuse screening, PC connection	*Summer/Fall 2017* Funding to post-acute care services and supportive housing providers for: - Inter-connectivity and information exchange via RHIO - Innovative approaches for advancing DSRIP goals

Wave 1: Investing in PPS Expertise
In Wave 1, BPHC worked with its partners to identify best practices for care delivery. BPHC also contracted with select expert organizations for implementation support; for example, payments were distributed to CBO partners a.i.r. bronx (to provide home-based asthma services) and Health People (to deliver diabetes self-management courses, using the Stanford Model). To aid the PPS in launching the Integration of Primary Care and Behavioral Health project, the Institute of Family Health also received a disbursement to act as a consultant to the Central Services Organization (CSO) for education, training and program roll-out.

Wave 2: Implementation of Foundational Requirements
In Wave 2, BPHC provided funding to each of its seven largest partner organizations to hire DSRIP Program Directors to oversee DSRIP-related transformation projects for these organizations. These organizations are Montefiore Medical Group[1], SBH Health System, Institute for Family Health, Morris Heights Health Center, Union Community Health Center, Acacia Network and Bronx United Independent Practice Association (IPA), which together employ over 75% of BPHC's primary care providers (PCPs) and deliver 97% of primary care services to BPHC patients. During this wave, BPHC also funded PCMH

[1] Montefiore Medical Center got funded for its Montefiore Medical Group (MMG), and not the Montefiore Independent Practice Association (MIPA) providers during this wave.

technical assistance and coaching services to aid providers in achieving the NCQA PCMH 2014 Level 3 recognition by the end of DY3Q4. The CSO continues to monitor partners' transformation progress and authorize payments as benchmarks are reached. As of March 2017, of the 760 eligible PCPs, 67% have achieved of PCMH 2014 Level 3 recognition. The PPS also used this phase to launch Workforce recruitment and training programs, utilizing services from SEIU 1199 Training and Employment Funds (TEF) and for consultant assistance with the Workforce needs assessment.

Wave 3: PCMH and Project Support (Large Primary Care and Behavioral Health Providers)
In Wave 3, BPHC funded large Primary Care and Behavioral Health providers to advance team-based care models; care coordination and transitions; connectivity and analytics. BPHC conducted a Request for Information for Clinical Integration (RFI) process with the seven largest primary care partner organizations. This process sought to determine staffing and baseline funding needs to achieve DSRIP clinical integration objectives. CSO reviewed the proposals internally and then with each of the partners to determine how they plan to achieve DSRIP goals when funded. Baseline funding decisions were based on identified needs and patient attribution. An annual review and update process for the PPS baseline funding schedule and distribution plan was defined.

Wave 4: PCMH and Project Support for Independent Providers, ED Care Triage and Care Transitions
In Wave 4, BPHC continued funding independent providers to advance team-based care models; care coordination and transitions; connectivity; analytics; and PCMH implementation. Independent providers have been matched with PCMH consultants for training, education and application processes to aid providers in achieving the NCQA PCMH 2014 Level 3 recognition by the end of DY3Q4. The hospital-based projects were developed by the Montefiore Care Management Organization (CMO) and implemented at SBH Health System and Montefiore's Bronx-based Hospitals.

Wave 5: Community-Based Organization & Community Behavioral Health Support
Wave 5 concentrates on deepening engagement with behavioral and social service providers to improve population health. BPHC has funded CBO/CBH capacity building, interconnectivity and information exchange via the Bronx Regional Health Information Organization (RHIO), and innovative approaches for advancing DSRIP goals. BPHC aims to develop an integrated delivery system that reduces the care fragmentation that so often contributes to poor population health outcomes. BPHC believes that the creation of pathways for connection and collaboration between primary care and both behavioral health and social service providers is critical to achieving that goal. To this end, BPHC has developed projects for meaningful engagement of community-based behavioral health and social service providers in its DSRIP initiatives, as described below.

The BPHC **Community Health Literacy (CHL) Program** aims to improve patient health literacy and healthcare system navigation, as well as to connect eligible individuals to primary care, Health Homes and other relevant services and programs. BPHC's primary population of focus for the CHL Program targets under-utilizers of healthcare services. BPHC is providing DSRIP funds to seven selected community-based organizations, including base allocation and performance incentives to operationalize this program in support of community health literacy.

