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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.

Our CNA identified a number of services gaps to be address through the development of an integrated delivery system (IDS), including high rates of potentially preventable visits (PPVs) and bed utilization issues. CNA data shows an average rate of 35 PPV events per 100 Medicaid beneficiaries in our service area. Related CNA data indicates that hospitals within the PPS network range in daily bed utilization, with some hospitals as low as 64% and others as high as 89% daily bed utilization. To address these gaps, we will restructure one or more of the PPS hospitals to decrease the number of excess beds and reallocate resources to promote community-based services to decrease PPV events.

Our CNA also showed that access to care is a challenge, as specialty care, behavioral health, and primary care services are difficult to access, compared to emergency room services. To address this gap and other access issues, we are working with partners to plan and identify solutions based on region-specific needs, utilizing a data-driven approach. For example, while we understand there is a need for additional primary and urgent care sites, we are conducting an analysis of partner sites, and coordinating with other PPSs in our region to maximize available resources. At the core of this process will be Mount Sinai's transformational Management Services Organization (MSO).



The PPS, supported by the MSO, will provide the infrastructure and machinery through which the IDS will achieve its goals and includes services such as information technology to support data sharing, care coordination, workflow optimization, patient and physician engagement, analytics and quality reporting. In the initial stages, the focus will be on data sharing and interoperability across providers aimed at strengthening coordination and collaboration in transitional and longitudinal care programs for high-risk populations. To jointly manage patient populations across previously siloed providers, this includes the implementation of common care management tools that support data sharing, aggregates patient information and advanced analytics. The PPS will measure and report progress toward PPS goals.

The MSO will provide the support and essential resources for the PPS' proposed projects such as the scaling of Mount Sinai's well-established Community-based Preventable Admissions Care Team (C-PACT) to reduce 30-day readmissions; focused programs to integrate behavioral health services and primary care; and an intensive effort to increase early access to and retention in HIV care. It will carefully track analytics in order to allocate and tailor resources where they are required to enhance overall outcomes.

Other programs we will draw from include the VNSNY Population Health Management program, which focuses on prevention and improved health outcomes by collaborating with patients, providers, and payers and applying an evidenced-based care coordination approach. Care Coordinators use a comprehensive health assessment tool and utilization data that synthesizes more than 20 factors to stratify patients' risk level and the tool yields a validity of approximately 71-73%. Through provider engagement, education, and a focus on practice transformation, the MSO will lead the effort to ensure that population health goals are attained at the local level and throughout our entire network.

The MSPPS is well positioned to successfully implement an IDS and address the access and efficiency challenges identified in the CNA. Our network is comprised of one of the largest hospital systems in the state, along with a wide range of providers covering the continuum of care including comprehensive primary care, long term care, behavioral health, specialty care, dental care, and community based supports and service providers. Our PPS and partners are committed to building comprehensive infrastructure to support population health, focusing on underserved populations

- 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.

Our PPS is a diverse network of resources and assets including medical, behavioral health and social service organizations, such as physicians, hospitals, Federally Qualified Health Centers and other D&TCs (Article 28), substance abuse treatment programs (Article 32), mental health providers (Article 31), OPWDD (Article 16) providers, certified home health agencies, licensed home care agencies, pharmacies, nursing home/skilled nursing facilities, assisted living facilities and programs, community



paramedicine, long term care providers, and community based healthcare, social and legal service organizations and housing providers that provide needed wrap-around supports.

In mobilizing our assets, we will focus on specific geographies that our CNA identified as high need. We will also build upon existing population health infrastructure including a Medicare Shared Savings ACO, Health Homes encompassing Manhattan, the Bronx, Queens, and a Community-based Care Transitions Program (CCTP). Collectively, these foundational programs offer transitional and longitudinal care management expertise supporting expanded care coordination efforts network-wide. The IDS will leverage the Provider Partners of Mount Sinai, a clinically-integrated IPA of ~ 3,500 physicians, already engaged in risk-contracts with Health First. Similarly, we will build on ArchCare's Program of All-Inclusive Care for the Elderly (PACE), a proven model of care for dual eligibles, to expand access to quality primary care and advance the shift towards value-based payments. Our existing programs and services support our ability to address gaps in services and needs outlined in the CNA, including access to care, including primary, specialty, and behavioral health services.

In addition, the MSPPS will develop strategic resources that allow it to:

- Deploy a common population health and care management system across the PPS network to enable identification of high risk patients and implementation of patient-specific intervention plans.

- Repurpose and strengthen existing facilities. While there is a need to address excess beds, our PPS is conducting an analysis to ensure that we are comprehensive in approach. Upon identifying where there is excess, we'll engage provider and labor partners on how to repurpose those beds, and identify where additional community-based services and supports are needed to be built or expanded.

- Expand access to primary care, urgent care, and behavioral health. Building on the above analysis, we would work with our partners and other PPSs to identify gaps in access that can be addressed through expansion, revision or new builds.

- Develop customizable patient and provider navigation and clinical support programs. Utilizing community-based coordination staff to assist both patients and providers in navigating the complexities of accessing care across multiple providers, payors and systems.

- Develop a comprehensive call center, serving several functions including triage and referral coordination. The call center will serve as a "one stop" patient resource and will assist in directing patients to the appropriate providers at the right level of care. In addition, it will be capable of providing necessary follow-up for identified patients, and clinical services including telemedicine. This center will coordinated care through our care management tools, including connectivity to existing plan call centers.

- Enable comprehensive data sharing across providers. We will support linking provider EHRs through several Regional Health Information Exchanges (RHIOs) and the State Information Exchange. The goal will be to provide point of care decision support including implementation of best practice guidelines.



- Provide contracting and population health analytical support. The PPS and MSO will provide a broad range of services, including beginning risk contract negotiations, actuarial services, quality reporting, and advanced clinical and financial analytics

- 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.

Challenges will arise, such as in patient/provider engagement, workforce reconfiguration, and achieving system-wide interoperability. We will quickly identify issues and work with our provider and labor partners to deploy evidence-based approaches so we may constantly evaluate our methods using evidence-based, data driven metrics. This process will allow us to create innovative solutions expanding on existing approaches.

We anticipate the need to educate patients and communities as we transition to new models of care. We will focus on engaging all levels with language and culturally appropriate tools by utilizing peer advocates, coaches, literacy experts and others. Collaborative re-engineering of team-based care to align incentives and enable efficient communication between patients, care coordinators, and providers is key. This will be supported by targeted outreach programs, as well as training of providers and front-line staff. The call center will provide immediate one-on-one support of patients and families, as well as support lines for providers and front-line workers.

Workforce challenges due to current shortages of primary and behavioral health providers in several communities, shifting infrastructure, and increasing caseloads are also likely. As host to the largest Graduate Medical Education training program in the country and the Phillips Beth Israel School of Nursing, we will work with these resources to fill identified workforce gaps. We will also work with TEF and labor partners to recruit and train community health workers and navigators from our target communities, as detailed in Project 2.c.i.

Implementing uniform systems to facilitate credentialing of providers is key. Adequate reimbursement rates are critical for expanding and sustaining meaningful changes. Our network, in partnership with the MSO, will implement care models integrating clinical services with care coordination to accommodate a larger number of patients.

Data sharing in a secure and confidential way continues to be a concern for our PPS, particularly in regards to SHIN-NY readiness. Achieving interoperability will require integration with already existing systems. We will work closely with partners to address ongoing data sharing and consent issues, and provide feedback as appropriate to support statewide goals.



- 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.

We have, and continue to build, multiple avenues for collaboration with other PPSs, both directly and through our partners. We will engage other PPSs in the same service area to identify overlap in partners and projects, to develop shared approaches and protocols, share data, and collaborate on project development. For example, we are building a strategic relationship with Bronx Lebanon PPS to do joint planning, achieve economies of scale, and establish shared protocols. Additionally, our relationship with Bronx Lebanon PPS will result in a shared committee structure, providing crossover during the implementation planning process between our IT, Clinical, Workforce and Finance development. We will also continue to solidify our relationship with other PPSs in our service area, through ongoing outreach such as with New York Presbyterian and AW's PPSs.

Our PPS plans to coordinate its DSRIP projects with other PPSs who serve overlapping geographic areas using a variety of methods. Many of our partners have representatives at other PPS committees and workgroups and will be able to share and communicate "best practices" and processes from the other groups. This information sharing will ensure our PPS is aligned with the development of other systems in both processes and reporting. With the breadth and depth of our partners, many of whom are in multiple PPSs, Mount Sinai is well-poised to engage other PPSs. We believe these partners are key to driving performance and standardization across the system. Through these partners, we can further engage other PPSs and other community providers. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.

We will also work with other PPSs to identify and coordinate project implementation in the same clinical implementation sites where possible. This is particularly important as we develop our IDS, as we want to ensure optimal use of existing resources and not build duplicative resources as part of the DSRIP program. As such, we will undergo a process for evaluating clinic site locations against existing needs identified by our CNA, as well as engage other PPSs that overlap in our service area. This process will help us optimize available resources. Furthermore, we intend to begin a detailed mapping process as part of implementation planning with our partners and other collaborating PPSs where we identify hotspots of needs, service areas of each partner and begin the process of aligning gaps with the build out of our IDS.



We will use the MIX, where we can coordinate with PPSs and partners to share ideas and learn from others. To ensure effective alignment, we will task our project managers and consultants to strategize with external support of the other PPSs. Additionally, we plan to converse with the State to convene learning collaboratives. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models. We anticipate hosting speakers to inform providers on payment and care delivery changes. Some of this work has already occurred, such as our panel on Implications for Post-Acute Care Under Value-Based Payment Models. Common unions with other PPSs will provide an additional venue to connect across PPSs around shared protocols and practices. To the extent possible, we will work with our main workforce strategy vendor, TEF, and other willing PPSs to develop joint workforce curriculum.

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 size of the MSPPS provides a rare opportunity to develop and execute the vision of a systematic, multi-level collaborative transformation of the content and structure of health care delivery. Through the implementation of the strategy and action plan described below, we expect a dramatic transformation in the physical and geographic footprint of health services. The MSPPS will promote health and reduce the severity of illness, thereby reducing the need for inpatient beds and long-term care beds over time. The new “footprint” of the MSPPS will be transformed such that the increasing majority of services provided are in ambulatory, community, and home-based settings.

To accomplish this transformation, all of our committees within our PPS governance structure will play a key role. Our Finance Committee is creating a strategy to address how, within our PPS, each type of partner may weather the transition from FFS to value-based payments as the system and infrastructure shifts. Workforce Committee is assessing the current workforce landscape and developing strategies so we may appropriately retrain, redeploy, and hire staff. This will necessitate appropriate incentives, engagement of patients and providers, early identification and engagement of workers impacted, as well as detailed analytical reporting to track the status of our workforce.

As a result of this overarching strategy, we expect the following:

Expansion of primary care services, through increased facility capacity and workforce, telemedicine, and coordination with out-of-hospital healthcare workers (e.g. EMS, Home Health)



Expansion and integration of behavioral health (both mental health and substance abuse) services within physical health services, and vice versa, at all levels of care (projects 3.a.i. and 3.a.iii.)

Expansion of existing and development of new care coordination and navigation services (project 2.c.i.)

Streamlined and standardized methods of communication, specifically around data sharing and referrals, between providers and facilities/agencies to promote better post-acute care transitions and reduce readmissions

Expand pPrimary and secondary prevention programs for high-risk conditions such as HIV/AIDS (project 4.c.ii.)

Leverage existing successful collaborative efforts, such as what the Mount Sinai Hospital and Terence Cardinal Cooke Health Care Center have accomplished with affiliated nursing homes, assisted living, home care affiliates to expedite best practices in care transitions (projects 2biv and 2bviii). We will build upon and repurpose training goals of renowned programs in geriatrics and palliative care to foster more humane and appropriate settings for advanced disease management across the continuum.

Many of the beds, which may need to be repurposed, based on our preliminary review, appear to be behavioral health beds. As beds are repurposed, we will build additional behavioral health infrastructure in the community. This project has significant linkages to our 3.a.i project, which support this transition through increasing capacity and access to primary care and behavioral health. The transformation of Behavioral Health services is a major priority for our PPS. The preliminary vision and plan is as follows:

Development of expanded ambulatory and community-based social support services to reduce unnecessary ED visits and EMS transports while also permitting more timely discharge from inpatient settings.

Standardization of treatment models and clinical pathways in ambulatory and community psychiatric and substance use treatment settings across the PPS.

Integration of mental health, substance use, and physical health treatment for all ages and at all levels of care.

Standardized management and treatment model for psychiatric hospitalizations that result in more efficient, higher quality care, and reduced Length of Stay.

Proactive assessment and management of inpatients on medical/surgical units for potential co-morbid mental health and/or substance use disorders to improve early identification and access to care, as well as reduce length of stay on medical/surgical units.