The seven selected organizations (ArchCare, Bronx Community Health Network, Health People, The Bronx Health Link, BronxWorks, Mary Mitchell Family & Youth Center, and Regional Aid for Interim Needs [R.A.I.N.]) first participated in a training module on seeking and using health insurance, which was developed and delivered by the NYC Human Resource Administration's Office of Health Insurance Access. Education to community members on this topic began in DY2Q3 and has reached 1,840

community learners to date. Training on Care Navigation & Health Literacy was developed and delivered to CBOs by the Memorial Sloan Kettering Immigrant Health and Cancer Disparities Service in February 2017, with community education on this topic slated to begin in early March. An implementation plan has been included as an attachment to this document *(Mid-Point Assessment Action Plan_Recommendation 4_CHL MPA Implementation Plan).*

The BPHC **Critical Time Intervention (CTI) Program** has been described in detail in the response to Recommendation 3. As discussed therein, CTI is a nine-month, evidence-based, intensive care transitions model designed to prevent homelessness and other adverse outcomes in people with Serious Mental Illness (SMI) following discharge from hospitals and shelters. BPHC has contracted with four providers for Critical Time Intervention services to implement the program in three components (Coordinated Behavioral Care IPA [CBC], Visiting Nurse Service of New York [VNSNY], Riverdale Mental Health Association [RMHA], and SCO Family of Services [SCO]). Each of the four providers submitted a budget as part of their response to the request for proposals. Each provider agreed to provide services to at least 80 patients over the course of one year and their budgets were approved.

As part of Phase A, BPHC distributed 25% of the approved budget to each CTI provider when contracts were fully executed in November 2016. As part of phase B, BPHC will distribute 50% of remaining budget in five quarterly payments (10% each). Upon completion of the final Phase C, BPHC will pay each participant a maximum of the remaining 25% of approved authorized payment. This remaining funding is to be paid as an incentive for reducing Emergency Department (ED) and hospital utilizations of the patients enrolled in the CTI Program. To receive the full maximum incentive payment, the CTI providers must achieve a 25% reduction in ED/inpatient utilization of the enrolled cohort. Partial payments will be distributed based on the percentage of reduction achieved.

CTI providers will enroll patients into their patient cohort for the Phase C calculation between January and June of 2016. The cohort will close on June 30, 2016. BPHC will follow patients in the cohort until December 31, 2016 or for six months. BPHC will review all ED visits and inpatient visits for the period of time in which they are to be enrolled in the program backward and forward once the cohort closes. For example, if the patient were enrolled on June 30, 2017, BPHC would look six months before patient enrollment in the program and six months from enrollment in order to determine if there was a change in the average utilization of the cohort. A comparison will be made to determine if there is an overall 25% reduction in utilization of the cohort. An implementation plan has been included as an attachment to this document *(Mid-Point Assessment Action Plan_Recommendation 4_CTI MPA Implementation Plan).*

The BPHC **Community Behavioral Health (CBH) Initiative** has been described in detail in the response to *Recommendation 3*. As discussed therein, the purpose of the CBH Initiative is to develop and implement strategies for sustainable, standardized best practice and evidence-based screening, referral and follow-up practices across systems. The Initiative provides funding and a variety of other resources to support connectivity to make the BPHC delivery system more efficient and responsive to the patients it serves. The initiative is community-driven, with work plans developed by a group of Bronx-based behavioral health agency representatives. Indigenous, community-based behavioral health leadership provides expert facilitation and support for the planning and implementation throughout the initiative, with additional technical assistance from a broad spectrum of subject matter experts. An implementation plan has been included as an attachment to this document *(Mid-Point Assessment Action Plan_Recommendation 4_CBH MPA Implementation Plan).*

Wave 6: Post-Acute Care and Housing Support

In Wave 6, which is currently being formulated, BPHC will work with Nursing Home (skilled nursing facilities as well as long-term care facilities), certified Home Health agencies, Hospice, Supportive Housing, and Medical Respite partners to build capacity, create interconnectivity and information exchange via the Bronx RHIO, and initiate innovative approaches for advancing DSRIP goals. This includes partner involvement in referral management initiatives and ensuring smooth transitions between care settings in addition to supporting individuals in community-based care settings and prevent avoidable admissions and ED visits. An RFP process is under development to determine the best practices for collaboration with these groups of partners. A budget of estimated $5 Million for supporting services has been set aside.

Ongoing Engagement and Support to PPS Partners

BPHC and the **Bronx RHIO** are working together closely to ensure data can be shared in a secure manner among PPS partners through the health information exchange. All BPHC partners are strongly encouraged to establish connectivity to the Bronx RHIO, and the CSO works with partners to institute and expand their relationship with the qualified entity (QE). Enabling encounter notification services for admission, discharge, transfer and use of the ED notification sharing is a priority. Providers and CBOs have been involved in the patient QE consent strategy and trainings will be conducted periodically to ensure accurate and consistent messaging. Furthermore, because much of our Population Health Management and performance improvement strategies rely on the Bronx RHIO's IT Platform for analytics, it is imperative that BPHC partners participate in the BPHC interoperability plan by connecting to the QE. The Bronx RHIO has the IT infrastructure needed to support our population health management approach through their population health dashboards.

In line with its commitment to care coordination improvements through interoperability, BPHC has prioritized the development of a **care coordination management system (CCMS)** that can connect all partners to shared care planning data for higher risk patients. This system has been described in detail in the BPHC response to Recommendation 2 and will improve the effectiveness of multidisciplinary teams and facilitate information sharing patient tracking across the PPS. The CCMS platform will be integrated with partner EHRs via the Bronx RHIO to decrease the need for documentation in multiple systems. Data permission levels within the CCMS platform are set by function and access requirements so that only relevant information will be shared. BPHC has drawn on its participating Health Homes' experience with data sharing and patient confidentiality protection in coordinated care to inform PPS policy, in accordance with federal and state privacy laws.