Streamlined communication and care pathways between PPS partners to provide critical psychosocial support services, in-home and community-based services, peer support services, housing, and wellness services.



Systematic integration of behavioral health into all projects to ensure standardized communication and care pathways for patients with behavioral health diagnoses at all levels of care and treatment settings.

A defined conceptual and operational model of large-scale care coordination has been developed, and will be supported through our care coordination and care transitions projects, such as 2.b.iv and 2.b.viii. These projects support and build upon existing programs, such as our mobile acute care program (which will be expanded system-wide). We have a blueprint for tracking the evolution of the care management model, which consists of an integrated, standardized workflow management and monitoring to produce a seamless patient experience across the continuum. This blueprint tracks the population health needs from the early ambulatory care settings for primary and specialty outpatient care, to ED visits and urgent care venues, to acute hospital care that is attended by advanced utilization management and discharge planning, to care transitions from hospital to post-acute to home. The model includes social workers, patient navigators, legal professionals, and nurses, working in collaboration with all clinical team members. Risk stratification tools will be utilized to understand type of intervention and resources required for our patient population.

We expect this will result in a substantial reduction in the number of inpatient psychiatric and detoxification/rehab beds, as well as long term and general medical/surgical beds across the system, as a result of the population remaining in the community longer and more frequently over the next five years. To do this successfully, we will first focus on expanding primary care and outpatient services so we can reduce admissions, which will then lead to a smoother transition as a focus on reducing available beds.

Key Milestones for IDS Development: Governance

- Establish clear overall organization and governance structure for IDS Subgroup and for each major IDS component
- Determine clear Subgroup deliverables, meeting times, and annual calendar deliverables
- Create clear communication pathways between the Subgroup and other committees for planning and data sharing purposes

Strategic Plan

- Systematic data collection and analysis to begin a comprehensive approach to reductions of acute and long term care beds, and develop measurable targets for IDS points of access throughout

Operations and Performance Management

- Establish organization and support structure
- Establish clear clinical protocols and care pathways



- Establish strategic plan for IT infrastructure, build, and reporting and analytic tools
- Establish centralized communication centers and clear communication between partners
- Define risk stratification model IT Infrastructure Development
- Development of population management tools
- Data sharing across entities
- Best practice guidelines analytic reporting, including claims data from payors
- Focused plan for systematic assessment of patient, family, and community engagement and feedback Workforce
- Conduct gap analysis on primary care, specialty and behavioral health providers to assess and meet the need
- Refinement of staffing and resource needs
- Early identification of impacted staff
- Develop and deploy retraining and redeployment programs as needed Payor Contracting
- Organization and support structure
- Partner alignment
- Define and establish potential risk-bearing models Patient/Family Engagement
- Define ongoing feedback and engagement process for patients/families

- 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.).

Our governance strategy for this projects will be guided by the driving principles of system transformation, which are innovations in access to care; proactive treatment and health promotion methods that transcend traditional physical and geographic limitations; focus on the socio-economic determinants of health that impact patients' overall health; use of evidence based treatment approaches and best practices to ensure standardization of the treatment and prevention of disease; integration of physical health and behavioral health care at all levels of care; and patient and family oriented care, education, and empowerment. Our Clinical Committee has a specific subgroup focused on



IDS development. As the governance structure evolves, this subgroup will play a central role in developing, monitoring, and reporting on the IDS. The governing body of the subgroup is comprised of two co-leads and over fifteen active members who represent a broad range of our partner organizations. The subgroup will be the key conduit between the Leadership Committee and the MSO. The Subgroup will direct the work of the MSO as it pertains to IDS and will report to the Leadership Committee. Throughout the project, the Subgroup will work closely with the Leadership Committee to provide a comprehensive and overarching governance structure for all of the projects taken on by the PPS to ensure a fully integrated system and the MSO.

The governance of this project and expectations of partners will be clearly established in our partnership agreements, as well as in the project workplan. The PMO will also work with each partner to ensure that they have clear workplans established that support achievement of provider and project specific metrics and milestones.

With any integrated system, the first milestone is to ensure engagement from all members. This governance structure will provide fluid connectivity between all of our partners, because our full provider network is participating in the IDS. To ensure active involvement of all PPS partners, the PPS will host a series of meetings as part of implementation planning with all partners. This will serve as an opportunity to discuss the overarching goals and vision of the IDS and what it means for each of our partners to be part of our IDS. We will also circulate surveys to gauge provider interests, feedback, and progress. The subgroup will engage with providers broadly and then share key information to the MSO and Leadership Committee. Key decisions and developments will be discussed and voted equally throughout members of the subgroup, and the subgroup will solicit feedback from Leadership Committee where appropriate.

A critical element of an integrated system relies on communication across all partners, which is another milestone for our PPS and will take a significant amount of IT infrastructure for successful interoperability within the PPS network. We will consistently engage with the MSO to establish system-wide tools that will be used for care management and coordination, as well as data sharing. The subgroup will work closely with the IT Committee to ensure all partners are meeting the metrics set forth pertaining to Meaningful Use. Furthermore, subgroup members will be tapped to support rapid-cycle evaluation needs through the Performance Management Workgroup (PMW), responsible for collection, monitoring and dissemination of key performance and outcomes data (See Section 6.2 in Organizational Application). The PMW will engage subgroup and Clinical committee members to support performance measurement and driving towards achieving outcomes across our PPS.

The subgroup members will also provide input and direction to the PMO and the MSO as we work closely with MCOs to develop and implement key components moving toward becoming a risk-bearing



entity, which will ultimately lead to our third milestone of establishing value-based contracts. The subgroup will work with the PPS Finance Committee as we have regular meetings with the MCOs to discuss network development and payment issues. Cross functional teams will be established to ensure the appropriate mix of expertise and support is available to the PMO and MSO as the PPS moves forward with payment reform efforts. As the PPS evolves into a risk bearing entity (see Section 2), the IDS subgroup will continue to play a critical role providing key insight, guidance and expertise needed to ensure appropriate management of risk.

An essential component of this project is addressing over-bedding across the PPS network, which serves as another milestone for our PPS. Specific annual goals will be identified to ensure progress toward this goal, which we are approaching focused not only on bed reduction, but also how we can effectively repurpose beds and retrain/redeploy existing workers impacted, including frontline and operational staff. In DY 1, 2, and 3 there will be an emphasis on expanding capacity of primary care and additional outpatient resources, behavioral health and other ways to increase access. This will ensure that patients are not displaced in the system and will allow for a smooth transition during DY 4 and 5 as we reduce overall bed capacity across the network.

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

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

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

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

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

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



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

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

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

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

The organizations within the PPS are at varying stages of readiness for the implementation of the ten projects selected. Capital funding will assist in filling a number of gaps related to HIT interconnectivity, and expanding access to clinical and social services for individuals served. Funding these specific endeavors will allow the network to demonstrate transformational change through the reduction of hospitalizations, emergency rooms visits and Medicaid expenditures while improving health outcomes of the Medicaid population – the crux of the state’s vision of DSRIP.

There are a number of overarching themes for how capital dollars would be expended across the partners for Project 2.a.i including:

IT Infrastructure – HIT/RHIO interconnectivity; purchase of care management/electronic medical record software; software integration;

Access to Care – expansion and integration of clinical services (behavioral and medical); increasing hours of operation or renovating clinical facilities from acute to step down units or increasing FQHC space; investment in telemedicine;

Outreach and Engagement – one time development of marketing and promotional materials to engage patients within the PPS inclusive of media and social media platforms

The need for IT infrastructure funding support will assist in the purchase, dissemination, and integration of care management tools. Also integral to the MS PPS will be the establishment of a call center that will play a critical role for care management and coordination. Capital funding will be utilized for building up the infrastructure of the call center.

According to the CNA, there is a significant shortage of access to primary and behavioral healthcare for residents of New York City. We intend to request capital funding improving access to care such as increasing the co-location of primary and behavioral healthcare services as well as building more urgent care and primary care clinic sites. The integration of primary and behavioral health services is particularly important as the CNA revealed there is a high prevalence of co-occurring conditions in our patient population and communities for which we serve.

The landscape of healthcare is rapidly changing. In order to meet the needs of our patient population, outreach infrastructure and materials to message the goals of the project and the services provided within the PPS is important. Information about where to access services, the types of services provided, and the diversity of providers will again address one of the concerns echoed within the CNA.



- 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
The Brooklyn Hospital Center	Hospital Medical-Home Grant	January 2013	December 2014	The Hospital- Medical Home Demonstration is a health care quality and safety improvement program for Medicaid members in New York State. The program, funded by the Centers for Medicare and Medicaid, provides funding to New York State teaching hospitals and is operated by the NYS DOH. The focus of the Hospital- Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians.



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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Sinai School of Medicine and sub-set of PPS partners	CMMI MACT – Mobile Account Care Team			The MACT program treats patients requiring hospital admission for selected conditions at home. The core MACT team will involve physicians, nurse practitioners, registered nurses, social work, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team provides services for 30 days after admission.
Mount Sinai Health System and sub-set of PPS partners	NY-RAH (New York Reducing Avoidable Hospitalization)	October 2012	December 2016	This CMS quality improvement project that utilizes proven, evidence-based methodology INTERACT; promotion of evidence based care paths; training program of early interventions; and improved discussions of goals of care and palliative care referrals where appropriate. Currently involving 475 clients in the SNF who are in the SNF for > 100 days.
Mount Sinai Health System and sub-set of PPS partners	IMPACT	October 2012	December 2016	IMPACT (Improve Processes And Care Transitions) is a project designed to reduce readmissions of post-acute care patients utilizing greater communication between the sending hospital and the receiving SNF (and vice versa). The focus is on process, data transfer, MD to MD communications, hospital discharge planning and IT innovation. The number of clients is a rolling total of all the patients discharged from the Mount Sinai System hospitals.



- 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.

Project 2.a.i both differs from and greatly expands upon TBHC's Hospital Medical-Home Grant, which ends this month, in that the project requires the creation of care coordination teams to address a targeted patient population. Under the grant, TBHC has worked to become recognized as a Patient Centered Medical Home (PCMH) and has developed care transition protocols. Project 2.a.i greatly expands upon TBHC's grant by connecting TBHC with a broader network of partners in an integrated system. Moreover, Project 2.a.i significantly expands upon TBHC's Hospital Medical-Home Grant and the Mount Sinai CMMI MACT, NY-RAH, and IMPACT programs in that the targeted at-risk populations served will include patients served by all PPS providers participating in this project beyond those discharged and served by the hospitals. Multidisciplinary teams established will be comprised of providers across the PPS and not simply limited to Mount Sinai providers. Information sharing platforms and protocols will be expanded to all PPS providers.

6. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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



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

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



2.b.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 and <http://innovation.cms.gov/initiatives/CCTP/>.

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

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



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

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

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

Medicaid beneficiaries were hypertension, asthma, depression, diabetes, and depressive and other psychoses. This project responds to the data through the development of a robust network of community and care transition resources to keep vulnerable populations with chronic conditions out of the hospital and in the community.

High rates of hospital utilization overlap with the multiple Health Professional Shortage Areas (HPSAs) within our service area. A lack of primary care, particularly in Manhattan, is highlighted in HPSA data. Qualitative data from the CNA also reveal Medicaid beneficiaries struggle to access preventive care, with 46% of PPS providers responding that patients have a “difficult” time accessing routine primary care and preventive services. Only one in five agreed that Medicaid patients are able to visit a PCP in the week following hospital discharge.

MSPPS will build on current innovative programs to support patients post hospital discharge. For example, Mount Sinai’s Preventable Admissions Care Team (PACT) model has shown a 40% reduction in avoidable admissions and a 50% reduction in ED visits among high risk patients. Consistent with CNA findings, many patients served by PACT live below the poverty line, suffer from mental illness and/or substance use disorders, have high rates of adult obesity, and low rates of medication and post-discharge follow-up care adherence.

Regional health disparities and barriers will be addressed through the development of transitions of care (TOC) teams that leverage existing programs and community-based resources, expand the workforce to reflect the diversity of our communities, address disease-specific care gaps, and acknowledge the cultural nuances and linguistic needs of the target population. Master’s prepared social workers or similarly trained staff will be deployed to acute care facilities and community dwellings to engage high risk patients through comprehensive assessments to identify the areas of psychosocial strain that compound the risk of “super” utilization (e.g. unmet mental health/substance misuse concerns, lack of PCP, lack of sufficient formal/informal supports, and barriers to accessing treatment, including legal concerns). The intensity of intervention is determined following the assessment and support services are tailored for each patient. All patients will be linked to primary care and an extended community-based team of providers who are able to address ongoing medical, emotional, and social needs for long-term stabilization. PACT workers will be culturally and linguistically matched to patients when possible, licensed, and trained to address multiple presenting difficulties, including mental health concerns, housing instability/homelessness, addiction, social isolation, and language/literacy differences, with support from other care management staff. Engagement in the project and utilization outcomes will be tracked and used in staff performance evaluations. To do this, we will work closely with



our IT committee to establish appropriate tracking mechanisms and regularly review data points and progress.

For patients not identified as high-risk at the time of their hospital admissions, MSPPS care management staff will implement a standardized assessment tool to identify social support services or longitudinal care management programs such as Health Homes and PACE, so that appropriate outreach and engagement can occur during the admission and discharge planning process.

- 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.

MSPPS will target an identified population that can be directly impacted by PACT and/or longitudinal care management teams. ED and inpatient utilization data, as well as information from our CNA will primarily identify the target population. CNA data shows that, in 2012, there were 1,257,597 potentially preventable Medicaid emergency department visits (PPVs) in our service area, or an average rate of 35 events per 100 Medicaid beneficiaries. Although Manhattan has the lowest number of PPVs, accounting for 16% of preventable visits in NYC and Westchester County, it has the highest PPV rate of the counties at 42 events per 100 patients. Not surprisingly, of the counties within our service area, Manhattan has the most hospitals, which is likely a driver of preventable hospitalizations, as individuals experiencing barriers to primary care have easy access to EDs. We anticipate high-utilizing Medicaid residents living in Manhattan will comprise a significant portion of our patient population.

While the patient population will stretch somewhat broadly, specifically we will target patients at-risk for readmissions due to underlying chronic conditions and co-morbidities, such as cardiovascular conditions, diabetes, and substance abuse and mental health disorders. CNA data show that of the more than 3.5 million Medicaid enrollees in NYC, 30%, have a cardiovascular disease or disorder. Medicaid patients in Brooklyn represent more than a third of New York City area beneficiaries with cardiovascular conditions, followed by patients in Queens and Manhattan. Moreover, the rate of heart disease hospitalizations and preventable hospitalizations for adult hypertension and adult angina without procedure are higher within our service area is higher than the statewide rates. In 2012, in our service area as defined in our CNA, 28.8% of Medicaid beneficiaries with diabetes had at least one inpatient admission for diabetes. Medicaid patients with diabetes who had an ED visit for diabetes average 2.3 hospital visits per member. This utilization suggests that more can be done to manage diabetes in the community rather than in acute settings. Our service area also has the highest rates of mental health readmissions within 30 days compared to other areas of the state, as well as the highest percentage of substance abuse readmissions within 45 days.

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



Our current assets and resources for this project are broad and varied, including model programs that provide guidelines and best practices for implementation and trained workers that is highly skilled in effective interventions for the target populations (as indicated below). These programs need to be expanded and new workers trained to bring this project to scale. Participating providers fall under the following categories to ensure that health and social needs are addressed.

Care Management and Care Coordination to Manage Conditions and Connect Patients to Needed Services and Resources:

- Health Homes and care coordination programs
- PACT Clinics and FQHCs
- Home care services, including hospice and palliative care resources
- Community paramedicine

Primary and Specialty Care Providers to Address Physical Health and Manage Chronic Conditions:

- Community-based primary care clinics
- Program of All-inclusive Care for the Elderly (PACE)
- Outpatient specialty care
- Mental health and substance abuse treatment programs (in-home and community based)
- Harm reduction community-based programs
- PACT Clinics
- Home care services, including hospice and palliative care resources

Skilled nursing facilities

Telemonitoring for patient engagement and self-management skills training

Supportive Housing and Community-Based Social Services to Support and Stabilize Patients

- Supportive housing programs and housing services, including Single Point of Access housing and Medicaid Assisted Living Program
- Re-entry programs and alternatives to incarceration services
- Disability rights services
- Home care workers
- Legal aid/legal health services and benefits advocacy
- Nutritional programs (in-home and community based)
- Tenants/neighborhood organizations
- Vocational training and employment programs



- Senior day centers and department of aging resources
- Educational systems
- Youth programs/homeless youth programs

MSPPS will build on existing relationships and form new partnerships to ensure that the PPS is flexible enough to respond and address specific patient needs. Our current workforce provides a strong foundation to meet the needs of the population targeted in this project, but it will need to be expanded to meet the needs of this project. This requires working closely with Workforce Committee and partners to identify and train workers to meet this project's needs. We will draw upon existing trained social workers, case managers, care coordinators, and physicians to trigger necessary interventions and address the underlying conditions that are driving readmissions. Current care coordination practices and systems used by our participating Health Homes will be leveraged.

Because this project will require an expansion of sites and services, we anticipate retraining current staff and hiring additional staff for these positions to ensure that the patients at-risk of readmissions are accurately identified, medical and social needs are addressed, and follow-up is conducted. Some partners will need to hire new workers, which may be harder for smaller organizations. Working with Finance Committee, MSPPS will manage its flow of funds to allocate and set aside some dollars for project implementation (assuming the PPS begins receiving DSRIP incentive payments). A critical function of the PPS is supporting partners to reinvest DSRIP payments to fund ongoing transformation, including appropriate staffing to ensure metrics and milestones are achieved. Furthermore, engaging patients and families require outreach and education. Project 2.b.iv will be bolstered by our project 2.c.i, where our PPS will support growth of additional community navigation services. Under 2.c.i, patients and families will receive further education about the availability of services, including how they might engage with workers providing care transitions services to them. This project is complemented by Projects 2.b.viii to ensure discharged patients receive the best care possible.

- 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 key challenge is identifying and engaging the target population. Most patients have complex issues contributing to readmission. Our CNA data showed our target population will be diverse culturally, linguistically, and in geography. In addition to chronic and acute medical conditions, our target population suffers from mental illness, serious substance abuse disorders, and some are homeless. Our challenge is to identify these patients before they are readmitted, engage them in a care plan, and help them access the services they need.

One challenge is ensuring the initial point of contact and subsequent assessment is presented to patients in an engaging and non-judgmental manner. We know that many issues stem from inadequate discharge follow-up and insufficient communication. Staff must have the skill, training, and capacity to engage patients, caregivers, and families; hear their perspective and values; and apply an accurate intervention supporting their social and health needs. To engage patients, we will implement the



following strategies:

- Staff will be recruited, retrained, and empowered, to interact with patients, caregivers, and families to establish trust and help identify patients in need of greater care management services
 - Case managers will be instructed to have in person and have face-to-face interactions to build relationships
 - To best meet cultural and/or linguistic needs, staff will be recruited from the communities where our target patients live and work
 - Telemonitoring has also proven effective in engaging patients with hypertension and diabetes; achieving greater self-efficacy, and identifying changes in condition on a timely basis
- As noted, a significant challenge will be ensuring patients have access to both needed medical and social services. To address this challenge, community-based resources for patients will be clearly articulated in care plans with streamlined referral processes and on-going feedback mechanisms. For this to occur, leadership, practitioner, and line staff buy-in is necessary. For some, this may require a culture shift towards holistic care, away from disease/ailment-specific treatment. The MSPPS will address this through worker retraining strategies.

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

We continue to build multiple avenues for collaboration with other PPSs, both directly and through our partners. By way of cross-PPS meetings, we will work with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop common approaches and protocols, share data, and collaborate on project development. For example, we are currently building a strategic relationship with the Bronx Lebanon Health Center PPS to facilitate joint planning, achieve economies of scale, and establish shared protocols.

We also have engaged with the New York City Department of Health and Mental Hygiene (NYC DOHMH) to collaborate on projects that both MSPPS and HHC share. In addition, our workforce and union stakeholders overlap with other PPSs, providing an additional avenue to connect across PPSs around shared protocols and practices. We will leverage these connection points to 1) identify areas for collaboration, 2) develop relationships with other PPSs, and 3) advocate for shared efforts where possible.

We will also work with other PPSs to coordinate project implementation in the same clinic sites where possible. Using the MIX and through State DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models. We anticipate hosting speakers to inform providers on payment and care delivery changes.

With the breadth and depth of our partners, many of whom are in multiple PPSs, MSPPS is well poised to engage other PPSs. These partners are key to driving performance and standardization across the system. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that, regardless of where Medicaid patients seek services, they have access to the best care possible.



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.

In order for this project to be successfully implemented, all partners need capital investment in a shared IT infrastructure that facilitates care coordination and patient tracking. This will ensure seamless communication between partners around all patient clinical needs and reduce duplication of services and confusion for patients and providers. Funds requested will go towards purchasing tablets, computers, and phones for staff and allowable one time IT costs for connectivity platform hardware.

Capital funding for IT infrastructure is incredibly important to the success of this DSRIP project – real-time ability to engage and connect with other care team members while in the field will significantly enhance a community-based provider's ability to provide care to patients in their home or other non-traditional health facility setting. Providing front-line



workers in the community with tablets and computer (and the ability to connect) will allow our PPS to push data related to a patient’s care to the provider in the field, allow the provider in the field to update and receive advice and consultations remotely (increasing access and efficiency), as well as allow the PPS to provide population health management tools and resources supporting community based care.

As our PPS creates and expands multiple programs to allow for effective coordination of care, we will need to invest substantially in space allocation to allow for staff expansion and to ensure co- location services. This is reflected in our request for capital funding for new building space, as well as renovation of existing space to optimize DSRIP programs, including the conversion of inpatient units to outpatient space and expansion of space for day programs and behavioral health services.

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

Yes	No
<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
The Brooklyn Hospital Center	Hospital Medical- Home Grant	January 2013	December 2014	The Hospital- Medical Home Demonstration is a health care quality and safety improvement program for Medicaid members in New York State. The program, funded by the Centers for Medicare and Medicaid, provides funding to New York State teaching hospitals and is operated by the NYS DOH. The focus of the Hospital- Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians.



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Delivery System Reform Incentive Payment (DSRIP) Program
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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Sinai School of Medicine and sub-set of PPS partners	CMMI MACT – Mobile Account Care Team			The MACT program treats patients requiring hospital admission for selected conditions at home. The core MACT team will involve physicians, nurse practitioner s, registered nurses, social work, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team provide services for 30 days after admission.



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

Project 2.b.iv both differs from and expands upon TBHC's Hospital Medical-Home Grant, in that our proposed DSRIP project requires the creation of care coordination teams to address a targeted patient population. Under this DSRIP project, unlike the grant, care coordination teams extend into external community based providers supporting the patient's care in the community. Under the grant, TBHC has worked to become recognized as a Patient Centered Medical Home (PCMH) and has developed care transition protocols. The PCMH requirement under the Hospital Medical-Home Grant, while aligned with Project 2.b.iv objectives, is not required for Project 2.b.iv. Furthermore, TBHC's existing grant is an excellent foundation to build and expand care coordination activities and integration with other community providers, which is done through this DSRIP project.

Moreover, Project 2.b.iv significantly expands upon TBHC's Hospital Medical-Home Grant and the Mount Sinai CMMI MACT in that the targeted at-risk populations served will include patients served by all PPS providers and sites that are participating in this project beyond those discharged and served by the hospitals. Under Project 2.b.iv, care transition protocols developed through the aforementioned Medicaid initiatives will be greatly enhanced and expanded to all participating providers and sites. Multidisciplinary teams established will be comprised of providers across the PPS and not simply limited to Mount Sinai providers. Information sharing platforms and protocols will be expanded to all PPS providers through this DSRIP 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.



2.b.viii Hospital-Home Care Collaboration Solutions

Project Objective Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high risk patients.

Project Description: Many patients who previously were transferred to skilled nursing facilities (SNFs) are now being discharged to less restrictive alternative locations, primarily home-based. Aside from the many benefits of returning to a known and personal setting, there are the risks of potential non-compliance to discharge regimens, missed provider appointments, and less frequent observation of an at-risk person by medical staff. This project will put services in place to address these risks by matching services with transition care management. Services are expected to last more than 30 days.

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. Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.
2. Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.
3. Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.
4. Educate all staff on care pathways and INTERACT-like principles.
5. Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.
6. Create coaching program to facilitate and support implementation.
7. Educate patient and family/caretakers, to facilitate participation in planning of care.
8. Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.
9. Utilize telehealth/telemedicine to enhance hospital-home care collaborations.
10. Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.
11. Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.
12. 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.

Project 2.b.viii ultimately aims to enhance current discharge plans and regimens for individuals discharged from hospitals to home care settings to decrease readmission rates and allow home care patients remain in the community. To identify the need for this project, we analyzed the current health care infrastructure, causes for hospitalizations, current readmissions rates, and discharge follow-up data.

Home care agencies serve patients who would otherwise be treated in a nursing home or skilled nursing facility (SNF), the vast majority of whom are elderly. Health care infrastructure data highlighted in our CNA show that the number of certified home health agencies (CHHAs) and licensed home care services agencies (LHCSAs) within our service area now exceeds nursing homes and skilled nursing facilities, suggesting a growing sector in health care delivery. However, hospice programs and palliative care services are considerably lacking.

MSPPS has designed Project 2.b.viii to support and enhance the home care sector within our services by including all PPS home care services and integrating hospice and palliative care services into home care options. This will ensure that, for patients with complex or advanced illness, treatment decisions are made as early as possible, enabling all members of a care team to provide care consistent with the wishes of patients and/or their families.