Initiatives under Development for Future Partner Engagement and Funds Flow

As discussed in the response to Recommendation 1, BPHC is engaged in ongoing efforts to develop a PPS-wide **referral management system (RMS)**. Vendor vetting is currently underway, in collaboration with the IT Subcommittee and Executive Committee, with a decision expected spring 2017. The referral management system will be made available to all PPS members to make referrals among and between community-based services providers, including medical, mental health, substance use, and social service providers. To achieve DSRIP goals towards smooth transitions of care, BPHC's RMS requirements include: mobile capabilities for use in the field; specialized capabilities for both social and clinical closed-loop referrals; an interactive provider portal; ability to integrate with CCMS and/or electronic medical records (EMR); secure messaging between senders and receivers within system; ability to transfer patient health information (PHI) securely; ability to attach and send documents (i.e., consult request, consult reports, ancillary test and lab results); ability to identify pre-requisites for specialty services and diagnostic testing; provider-to-patient communication to share referral details and reminders; and

customizable reports. By the end of DY3Q2, BPHC will have the ability to make "hard referrals" and communicate between providers via the BPHC referral management system, to conduct closed-loop tracking of referrals, and to identify gaps in the system where additional resources and partnerships are needed to enhance patient access to needed services. An implementation plan can be found in the attachments to this document *(Mid-Point Assessment Action Plan_Recommendation 1).*

The BPHC Pharmacy Workgroup has designed a **Pharmacy Engagement Pilot** to evaluate pharmacy-led interventions to improve patient-adherence based on preliminary reports from pharmacists, which showed 40-50 people (50%) filled their prescriptions within a week of being contacted. Pharmacies will identify and contact Medicaid patients who are 60-79% adherent to depression medications and report their Percent Days Covered (PDC) pre- and post-intervention. For each patient in their cohort pharmacies will report: 1) the average pre-intervention PDC (1/1/2017 – 3/31/2017), 2) the date and type of intervention, and 3) the monthly post-intervention PDC (4/1/2017 – 6/30/2017). BPHC will analyze the data for significant changes in patient-adherence and determine how best to fund pharmacies to undertake similar initiatives to expand the successful interventions from the pilot phase.

BPHC continues to convene quarterly meetings of the Cross-**Health Home** Work Group for collaboration around provider and community education, bottom-up referral processes, and other topics. This group includes the three Health Homes (HHs) serving the vast majority of BPHC attributed Health Home enrolled patients: Bronx Accountable Healthcare Network (BAHN), Community Care Management Partners (CCMP), and Coordinated Behavioral Care (CBC). These HHs represent approximately 40 care management agencies (CMAs).

Significant progress has been made to increase the number of bottom-up referrals to Health Homes from BPHC's large primary care practices. The increased activity has prompted the development of more streamlined processes for receiving and processing such referrals. This effort to expand enrollment stems from BPHC provider education initiatives, Care Coordinator hiring and training, and community outreach to enhance understanding of the benefits of care coordination and to clarify referral procedures. In coordination with its HH partners, BPHC has contributed to the establishment of referral pathways from primary care to HH, as well as from CBOs and community behavioral health providers to HH.

To further expand the reach of care coordination, BPHC seeks to assist primary care practices that do not have embedded care coordinators by matching these practices with Care Management Agencies (CMAs) for care coordination service provision. A payment model has been developed and matchmaking is underway with interested parties. Furthermore, BPHC seeks to increase the enrollment of children in Health Home At-Risk (HHAR) and Health Home care coordination services by raising awareness among pediatric providers of the existence of both HH an HHAR care coordination services, in collaboration with Health Home partners. BPHC also plans to provide financial support to HHs for the improvement of referral management, communications with referring providers, data and analytics, and continuous quality improvement (CQI) to advance DSRIP goals.

BPHC is also evaluating the most effective ways to engage **Non-Primary Care Providers** to advance DSRIP goals. Initiatives under consideration include involvement in the PPS-wide closed-loop referral management system, training on billing and coding best practices, training on universal screening practices and engagement with care coordination.

Partner Engagement

In line with speed and scale projections.

Funds Flow

See attachment:
- Mid-Point Assessment Action Plan_Recommendation 4 – Five Year Funds Flow

Implementation Plan:

See attachments:

- Mid-Point Assessment Action Plan_Recommendation 1
- Mid-Point Assessment Action Plan_Recommendation 4_CHL MPA Implementation Plan
- Mid-Point Assessment Action Plan_Recommendation 4_CTI MPA Implementation Plan
- Mid-Point Assessment Action Plan_Recommendation 4_CBH MPA Implementation Plan
- Mid-Point Assessment Action Plan_Recommendation 4_Funds Flow

Implementation Date:

All activities described in the attached MPA Implementation Plans will be completed by September 30th, 2017.