In general, CNA data show that the NYC region as a whole performs poorly in terms of ensuring ambulatory follow-up within seven days of hospital discharge. Approximately one in four individuals discharged from hospitals in our service area are readmitted, a rate higher than the statewide average. There is also a large number of Medicaid beneficiaries who have multiple visits to the ED in a given year. In terms of hospitalizations among the elderly population, CNA data show that for every 10,000 adults ages 65 and older in our service area, on average 174.47 are hospitalized for falls, a rate slightly lower than the state average of 193.4 per 10,000 adults ages 65 and older.

Qualitative survey results from providers surveyed for our CNA indicate that current care coordination efforts are largely “ineffective,” primarily because there is a lack of communication and follow-up between different levels of care, system silos, and inadequate IT infrastructure to support coordination across providers for high-risk beneficiaries. Other respondents to our CNA survey indicated there is insufficient coordination between providers in terms of developing care plans for patients.

To address these gaps, we will use a standard assessment to trigger care pathways with evidence-



based decision support and disease prevention/management programs to engage patients with appropriate services. This will include assessment and referral for psychosocial strain, chronic diseases, mental health and substance abuse disorders, specialty care, and palliative care. All patients will be linked to primary care and to a community-based team of providers including PACE for frail elderly, as available. Training inpatient and outpatient staff on these modified care pathways and tools in a systematic way will standardize a more effective and timely response to patient's needs and uniformly apply them throughout various care settings in the community. For patients unable to access office-based care, we will provide home-based primary care to reach this vulnerable population. This will be used to enhance care of high risk patients in the PACT Clinic model as above as well when patients are unable to come in. Telemonitoring will be another resource that will promote medication adherence, enhance patient engagement and self-efficacy, and provider early identification of changes in conditions, which has been shown to be effective with patients with COPD, diabetes, and multiple medications.

- 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 that we anticipate engaging in Project 2.b.viii will include Medicaid beneficiaries in our service area that are discharged from hospitals into home care settings who are at-risk of readmission. We anticipate our population will be largely focused on individuals age 65 and older, as well as individuals with diagnoses that put them at high-risk of readmissions and those with numerous prior hospitalizations. Patients served by home care agencies with select diagnoses that put them at-risk of readmission, including stroke, cancer, chronic obstructive pulmonary disease (COPD), diabetes, pneumonia, and depression, will be targeted. Discharged patients with multiple medications (polypharmacy) and problematic medications will also be included in the target population, as well as patients with poor health literacy and an absence of a caregiver support.

Additionally, we will use measures created by INTERACT, which focus on early identification of at-risk individuals. Using the metrics and guidelines that INTERACT uses to discern their target population, we will be able to mirror these processes to more accurately define our actively engaged population.

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

There are a number of innovative programs that MSPPS can draw upon and scale up to help achieve the objectives of this project. Interdisciplinary, hospital-based Rapid Response Teams (RRT), utilizing the Mount Sinai Hospital-Medical Home Demonstration's (H-MHD), Care Transitions Program and the Preventable Admissions Care Team (PACT), as well as PACT's continuum of services (Community PACT, Outpatient PACT, and PACT Plus), will serve as an asset



and resource for Project 2.b.viii, providing insight on evidence-based best practices and clinically successful models to inform the successful implementation of this project.

PACT is a social work driven program that targets high-risk patients and facilitates their care transitions, confirms home care services and post-discharge medical follow up, and involves caregivers and links them before discharge to community resources and primary care.

Implementing a similar community or home-based RRT, such as PACT, will stratify patients in various ambulatory settings, identify those at highest risk for readmissions, allocate resources, standardize care through a single comprehensive assessment, and direct coordination of ongoing care prior to hospitalization or after hospital discharge according to severity of illness, risk for readmission, and mortality and prognosis discussions.

Redefinition of roles, retraining, and redesign of union and non-union healthcare workforce can staff RRTs in the hospital, home care, and community programs to effectively serve patients during periods of transition.

In addition, we will draw upon MSPPS's Health Homes programs, Community Paramedics Program, the GEDI-WISE Program at Mount Sinai Hospital, the IMPACT To Reduce Readmissions from Nursing Homes Collaborative, NY-RAH, and INTERACT tools for skilled nursing facilities, home care, and care coordination expertise. We will also leverage the expertise of Mount Sinai's Clinical Institutes, including Population Health, Primary Care, Palliative Care, and various specialty-specific institutes.

Other MSPPS assets and resources for this project include:

- Our broad network of home care providers (CHHAs, LHCSAs, and Managed Long Term Care providers)
 - Primary care physicians
 - Program of All-inclusive Care for the Elderly (PACE)
 - Specialists
 - Medicaid Assisted Living Program (ALPs)
 - Hospice and palliative care providers
 - Pharmacies/medication management programs
 - Telehealth providers
 - Urgent care centers
 - Legal aid/legal health services and benefits advocacy
 - Patient portals that are currently available in most provider EHR but still not widely used; potential for expansion to include educational materials and other electronic tools for patient use
- extended hours can increase access to care, facilitate triaging for specialty care, and reduce utilization and costs.

Community resources that will need to be expanded and incorporated to ensure the success of Project

2.b.viii include:

- Benefits/entitlement enrollment centers
- Affordable permanent or transitional housing, supportive housing, and congregate living residences
- Neighborhood volunteer organizations
- Community wellness, socialization and self-management and diabetes prevention programs
- Adult day and social day care programs



- Nutrition and meal delivery programs
- Senior transportation services
- Affordable housing services
- Faith-based support services

We also anticipate a significant need to expand palliative care programs and move them upstream and into the community. Expansion and funding of home-based, ambulatory palliative care programs will 1) expand our capacity to rapidly respond to patient pain and distress related to acute symptoms that may bring them back into the hospital, and 2) increase advanced care planning. Palliative care will also facilitate transition of care goals, hospice referrals, and care intensity that will reduce the need for inpatient or even critical care.

- 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.

Project challenges include:

1. Caregiver may not be available and/or involved at discharge of the patient. To address this challenge, the level of caregiver support for each patient and need for caregiver outreach will be assessed at the time discharge and caregivers will be linked to supportive services accordingly.
2. Issues around information sharing, including lack of a common medical record, absence of cross-setting medication reconciliation, and communication gaps between disciplines and health care settings. Integrated HIT/ EHRs will facilitate health information exchange and provide access to medical records and medication lists.
3. Addressing and documenting advance directives at each transition in the disease continuum and care spectrum. Home and office-based palliative care consultations for chronically ill patients will increase advance care planning and educating staff about Medical Orders for Life Sustaining Treatment (MOLST) will facilitate end of life discussions and allow integration of patient's and family's wishes into a unified care plan. Additionally, the implementation of a common care management information platform for all providers in the integrated delivery system will allow the transfer of this vital information across care setting.
4. Collaboration with multiple experts and disciplines can lead to disagreements and delay completion of evidence-based care pathways. MSPPS will establish clear protocols and evidence-based guidelines to resolve conflicts of opinions. In addition, the development of a learning collaborative, training guides, and opportunities for providers from various settings to meet and discuss project issues face-to-face will improve communication.
5. Lack of integrated health IT infrastructure and need for expanded telemedicine services. Significant investments are needed to create a shared HIT infrastructure, functioning HIE, and telemedicine services will require innovative payment models and policy changes. Early and



continued engagement with MCOs and policy/regulatory changes will facilitate integration and collaboration among previously competitive parties.

6. Regulations impacting provider-to-provider hospital-home care. As we delve deeper into operational details and implementation planning, we will work with DOH to seek regulatory relief to optimize the implementation of this project.

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

We continue to build multiple avenues for collaboration with other PPSs, both directly and through our partners. By way of cross-PPS meetings, we will work with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop common approaches and protocols, share data, and collaborate on project development. For example, we are currently building a strategic relationship with the Bronx Lebanon Health Center PPS to facilitate joint planning, achieve economies of scale, and establish shared protocols. We also have engaged with the New York City Department of Health and Mental Hygiene to collaborate on projects that both MSPPS and HHC share. This PPS collaboration will provide opportunities to create shared training protocols and materials to streamline processes and care provided in overlapping service areas. In addition, our workforce and union partners overlap with other PPSs, providing an additional avenue to connect across PPSs around shared protocols and practices.

We will also work with other PPSs to coordinate project implementation in the same clinic sites where possible. Using the MIX and through State DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models. We anticipate hosting speakers to inform providers on payment and care delivery changes.

With the breadth and depth of our partners, many of whom are in multiple PPSs, MSPPS is well poised to engage other PPSs. These partners are key to driving performance and standardization across the system. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.



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.

In order for this project to be successfully implemented, all partners need capital investment in a shared IT infrastructure that facilitates care coordination and patient tracking. This will ensure seamless communication between partners around all patient clinical needs and reduce duplication of services and confusion for patients and providers. Funds requested will go towards purchasing hardware for staff, licenses for PPS selected integrated software needs, and staff IT education/training.

Capital funding for IT infrastructure is incredibly important to the success of this DSRIP project – real-time ability to engage and connect with other care team members while in the field will significantly enhance a community-based provider’s ability to provide care to patients in their home or other non-traditional health facility setting. Providing front-line workers in the



community with tablets and computer (and the ability to connect) will allow our PPS to push data related to a patient’s care to the provider in the field, allow the provider in the field to update and receive advice and consultations remotely (increasing access and efficiency), as well as allow the PPS to provide population health management tools and resources supporting community based care.

As our PPS creates and expands multiple programs to allow for effective coordination of care, we will need to invest substantially in space allocation to allow for staff expansion and to ensure co-location of program leadership, newly hired staff, and ideally for patient visit space as well. This is reflected in our request for capital funding for new building space as well as renovation of existing space to optimize DSRIP programs, including the conversion of inpatient units to outpatient space or expansion of space for day programs, behavioral health programs, etc.).

- 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 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.



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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
The Brooklyn Hospital Center	Hospital Medical- Home Grant	January 2013	December 2014	The Hospital- Medical Home Demonstration is a health care quality and safety improvement program for Medicaid members in New York State. The program, funded by the Centers for Medicare and Medicaid, provides funding to New York State teaching hospitals and is operated by the NYS DOH. The focus of the Hospital- Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians.
Mount Sinai School of Medicine and sub-set of PPS partners	CMMI MACT – Mobile Account Care Team			The MACT program treats patients requiring hospital admission for selected conditions at home. The core MACT team will involve physicians, nurse practitioners, registered nurses, social work, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team provide services for 30 days after admission.
Mount Sinai Health System and sub-set of PPS partners	NY-RAH (New York Reducing Avoidable Hospitalization)	October 2012	December 2016	This CMS quality improvement project that utilizes proven, evidence- based methodology INTERACT; promotion of evidence based care paths; training program of early interventions; and improved discussions of goals of care and palliative care referrals where appropriate. Currently involving 475 clients in the SNF who are in the SNF for > 100 days.



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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Sinai Health System and sub-set of PPS partners	IMPACT	October 2012	December 2016	IMPACT (Improve Processes And Care Transitions) is a project designed to reduce readmissions of post-acute care patients utilizing greater communication between the sending hospital and the receiving SNF (and vice versa). The focus is on process, data transfer, MD to MD communications, hospital discharge planning and IT innovation. The number of clients is a rolling total of all the patients discharged from the Mount Sinai System hospitals.
St. Luke's Roosevelt Hospital Center d/b/a Mount Sinai Health Home	NYSDOH Medicaid Health Homes Program	Phase II: 4/1/13	Redesignation due 2/1/15	Care Management service and payment model that coordinates all aspects of medical/behavioral health and social service needs for adults with chronic conditions (including HIV and SPMI) to improve patient care, reduce unnecessary utilization (ED, hospitalizations) and reduce costs.



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

Project 2.b.viii both differs from and expands upon TBHC's Hospital Medical-Home Grant, which ends this month, in that the project requires the creation of care coordination teams to address a targeted patient population. Under the grant, TBHC has worked to become recognized as a Patient Centered Medical Home (PCMH) and has developed care transition protocols. The PCMH requirement under this grant, while aligned with Project 2.b.viii objectives, is not required for the project.

Moreover, Project 2.b.viii significantly expands upon TBHC's Hospital Medical-Home Grant and the Mount Sinai CMMI MACT, NY-RAH, and IMPACT programs in that the targeted at-risk populations served will include patients served by all PPS providers participating in this project beyond those discharged and served by the hospitals. Under Project 2.b.viii, care transition protocols developed through the aforementioned Medicaid initiatives will be greatly enhanced and expanded to all participating providers. Multidisciplinary teams established will be comprised of providers across the PPS and not simply limited to Mount Sinai providers. Information sharing platforms and protocols will be expanded to all PPS providers.

Using the Health Homes care coordination/care management model as a cornerstone and leveraging its programmatic relationships between providers and community-based organizations, DSRIP significantly expands upon the reach and scope of the NYSDOH Medicaid Health Home program to impact a broader population of Medicaid beneficiaries across a broader geographic area. Essentially, DSRIP allows for the scaling of the Health Home program.

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.c.i To Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently

Project Objective: This project will develop community-based health navigation services to assist patients in accessing healthcare services efficiently.

Project Description: Health literacy, community values, language barriers, and lack of engagement with community health care services can result in avoidable use of hospital services. People who do not understand how to access and use the healthcare system cannot be expected to use it effectively. This project is focused on persons utilizing the system but doing so ineffectively or inappropriately. The intended navigation services will provide bridge support until the patient has the confidence to self-manage his/her health. These community resources will not necessarily be licensed health care providers, but persons trained to understand and access the community care system. For example, navigators will assist patients with scheduling appointments and obtaining community services. Navigators will be resourced in-person, telephonically, or online; they will also have access to language services and low literacy educational materials.

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. Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.
2. Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.
3. Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.
4. Resource appropriately for the community navigators, evaluating placement and service type.
5. Provide community navigators with access to non-clinical resources, such as transportation and housing services.
6. Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.
7. Market the availability of community-based navigation services.
8. 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.

Research and data show that there are striking disparities in health outcomes for low-income communities and communities of color. Data from the CNA show that the populations within the MSPPS service area are incredibly diverse, with a greater proportion of African Americans, Asians, Hispanic/Latinos, and multi-racial residents and a greater proportion of foreign-born residents (37% versus 22%). Linguistically, there is also greater diversity in our service area compared to the state, with 49% of the population speaking a language other than English, compared to 30% statewide. Spanish is the most common language other than English within the service area.

CNA data also reveals that many individuals within the MSPPS service area have difficulty navigating the health care system, particularly while trying to access primary care, specialty care, and behavioral health care. Patients are often non-adherent with their health care treatment goals due to barriers like housing instability, transportation difficulties, financial concerns, and/or untreated mental health or substance use diagnoses. Of our CNA survey respondents, 49% of providers reported that their patients do not have adequate housing. Data also shows that, due to the socioeconomic status of much of the Medicaid population, transportation is a key factor in limiting patient access to care. Without help navigating complex systems to access needed services, oftentimes these patients end up in hospital emergency rooms. In 2012, there were 798,419 potentially preventable Medicaid emergency department visits (PPVs) in our service area. CNA data shows that Medicaid patients consistently have higher rates of preventable emergency visits compared to patients with other types of insurance. This disparity is particularly large in Manhattan.

Our CNA also reveals that, NYC performs the worst in NYS for ensuring that there is an ambulatory follow-up within seven days of discharge. Among patients who reside in shelters, single room occupancy housing, affordable and low-income housing units, or in short-term sub-acute rehabilitation facilities and skilled nursing facilities, there is a particularly high need for follow-up and navigation services.

Additionally, patients who are transitioning out of incarceration and re-establishing their lives in the community are also in high need for navigation services.

To increase the capacity of our current community-based navigator workforce to address gaps identified in the CNA, we propose hiring specialized navigators focused on locating and engaging patients who were previously known to care management, but were not appropriately followed-up with. Navigators will be partnered with provider sites focused on primary care/disease management and health maintenance/prevention to allow for increased access and easier



collaboration between care team members.

Navigators with specialized knowledge of specific resources and services that are particularly critical for our patient population – housing, transportation, and behavioral health – will be recruited to ensure that patients are actually connected to needed services. Housing specialists will connect and assist patients with affordable housing, supportive housing, and MRT housing applications. Transportation specialists will manage regional transportation hubs and act as a liaison between patients and transportation providers. Substance use specialists will connect patients to local treatment programs and staff. Depression management specialists will work with patients who have been diagnosed or are at-risk for depression, connecting them to community-based services, treatment, and programs while also assisting with medication adherence. Navigators will be recruited to reflect the cultural and linguistic diversity of the service area and have an understanding of the norms, strengths, values, and protocols of the communities in which they will be working.

- 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 that will be engaged in this project will be comprised of numerous groups, including:

- Patients with multiple chronic conditions eligible to participate in Health Homes
- Those with one chronic condition who are ineligible for Health Home participation, but are in need of health navigation services and additional support
- Current Health Home members who need extra support and assistance
- Individuals with low health literacy
- Those from low-income, communities of color experiencing high health disparities
- Beneficiaries in contact with multiple agencies and systems of care (e.g. the criminal justice system, NYC DOHMH, and child welfare system)
- Individuals experiencing homelessness and housing instability
- Referrals from both community-based organizations and primary care providers
- Individuals without family and/or caregiver support
- Individuals with substance abuse conditions and mental health issues

This project will assist in connecting patients to community-based resources and practice-based services. Both will help patients reach their health goals and will facilitate the engagement of all members of the care team. Community-based navigators will work with clients in a wide variety of settings, for example low-income housing units, shelters, SROs, and criminal justice transitional programs, to provide both short-term or longitudinal care coordination services. They will also support current Health Homes, transitional care, or practice-based care coordination services.



- 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.

MSPPS has many assets and resources that can be leveraged for this project. These resources will provide insight about best practices, protocols, and experienced staff that will be utilized to launch this DSRIP project. This project will build upon medical home initiatives, as well as services already being provided by MSPPS Health Homes (Mount Sinai Health Home, CCMP, QCCP, CHN Health Home, and CBC). Community health navigators in this project will enhance and support internal Health Home staff within our PPS network, as well as community-based providers and downstream Health Home care management agencies that work closely with the Health Homes. Health Home staff will be rededicated to specific shelters and “hot spots” of need. In addition, community health navigators will be trained by Health Home staff.

The project will also leverage the expertise and successful community health navigation model developed by City Health Works (CHW), a population health organization that partners with hospitals and primary care providers to manage teams of locally hired community health workers to provide personalized health coaching services. CHW has a proven track record for holistically addressing the social determinants of health in order to improve patient outcomes and reduce avoidable hospital activity. This project will build upon this model to link providers to patients in community settings and deliver accessible, evidence-based, and high-quality care. Under this model, health coaches are trained as community-based navigators for patients and their family and/or caregivers to efficiently access health care services by providing culturally and linguistically appropriate care. Patients and family/caregivers are taught the skills to become independent and confident in their ability to access the health care system appropriately and effectively. Health coaches will be available to work with patients in a variety of ways: in-person, via phone, text and email. They will also provide culturally appropriate, high-quality education materials developed for individuals with low health literacy. These health coaches will work alongside community-based navigators as needed to provide services specific to a diagnosis or associated practice or provider.

Additionally, this project will build upon the care coordination and transition projects already in place that will be expanded upon in Projects 2.b.iv and 2.b.viii. Community-based navigators will work closely with Preventing Admission Care Teams (PACT) clinics and Mobile Acute Care Teams (MACT). Where appropriate, individuals receiving a 30-day interventions from a transitional care program will also be connected to a community-based navigator through a warm handoff for ongoing services. Similarly, the navigators will work closely with existing practice staff, health coaches, and homecare providers to ensure that there are smooth transitions into and out of care. We will also engage EMS in innovative roles like community paramedicine to build upon patient touchpoints by helping patients navigate the healthcare system.

Additional clinical and community-based resources within the PPS that can be leverage for this project include:

- Community-based primary care clinics
- Outpatient specialty care
- Mental health and substance abuse treatment programs (in-home and community based)
- Harm reduction community-based programs
- Home care services, including hospice and palliative care resources



- Supportive housing programs and housing services, including Single Point of Access (SPOA) housing
- Re-entry programs and alternatives to incarceration services
- Disability rights services
- Legal aid/legal health services and benefits advocacy
- Nutritional programs and meal delivery (in-home and community based)
- Tenants/neighborhood organizations
- Vocational training and employment programs
- Senior day centers and department of aging resources
- Educational systems
- Youth programs/homeless youth 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.

Building the necessary data sharing infrastructure to link providers and share patient information will be a challenge. We'll provide solutions to enable interoperability so that organizations are connected through a shared IT platform and are able to connect to platforms developed by the NYSDOH, including Salient and SHIN-NY, and New York City's HHS Connect.

Another anticipated challenge is identifying and engaging a population that has low health literacy and then effectively addressing the multiple cultural and linguistic needs of the target population. Barriers include accessing the necessary information to identify and target the patient population, sharing information among patient care teams, addressing patient concerns and distrust about accessing health care, and following patients longitudinally across settings while keeping the work streamlined for staff. We will address these challenges by partnering with existing community-health navigation programs and our participating Health Homes to build on proven strategies to identify and engage patients and to differentiate services and partners where appropriate. Community-based navigators will be challenged in assisting patients who are completely disconnected from providers. Helping patients complete all necessary documentation to access needed services and conducting follow-up and follow-through to ensure that services are rendered will require a high-touch approach in collaboration with a wide array of service providers.

Other anticipated challenge includes avoiding the duplication of services and ensuring that community health navigators are working in close collaboration with PPS providers for those clients enrolled in Health Homes and other programs. We will work towards IT solutions to flag patients who are enrolled in specific initiatives or programs and coordinate with staff to manage caseloads appropriately.

Another challenge will be augmenting and further developing a workforce capable of delivering culturally competent services tailored to non-English speaking populations and individuals with low health literacy. Outreach tactics and strategies must be adapted to the various levels of health literacy across the target population. To address these challenges, we will work closely with our workforce committee in implementing guidelines and metrics around training, retraining, and hiring



- 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.

To avoid a duplication of services and successfully navigate patients across multiple providers and systems of care, MSPPS will work closely with other PPSs to develop planning and learning collaboratives and share best practices, lessons learned, training tools, and data. By collaborating with other PPSs directly and through our partners, many of whom are in multiple PPSs, we will identify overlapping projects and develop joint strategic planning and shared protocols. We recognize that patients have and will seek care within and outside the network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.

To that end, our goal is to collaborate in developing best practices to train navigators, address standards of care, and develop shared protocols and approaches. In doing so, we hope to provide continuity throughout the service area for our navigators and patients. We will also work with other PPSs to identify and coordinate project implementation in the same community-based sites, including clinics, where possible. By utilizing the "MIX" as a forum to share information and ideas, we will engage in a dialogue with other PPSs to address specific issues relevant to this project. Additionally, we will participate in state convened learning collaboratives to discuss local and national best practices and models with other PPSs.

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.

In order for this project to be successfully implemented, all participating partners need capital investment in a shared IT infrastructure that facilitates care coordination and patient tracking. This will ensure seamless communication between partners around all patient clinical needs and reduce duplication of services and confusion for patients and providers. Funds requested will go towards purchasing tablets, computers, and phones for staff and allowable one time IT costs for connectivity platform hardware.

Capital funding for IT infrastructure is incredibly important to the success of this DSRIP project – real-time ability to engage and connect with other care team members while in the field will significantly enhance a community-based provider’s ability to provide care to patients in their home or other non-traditional health facility setting. Providing front-line workers in the community with tablets and computer (and the ability to connect) will allow our PPS to push data related to a patient’s care to the provider in the field, allow the provider in the field to update and receive advice and consultations remotely (increasing access and efficiency), as well as allow the PPS to provide population health management tools and resources supporting community based care.

As our PPS creates and expands multiple programs to allow for effective coordination of care, we will need to invest substantially in space allocation to allow for staff expansion and to ensure co-location services. This is reflected in our request for capital funding for new building space, as well as renovation of existing space to optimize DSRIP programs, including the conversion of inpatient units to outpatient space and expansion of space for day programs and behavioral health services.

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

Yes	No
<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
The Brooklyn Hospital Center	Hospital Medical-Home Grant	January 2013	December 2014	The Hospital- Medical Home Demonstration is a health care quality and safety improvement program for Medicaid members in New York State. The program, funded by the Centers for Medicare and Medicaid, provides funding to New York State teaching hospitals and is operated by the NYS DOH. The focus of the Hospital- Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians.
Mount Sinai School of Medicine and sub-set of PPS partners	CMMI MACT – Mobile Account Care Team	November 17, 2014	August 31, 2017	The MACT program treats patients requiring hospital admission for selected conditions at home. The core MACT team will involve physicians, nurse practitioners, registered nurses, social work, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides. The core MACT team provide services for 30 days after admission.
Mount Sinai Health System and sub-set of PPS partners	NY-RAH (New York Reducing Avoidable Hospitalization)	October 2012	December 2016	This CMS quality improvement project that utilizes proven, evidence- based methodology INTERACT; promotion of evidence based care paths; training program of early interventions; and improved discussions of goals of care and palliative care referrals where appropriate. Currently involving 475 clients in the SNF who are in the SNF for > 100 days.



Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Mount Sinai Health System and sub-set of PPS partners	IMPACT	October 2012	December 2016	IMPACT (Improve Processes And Care Transitions) is a project designed to reduce readmissions of post-acute care patients utilizing greater communication between the sending hospital and the receiving SNF (and vice versa). The focus is on process, data transfer, MD to MD communications, hospital discharge planning and IT innovation. The number of clients is a rolling total of all the patients discharged from the Mount Sinai System hospitals.

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

Project 2.c.i both differs from and expands upon TBHC’s Hospital Medical-Home Grant, which ends this month, in that the project requires the development of community health navigators to address a targeted patient population. Under the grant, TBHC has worked to become recognized as a Patient Centered Medical Home (PCMH) and has developed care transition protocols. The PCMH requirements under this grant, while aligned with Project 2.c.i objectives, is not required for this project.

Moreover, Project 2.c.i significantly expands upon TBHC’s Hospital Medical-Home Grant and the Mount Sinai CMMI MACT, NY-RAH, and IMPACT programs in that the targeted at-risk populations served will include an expanded patient population beyond those discharged and served by the hospitals, including all those served by all PPS providers participating in this project. Under Project 2.c.i, community health navigators will coordinate with these programs to ensure that community health navigators avoid duplication of services and are integrated effectively.



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.

According to the CNA, about 1.3 million NYS Medicaid beneficiaries are diagnosed with a mental health (MH) condition. Of this population, 53% of these beneficiaries live in NYC. Depression, chronic stress and anxiety, and schizophrenia are the most common conditions, with the highest prevalence rates in Brooklyn. Additionally, of the 370,898 NYS Medicaid beneficiaries with substance use disorder (SUD), 60% live in NYC with the highest prevalence in Brooklyn. National data from the CDC demonstrates that 6.8% of children aged 3-17 have Attention Deficit Disorder, 3.0% have anxiety, 2.1% have depression, and 1.1% have Autism spectrum disorders. Of those aged 12-17, 4.7% have an illicit drug use disorder, 4.8% have an alcohol use disorder, and 2.8% have cigarette dependence. Also, 11% of non-pregnant women of reproductive age reported depression in the last year. Of women aged 18-44 who recently gave birth, 9-18% experienced postpartum depression, and 8% of pregnant women had major depression in the past year.

During our planning phase, we surveyed over 100 PPS partners to learn more about the accessibility issues and barriers that Medicaid beneficiaries experience when trying to access health services. About 59% of the partners that responded to our CNA survey indicated that Primary Care Providers (PCPs) and MH/SUD providers are "ineffective" at managing Medicaid



beneficiaries with an MH/SUD co-morbidity, and cite the following barriers: PCPs not trained to work with these patients, the current delivery system operates in "silos", and PCPs and MH/SUD providers lack IT infrastructure to facilitate regular communication. About 46% of the survey respondents indicated that Medicaid beneficiaries find it difficult to access routine primary and preventive care.

In our service area of MH and SUD beneficiaries, 46% and 60%, respectively, visited the ED at least once, respectively, and 31% and 61% were hospitalized in 2012, respectively, compared to 32% and 42% of patients with cardiovascular disease [CVD], respectively. Of the total number of hospitalizations in 2012, 24% had MH conditions and 14% had SUD (34% had CVD). Of the total number of ED visits, 34% had MH conditions and 13% had SUD (27% had CVD).

To address the needs identified in the CNA, we will implement all three models outlined in the Project Requirements. The models will be team-based, with clear communication protocols and care workflows, leading to improved co-management. All participating sites will have communicating IT systems to allow for secure sharing of health information. All participating providers will receive ongoing training about physical health (PH) and MH/SUD conditions, treatment, and referral processes. Integrated care and enhanced care coordination services will prevent inappropriate ED visits and hospitalizations as evidenced by multiple national studies. A unique feature of our project is the implementation of the models across the life span and sub-populations to reflect the CNA (i.e. children/adolescent, seriously and persistently mentally ill (SPMI)/HARP population), and an additional sub-model of integrated MH, SUD, and PH services wherever possible.

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

Our target population is Medicaid beneficiaries in our service area. Through this project, our PPS will integrate primary care (PC) into MH and SUD treatment settings, SUD and MH care into PC settings, and combined PH, SUD and MH care. This includes settings that treat children, adolescents, women of reproductive age, and the geriatric population. Model A will target patients in PC patient centered medical home (PCMH) sites (including adult, geriatrics, pediatrics, family medicine, and reproductive health sites) who have co-occurring MH/SUD as determined by on-site screening tools. Model B will target patients in MH and/or SUD treatment programs not already engaged in PC. Model C will target pediatric, adult, and geriatric PC patients as well as reproductive health patients with depressive, anxiety disorders, and/or substance use disorders. We also plan to include children/adolescents with any of the following diagnoses/conditions depression/suicidality, anxiety/trauma, substance abuse, developmental disabilities, and attention deficit disorder.



- 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.

A number of our partners have already begun integrating PC into MH/SUD sites, including The Bridge, Lower Eastside Service Center, Odyssey House, and the Institute for Community Living. Mount Sinai Beth Israel will include their opioid treatment programs (OTPs) and other outpatient SUD treatment programs in the integration of PC as well as other PPS partner organizations with MH/SUD treatment programs. Mount Sinai Beth Israel has started planning for PC integration into MH/SUD and will be a model site for the project. St. Luke's is also embarking on transformation of its ambulatory platform of which revamping MH infrastructure and connections to community based providers and services is a key goal. These initiatives are embedded in 2.a.i and will support further integration of systems when paired with 3.a.i. We will utilize the model and expertise of the Mount Sinai Visiting Doctors program, which serves vulnerable populations, as well as our PC in oncology/geriatrics models to help design our PC integration into MH/SUD. The Institute for Family Health has a robust IMPACT program including a number of expert trainers and implementation specialists. Mount Sinai Hospital has also developed a unique integrated care program in their main PC practice which includes the IMPACT model for depressive disorders, as well as triage, short term active treatment, co-located psychiatry services, and guided referrals for patients with complex MH/SUD diagnoses. These combined resources will be leveraged to provide invaluable support, expertise, and insight into best practices for this project. We will also create an online implementation guide including resources provided by the AIMS and IMPACT websites, and build upon the unique skill sets, and enhance the roles of community health workers. As clinical protocols are developed, we'll engage staff and providers through our PMO and MSO to ensure they have the support to successfully implement.

For Model A we will collaborate with our community partners to hire, train, and integrate MH/SUD specialists within PC sites to achieve the required NCQA or Advanced Primary Care standards.

For Model B, we will hire and will train existing staff to function as Care Coordinators and MH/SUD/PH RNs, to provide an extension of full-time PC assessment and triage services. Physicians and/or advanced practice clinicians will be hired and integrated into selected MH/SUD practices. For other practices, we will devise a shared practice model allowing for physicians and advanced practice clinicians to serve multiple MH/SUD sites. Care Coordinators will engage MH/SUD beneficiaries to assist with identifying additional health needs and connect them with community providers.

For Model C, we will identify PC champions at each site and guide in hiring the depression care manager (DCM). We'll provide staff training implementation manuals, toolboxes for implementation, and technical support to troubleshoot challenges and assist with reaching goals. To expand and enhance current IMPACT programs, additional resources will be provided depending on need, including DCMs, psychiatric support, administrative assistance, training, etc.



- 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.

Recruiting DCMs for the implementation of this project will be a key challenge. We will work within our organizations and with local social work schools to train DCMs. Upfront funding of DCMs, behavioral health clinicians, and additional staff for non-billable services may be difficult for some PPS partners. Reimbursement from NYS for IMPACT models and waivers for licensing will offset some of the costs. In the MH/SUD settings, bringing facilities up to code as well as overhead such as equipment, phlebotomy, ancillary services, and support staff will incur costs. Sharing of these resources across sites may alleviate the burden, such as a shared physician across multiple MH/SUD settings.

Current workforce availability/skill challenges will be addressed through proactive engagement and training of existing clinicians and frontline staff. We will help grow the future clinical workforce by select placements of clinical trainees at sites across the PPS, while balancing educational and training program requirements. Space constraints will be a challenge as many practices have limited patient care rooms. Creative scheduling, room shares, expansions, and other creative solutions will be employed. Privacy and confidentiality safeguards will be in place at the patient, provider, facility, and EHR levels. We will also require finalization of MH/SUD integrated licensure in order to implement integrated MH/SUD programs. Finally, we will design a patient-centered approach to ensure we comprehensively address the needs of our patients.

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

We have, and continue to build, multiple avenues for collaboration with other PPSs, both directly and through our partners. Our goal is to develop shared approaches and protocols, share data, and collaborate on project development. For example, we are building a strategic relationship with Bronx Lebanon PPS to conduct joint planning, achieve economies of scale, and establish shared protocols.

We will use the MIX to coordinate with PPSs and partners to share ideas and learn from others. The establishment of learning collaboratives will also be a critical venue to share ideas.

We will work with other PPSs to identify and coordinate project implementation in the same clinic sites where possible. This is particularly important for this project, as many other PPSs have selected this project and have overlap in their provider network as we do. To the extent possible, joint planning and coordination of sites with other PPS, as well as common protocol development, will be critical to ensure resources are not duplicated.

With the breadth and depth of our partners, many of whom are in multiple PPSs, our PPS is well-positioned to engage other PPSs. Our goal is to raise the bar for not only our PPS, but with other



PPSs in our area to ensure that regardless of where Medicaid patients seek services they have access to the best care possible. By building scale and scope and standardizing the delivery of care across the network, we will provide better care for more people, and thereby concretely move towards measurably better health and reduced utilization of acute and crisis levels of care.

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.

There are three main areas of capital funding that are necessary for the implementation of this project: 1) IT infrastructure, 2) renovation costs or space acquisition, and 3) equipment purchases. Capital funding is required to support the costs of developing the IT infrastructure necessary to ensure that multidisciplinary providers within and between different community based settings can effectively communicate and share information that respects patient privacy and confidentiality. Capital funding will be critical in purchasing hardware, such as computers and printers, and to cover upfront software costs. Capital funding to support ongoing connectivity to the RHIOs is also going to be critical, if available. Capital renovation costs include expenses associated with meeting current state and local regulatory requirements for the provision of mental health/substance use disorders services within



primary care settings and vice versa. The renovation and structural changes could include, but are not limited to, the build of physical examination rooms, building or moving walls for waiting areas, psychiatric and addiction services, building utility rooms, and building out space for medical supplies some of which may require refrigeration. Capital funding will also be necessary for some partners to acquire new space to accommodate the needs of this project.

Capital funding will be needed to support the purchase of equipment such as exam tables, vital sign monitors, glucometers, EKG and INR machines, storage for medical supplies, refrigeration of medication, appropriate storage of medication (i.e. safe for controlled substances), and office furniture and computer hardware for new staff.

At this time, our intent is to provide a high level overview of needs. More detailed capital asks will be described in the Capital Restructuring Financing Program application due February 20, 2014.

- 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
Odyssey House, Inc.	OMH Funded Integrated Care Demonstration	1/1/2014	12/31/2016	We received funding from OMH through a demonstration project grant for an internal collaboration to hire and place a geriatric mental health social worker in our A28 clinic. The project delivers screening, assessment, psychotherapy can care coordination for behavioral health conditions in the primary care setting.
Internal Medicine Associates at Mount Sinai Campus	Collaborative Care Depression Program RFA	Future	Future	These providers will be eligible to bill a Medicaid monthly case rate for a specified form of Collaborative Care for depression services provided to Medicaid recipients. Payment for Collaborative Care services will only be made for patients diagnosed with depression who are actively tracked in a registry and receive depression care in a primary care setting by primary care providers using a defined evidence-based approach

- 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.

Our PPS partners were surveyed in November of 2014 to solicit a response to this question and none of our partners indicated any initiatives that were very similar to this proposed DSRIP project.

Our partner Odyssey House, is participating in an OMH funded Integrated Care Demonstration Project, however that project focuses specifically on the geriatric population. This DSRIP project focuses on a larger array of age groups, including children and adolescents.

We are also aware that some members of our PPS may have been, or will be, certified to participate in the ongoing New York State Medicaid Collaborative Care Depression Program even though this was not explicitly mentioned in response to our survey. While we intend to look to these participating sites as models of care and for best practices, the implementation of Models A,



B, and C go above and beyond this existing program. Under 3.a.i, we will expand upon the existing program by 1) serving children and adolescents, 2) including specific women's populations (i.e the reproductive health clinic population), and 3) including both new and existing program care pathways, which include other diagnoses beyond depression, such as anxiety disorders, substance abuse disorders, and screening for trauma.

Our goal is to develop innovative models and to build upon and to look for ways to improve what currently works with our most vulnerable and costly populations. As we move into the implementation phase, and have more in-depth conversations with our partners we will learn more about existing initiatives and how we can use DSRIP to expand and improve them to drive down unnecessary emergency room visits and avoidable hospitalizations ultimately building healthier communities and having a positive impact on population health.

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

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

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

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

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



3.a.iii Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance

Project Objective: To assist patients who have difficulty with medication adherence to improve compliance with medical regimens.

Project Description: Medication adherence is particularly important for persons with psychiatric conditions to maintain health and function. This program is based upon shared decision-making and behavior modification to effect sustained change. Tools in the New York City Department of Health and Mental Hygiene’s and the Fund for Public Health NY’s Medication Adherence Project (MAP), while not originally focused on behavioral health, would be useful to form the basis of this intervention. Other evidence based tools and educational materials may be used. Various factors influence “non-compliance” including health literacy, cultural values, language, and side effects of treatment. The goal of this program is to assist patients identify these issues and resolve them with motivational interviewing and structured conversations around medication compliance.

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

1. Develop a medication adherence program to improve behavioral health medication compliance through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY’s Medication Adherence Project (MAP).
2. Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.
3. Use EHRs or other technical platforms to track all patients engaged in this project.
4. Coordinate with Medicaid Managed Care Plans to improve medication adherence.

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.

Patients who live in poverty, have unstable housing, and struggle to navigate health systems have poorer health outcomes and higher Medicaid costs. Our CNA highlighted that out of the 1,328,558 NYS Medicaid beneficiaries diagnosed with a mental health condition, and of the 370,898 NYS



Medicaid beneficiaries diagnosed with a substance use Disorder, 53% and 60% live in NYC, respectively. Chronic alcohol, cannabis, opioid, and cocaine abuse are the most common substance use disorders, citywide. Furthermore, close to 70% of PPS members surveyed in our CNA noted that beneficiaries have a difficult to very difficult time accessing mental health services, and 59% indicated that PCPs and BH providers are “ineffective” or “somewhat ineffective” at co-management of behavioral disorders. Within our service area, all boroughs except for Queens, fall below the state and city averages for adherence to antipsychotic medication for people with schizophrenia, and medication management for antidepressants. For people living with schizophrenia in Manhattan and Brooklyn, 61% and 60%, respectively, adhere to their antipsychotic medication regimens compared to the state and city average of 64% and 63%, respectively. For people living with depression in Manhattan and Brooklyn, 48% and 47%, respectively, adhere to their antidepressant medication regimens compared to the state average of 50%. About 39% of CNA respondents noted that Medicaid beneficiaries have a “difficult” or “very difficult” time accessing substance use disorder services while 35% indicated that they were not sure about the accessibility of such services, potentially due to the burden of stigma.

Substance abuse and poor medication adherence contributes to unnecessary ED visits and avoidable hospitalizations. Health Home Care Coordinators and other Care Transition initiatives are helping patients link to and navigate systems who would otherwise not have a comprehensive approach to medication adherence. Our Medication Adherence Plan for Behavioral Health (MAPBH) proposes to utilize basic DOHMH MAP tools which will (1) be adapted for Behavioral Health and to include recovery oriented language and principles, and (2) integrate a modified version of a highly successful medication adherence program called Care4Today™ to promote self-efficacy and a systematic approach to medication adherence in the SPMI/HARP-eligible population, (3) expand the role of Care Coordinators and Peer Specialists in coaching and tracking, and (4) connect BH and physical health comorbidity through the lens of medication adherence. The Care4Today program is currently being adapted/optimized for use in the BH setting in a pilot at Mount Sinai Hospital. We will use the concepts of SIMPLE to address the gaps that are identified in our CNA: Simplify the regimen, Impart Knowledge, Modify patient beliefs and behavior, Leave out the bias, Evaluate adherence. This model will result in improved medication adherence and better health outcomes for our high-risk patient population.



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

Our target population will be Medicaid beneficiaries with phased onset. Preliminarily, three cohorts have been identified. Cohort 1: Health Home-identified/Health Home-eligible SPMI population with comorbid SUD and/or high ED visits. Cohort 2 will consist of two distinct groups: (1) Medicaid beneficiaries with first break psychosis, and (2) health home-eligible BH beneficiaries who either do not fill prescriptions, are frequent “no shows” for community care, and/or, if possible, beneficiaries that have disruptive behaviors in housing or vocational programs. Cohort 3: Health Home-identified/Health Home-eligible beneficiaries with depressive or anxiety disorders with comorbid serious chronic medical conditions. The rollout of these cohorts will begin in areas with most need. For example, in 2012, schizophrenia was the third leading cause of hospitalization for African Americans living in Brooklyn, resulting in 6,062 hospitalizations that year. In that same year, schizophrenia was the fourth leading cause of hospitalization for African Americans living in Queens, resulting in 1,524 hospitalizations that year. Brooklyn also has higher rates of chronic medical conditions with preventable deaths such as diabetes and avoidable hospitalizations such as cardiovascular disease. Our CNA indicated beneficiaries representing ethnic minorities are at highest risk and stigmatization in these communities with regard to MH and SUD. The MAPBH will focus on these communities in a culturally competent manner. Patient materials will reflect languages of the populations being served.

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

Our PPS includes the Mount Sinai Health Home and multiple partnerships with other Health Home leads, including robust involvement of our Care Coordination, Medical Homes, Supportive Housing sites, Mobile Crisis Teams, and integrated delivery systems. Our PPS also includes current partnerships with pharmacies (including a new formal partnership with CVS pharmacies and their Minute Clinics) and a vast number of providers across our service area with expertise in the identification, comprehensive treatment, and management of MH/SUD conditions.

We will explore avenues of repurposing some of our current care coordination workforce, while also developing a workforce with the skill sets needed to successfully implement our MAPBH, including culturally competent peer advocates and recovery coaches as possible. We will use the free tools available from the NYC DOHMH as part of the MAP package, as well as add an additional major treatment and care delivery platform to this project, known as Care4Today Mental Health Solutions™ (C4TMHS). This platform is a suite of structured content and technology designed to engage, enable, and empower MH/SUD patients to take increased responsibility for their health and recovery, with a primary focus on medication adherence for all medications (not only psychotropic medications). The solution is deployed both within the clinical setting (using psycho-educational and other content) as well as remotely (via mobile modality). It supports creation and real-time tracking of patient goals of wellness and self-management – starting with medication



adherence – in the context of a feedback loop with healthcare providers, who may access a dashboard showing patient status and progress. This program has had significant success in reducing hospitalizations for patients with schizophrenia and bipolar disorder in two major pilots in Europe. A modified version of this program will be piloted at Mount Sinai Hospital (MSH) in early 2015. Based on the results of this, C4TMHS™ will be woven into the broader MAPBH package.

Our MAPBH will need to reach MH/SUD providers as well as primary care providers. We will evaluate the capacity for primary IT connectivity across the PPS to include pharmacies, more effectively utilize formularies, perform medication reconciliation, and track prescriptions filled in-person, home-delivered, or skipped. The Mount Sinai Health System has a track record of successful negotiation and partnerships with MCOs currently implementing risk models, and for growing our ACO and Population Health Institute to promote healthier communities within all five boroughs. We are planning to integrate care and service coordination for the HARP-eligible population. The unique scope and scalability of the MSPPS MAPBH can make a significant impact on both MH/SUD and physical health conditions, and has the potential to be a cost-effective tool to sharply decrease emergency visits and hospitalizations due to both directly and indirectly to medication non-adherence.

- 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.

Necessary MAP tools modifications for MH/SUD populations will be achieved through a PPS team assigned to review and alter the MAP tools together with consumer input. We will also create formal communication and care pathway protocols to integrate MAPBH between and within the MSPPS, including but not limited to, PPS partners, electronic documentation systems, and pharmacies. IT and data collection integration between all partners as well as with pharmacies will be challenging. However, a primary benefit of the C4TMHS platform is that it is already a web-based and mobile platform, facilitating program scaling. Our goal is to design an integrated IT and communication platform. The MSH pilot, which will include IT integration, will be critical in expediting the early identification and resolution of IT-related obstacles. All clinicians, care coordinators, and navigators will be formally trained and educated, and are anticipated to utilize tools such as videos and role play from the original MAP, as well as the C4TMHS training modules, to achieve this goal. MAPBH and the component C4TMHS program will include multicultural content to address issues of stigmatization, and a major focus will be on consumer education. Educational and treatment materials will be provided in multiple languages, including planned development of a Spanish version of the C4TMHS platform.

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



We are committed to working with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop shared approaches and protocols, share data, and collaborate on project development. For example, we are building a strategic relationship with Bronx Lebanon PPS to do joint planning, achieve economies of scale, and establish shared protocols. We will also work with other PPSs to identify and coordinate project implementation in the same clinic sites where possible. We will use the MIX, where we can coordinate with PPSs and partners to share ideas and learn from others. To ensure effective alignment, our consultants will strategize with external support of the other PPSs. We are excited to engage our partners and other PPSs together in an innovative collaborative that focuses on national best practices and models. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to collectively raise the bar for not only our PPS, but for other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.

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

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

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

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

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

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

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

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



Yes	No

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

There are two main areas of capital funding that are necessary for the implementation of this project: 1) IT infrastructure and equipment costs, and 2) renovation costs.

The MAPBH project will have capital funding needs primarily in developing and refining IT infrastructure and computer equipment. For all of the DSRIP projects, many CBO partners may need to adopt an EMR to support the overall goals of the integrated delivery network. Existing CBOs and FQHCs with EMRs, as well as MSHS system and partner hospitals, may need to create communication and interfaces between EMRs to further create seamless sharing of information between different EMRs. However, it is important to note that one of the main components of our project, C4TMHS™, is primarily an internet and mobile-based platform. Therefore, the main component of IT infrastructure needs is ensuring that existing and newly adopted EMRs can smoothly interface with the C4TMHS™ platform.

Capital funding will also be critical in purchasing hardware, such as computers/tablets, printers, and upfront software costs. Ongoing capital funding is needed to support connectivity to RHIOs which will be critical. We also need to ensure that all our of our partners participating in this project have the financial means to set up and support the C4TMHS™ platform, including the cost of purchasing the application, and the costs of purchasing the mobile equipment necessary for this model.

Some partners may require additional space to meet with patients for MAPBH, particularly for the components of the program which include group therapy. Capital costs may therefore include minor renovations for space expansion and optimization.

As this time, our intent is to provide a high level overview of needs. More detailed capital asks will be described in the Capital Restructuring Financing Program application due February 20, 2014.

- 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.

Our PPS partners were surveyed in November of 2014 to specifically solicit a response to this question and none of our partners indicated any initiatives that were similar to this proposed DSRIP project. We believe that this DSRIP project is unique, especially with the inclusion of the C4TMHS™ component.

While a number of our participating partners indicated that they were participating in NYS DOH Medicaid Health Homes, this DSRIP project will expand upon the Health Home model, the Medicaid Health Home target population, and will go beyond care coordination to include a critical medication adherence component.

We also know that a number of our partner organizations will be providing Home and Community Based Services for the HARP-eligible population. It is of note that the C4TMHS™ program is specifically geared towards people with Serious and Persistent Mental Illnesses (SPMI), and we believe that this will provide an innovative and far reaching solution for the HARP –eligible population. The entire MAPBH program may be integrated within some of the HCBS services (such as Psychosocial Rehab, Peer Supports, Community Psychiatric Support and Training), in addition to existing direct clinical services.

Our goal is to develop innovative models and to build upon and to look for ways to improve what currently works with our most vulnerable and costly patient populations. As we move into the



implementation phase, and continue in-depth conversations with our partners we will learn more about existing initiatives and how we can use DSRIP to expand and improve them. The ultimate goal is to drive down unnecessary emergency room visits and avoidable hospitalizations, build healthier communities, and have a positive impact on population health.

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

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

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

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



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

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

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

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

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

Improve Medication Adherence:

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



Actions to Optimize Patient Reminders and Supports:

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

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

1. 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.

Our CNA shows that of Medicaid patients in NYC, over 30% have a known cardiovascular disease (CVD – heart, cerebrovascular and peripheral vascular) and an even greater number are at-risk for developing CVD. The two boroughs with the highest number of Medicaid beneficiaries living with CVD are Brooklyn (34%) and Queens (24%). There are higher rates of preventable hospitalizations in NYC than the State for adult hypertension (PQI #7) and adult angina without procedure (PQI #13). Furthermore, heart disease is the leading cause of death and the second leading cause of premature death in NYC and the state. Our CNA showed that Brooklyn has a disproportionately high percentage of premature deaths related to heart disease.

This data highlights the need to develop more coordinated systems of care to address cardiovascular health and wellness, increase risk factor control, and improve the management of patients with established CVD. Although specialists, services, and programs exist to address cardiovascular health, wellness, and risk factor management, they tend to operate in silos. Oftentimes these services are inaccessible to many groups of patients and are non-uniform, in terms of their individual resources and approaches to treatment.



Similarly, many patients with existing CVD lack efficient coordination of care. Factors limiting care coordination include insufficient IT systems leading to duplication of services and testing, underutilization of existing resources such as heart failure readmission programs, lack of existing collaborative relationships with community based services (e.g., urgent care, patient navigators, health coaches) to minimize avoidable ER visits and hospitalizations.

Due to the fact that diabetes and CVD share many of the same risk factors and contributing negative health behaviors, the screening and management programs for diabetes and CVD will overlap to a great extent and share many of the same resources. For example, multidisciplinary care teams that include physicians, nurse practitioners, registered nurses, registered dietitians, health coaches, pharmacists, home care workers, and social workers can work together through shared registries to facilitate positive health behavior change, support patient education, promote routine screening and health maintenance, and manage higher risk patients in need of more specialized care.

To ensure consistency in the delivery of these resources across the health system, the CVD program will be modeled after the Million Hearts Initiative. MSPPS will expand on this model to include services directed towards lifestyle modification. Registered dietitians will promote healthy eating habits and certified diabetes educators will offer diabetes education and self-efficacy. Health coaches experienced in facilitating health behavior changes will be employed, as well as social workers to identify and manage psychosocial barriers to lifestyle modification and access to care. By working with Project 3.a.iii., we will ensure pharmacy specialists work with both patients and providers on medication adherence, which will be part of our overall PPS comprehensive approach to medication adherence.

- 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 focus mostly on adult Medicaid beneficiaries who present risk- factors, or are diagnosed with a cardiovascular condition in primary care and urgent care centers. Our CNA showed Brooklyn has a disproportionately high percentage of premature deaths related to heart disease, so we anticipate working extensively with our Brooklyn partners. Adults more likely to have CVD will be targeted, including:
-Older adults;



-African Americans;
-Women past menopause;
-Individuals diagnosed with depression;
-Individuals with presenting conditions, diagnoses, and risk-factors, such as hypertension, smoking, physical inactivity, obesity, high blood pressure, high cholesterol, raised blood glucose, and diabetes; and
-Individuals with a family history of CVD.

We will coordinate efforts with Project 3.a.i. and 3.a.iii. to effectively weave together services for the overlapping patient population where appropriate. For example, where we have overlapping sites on both projects, we will coordinate care initiatives so care pathways are not duplicated, but instead complement each other.

The target population this project overlap to a great extent with the diabetes Project 2.c.i. Leaders from both projects will collaborate and work with care teams to share patient registries and develop unified and systematic approaches to screening, identifying, and managing patients with both diabetes and CVD. Similarly, we will promote education for both providers and patients as it relates to best practices for the primary and secondary prevention of CVD and diabetes.

- 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.

At the primary care level, a number of resources currently exist within our PPS, including:

- The Medical Home Initiative at the Mount Sinai Internal Medicine Associates;
- William F. Ryan Center community clinics;
- Mount Sinai Diabetes Alliance;
- Friedman Diabetes Center at Mount Sinai Beth Israel;
- Karpas Center at Mount Sinai Beth Israel, which offers a variety of preventive health education resources;
- Community Healthcare Network, which offers nutrition and social work services at all of their primary care centers;
- City Health Works, a community health organization that provides highly trained and experienced health coaches;
- Social Work Program at Mount Sinai (PACT), which works in conjunction with The Institute of Family Medicine to reduce readmissions among high risk patients; and
- Chronic Disease Management Center at The Brooklyn Hospital Center, which focuses on diabetes management and community support services through the Diabetes Club.

In terms of specialized programs for primary and secondary CVD prevention MSPPS can build upon:

- Cardiac Rehabilitation Programs at Mount Sinai and Mount Sinai Beth Israel, which deliver comprehensive and coordinated care addressing nutrition, education, physical activity, smoking cessation, diabetes care and psychosocial support.
- Complex lipid management programs at Mount Sinai St. Luke's-Roosevelt and Mount Sinai
- Complex hypertension management programs at Mount Sinai Hospital
- Heart failure management programs at Mount Sinai, Mount Sinai St. Luke's-Roosevelt and Mount



Sinai Beth Israel; and
-Stroke Center at Mount Sinai St. Luke's-Roosevelt.

Many of our PPS partners have experience in providing care to Medicaid beneficiaries with CVD, with existing programs in place to manage blood pressure, promote nutrition and exercise, and to manage patients with CVD and a secondary diagnosis. For example, ArchCare's home care program, Empire State Home Care Services, currently works with managed care organizations to provide tele-monitoring services that have shown significant positive outcomes year after year. Patients are monitored with the goal of managing their blood pressure and reducing their risk for a cardiac event or stroke. This is an effective adjunct for both patients and practitioners and will impact adherence to medication regimens while also cultivating patient self-efficacy. Betances, an FQHC partner, offers a robust nutrition and fitness program, a population health management team that utilizes an array of clinical analytics to manage this population.

New collaborative relationships are also important, such as partnering with local urgent care centers and the establishment of new urgent care centers and clinics. Through enhanced communication, standardized screening and management protocols, and new partnerships with community health organizations, the above resources can be mobilized and focused on a common goal. An additional major focus will be on medication adherence to improve outcomes across CVD, diabetes, and psychological health domains, for which coordination with 3.a.iii will be important.

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

The primary challenge to successful implementation relates to the coordination and standardization of care among the different providers and across the various care institutions. Addressing this potential challenge will require enhanced communication at multiple levels.

To do this effectively siloed IT systems will need to be integrated so vital health information can flow to participating providers and care centers. Communication at the personnel level is equally important.

Care coordination will be challenging system wide and we will need to work in conjunction with project 2.a.i. and 2.c.i. to ensure standardization across our partners. Such standardization and protocols include having participating care teams review screening and management protocols on an ongoing basis and communicate the challenges and successes to section leaders within the healthcare network to facilitate appropriate and timely changes. Similarly, access to specialty care can be coordinated at the individual primary care centers directly or via telehealth.

In particular, there is a lack of EMS data within many currently used EHR systems. Disease management can benefit from support by EMS so providers receive a more holistic picture of a patient's symptoms. We will explore how we can expand upon the current programs to address how we can better integrate emergency care systems with the work of disease managers and



clinicians. Early stage conversations are occurring between our IT committee, other PPSs and local RHIOs on opportunities for interim and long term solutions for data sharing.

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

We continue to build multiple avenues for collaboration with other PPSs, both directly and through our partners. By way of cross-PPS meetings, we will work with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop common approaches and protocols, share data, and collaborate on project development. In addition, our workforce and union stakeholders overlap with other PPSs, providing an additional avenue to connect across PPSs around shared protocols and practices. We will work with other PPSs, such as Bronx Lebanon PPS, to coordinate project approaches.

We will also work with other PPSs to coordinate project implementation in the same clinic sites where possible. Using the MIX and through State DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models. We anticipate hosting expert to inform providers on national best practices and approaches with the breadth and depth of our partners, many of whom are in multiple PPSs, MSPPS is well poised to engage other PPSs. These partners are key to driving performance and standardization across the system. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where patients seek services, they have access to the best care possible.

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.

Capital funding is necessary to support the costs of developing the IT infrastructure necessary to stand up this project and to ensure that different providers can communicate, and share information that respects patient privacy and confidentiality. Capital funding to support connectivity to RHIOs will be critical, in addition to purchasing hardware, like computers and printers, and upfront software costs. Smaller community-based organizations will also benefit from capital funding to support necessary IT infrastructure. These capital needs include providing tablet and laptops to frontline care workers providing care to CVD patients in the community and facilities that allow seamless sharing of patient care data.

We anticipate that new clinical equipment will be needed to implement this project, such as laboratory testing materials, depending on the needs of our participating partners.

At this time, our intent is to provide a high level overview of needs. More detailed capital asks will be described in the Capital Restructuring Financing Program application due February 20, 2015.

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

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



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 mellitus (DM) is a serious, yet preventable disease impacting our PPS population. Our CNA showed that the majority of the Medicaid patients with DM across the NYC area are in Brooklyn. In Brooklyn, 33% of DM Medicaid patients live, followed by Queens with 25% of Medicaid patients with DM. Additionally, African Americans and Hispanics are disproportionately affected by DM. Individuals in poor neighborhoods are more likely to die from the disease, for example, Central Harlem has a rate of 118 DM related deaths per 100,000 residents.

CNA data also showed DM is the leading cause of adult blindness, dialysis, non-traumatic foot amputation, and CVD. Diabetes multiplies risk of hospital admission, readmission and mortality. We will need to focus efforts in Brooklyn because the rate of hospitalizations for short-term complications of diabetes for individuals ages 18+ was 7.7 per 10,000. This is higher than the state average, which is only 6.1 per 10,000.

Adhering to best standards of diabetes care and management can dramatically reduce adverse events. However the data shows a severe imbalance between demand for services and available personnel, leading to long wait times, insufficient care, and difficulties navigating the system. MSPPS providers responding to our CNA survey corroborated this finding, indicating that DM is a major health concern.

Our goal is to reduce DM complications and related hospital admissions by designing new, cost-effective, multi-specialty, multi-tier care delivery in conjunction with partners in the community. Strategies include working with clinicians to redesign existing workforce roles and delivering effective education and social support to patients to implement lifestyle changes known to improve DM and CVD outcomes. Instituting IT infrastructure and processes at the health system and community level will support these efforts, while existing clinic-based staff will comprise population health teams, based on the Chronic Care Model principles for diabetes management.

PCPs will refer patients to endocrinologists, diabetes specialists, and certified diabetes educators (CDEs). To ensure DM patients access the right care at the right time, community health navigators and care managers assigned to DM populations in multispecialty offices will connect with CDEs and endocrinologists, effectively linking this project and Project 2.c.i. For smaller PCP practices, traveling CDEs will visit practices regularly according to the Diabetes Alliance model. Pharmacists will be included in care teams to address medication adherence, resource utilization, and polypharmacy. Behavioral health providers will be integrated into care teams, as many patients diagnosed with DM have a co-occurring mental health disorder.

Self-management and behavior change for disease prevention and management will be addressed through the multidisciplinary team model, which will include adequately trained local coaches. The team structure will address linguistic issues,



cultural diversity, and variations in learning and literacy levels. These teams will apply the Stanford diabetes self-management model in the community through specialized coaches.

- 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.

While all Medicaid beneficiaries with DM in our service area are potential targets, we will focus on three cohorts. Preliminarily, we will use can and Salient data to identify these patient populations, and we will also work through our partners to gain additional detailed information. Through our plan partners, we may also be able to get additional data. As previously detailed, we anticipate many of our efforts will focus in Brooklyn. and there will be considerable overlap with Project 3.b.i's target population.

High priority cohorts include:

1. DM patients at highest risk for emergency room and hospital admission utilization identified through "panels/metrics" from advanced algorithms based on electronic health records, claims, and other community organizations information.
2. DM patients with co-morbidities and those at high-risk for complications (A1C \geq 9.0%, with one or more comorbidities such congestive heart failure, cardiovascular disease, a mental health diagnosis, or asthma).
3. Patients with pre-diabetes and at-risk for developing diabetes. These patients will be identified through a more ambitious and community-oriented approach, and through close coordination with Project 3.b.i, which supports cardiovascular disease management.

IT resources, disease registries, and pre-defined and/or newly constructed algorithms will be used to identify patients in all three categories. Patient panels will be assigned to health teams within a comprehensive registry, which will be adjusted over time, based on ongoing quality improvement (QI) measures.



- 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.

MSPPS has a number of assets and resources to be leveraged, including several innovative MSHS programs. These existing structures and programs will be critical in sharing best practices and guidance. Assets include the Medical Home Initiative currently implemented across the PCP practices at Mount Sinai St. Luke's/Roosevelt, Mount Sinai Beth Israel, William F. Ryan community clinics, and the Mount Sinai Hospital Internal Medicine Associate clinics. Within practices, PCPs receive diabetes management training and nurse practitioners and physician assistant CDEs are embedded. CDEs run patient education programs and discussions of panels at high risk for hospital admission. These experienced providers will be mobilized, to the extent possible, and will provide valuable input on training modules to engage other providers to expand the service area and target population. Another resource is the MSHS Diabetes Alliance. This program relies on RD/CDEs in twenty-one ADA- accredited Centers of Excellence to deliver care to patients in the community primary care setting. The CDEs collaborate with endocrinologists and develop customized diabetes plan at the point of care, with particular focus on CVD and foot care. To maximize effectiveness and productivity, CDEs visit smaller practices intermittently and work closely with local PCPs and Navigators. Finally, the Friedman Diabetes Center at Mount Sinai Beth Israel will be a valuable resource as it is supported by philanthropy and offers free diabetes education to the local patient population.

Our partners also have a number of resources that will be mobilized to implement this project. The Pharmacotherapy Division at TBHC integrates pharmacists and pharmacy residents into collaborative drug therapy management services that covers the diabetes, HIV, and cardiovascular clinics. These services focus on disease prevention and risk reduction such as smoking cessation, medication compliance, and hypertension control. The hospital's Chronic Disease Management Center also offers comprehensive treatment services including podiatry, ophthalmology and endocrine care. Three of TBHC's ambulatory care health centers have achieved Diabetes Provider Recognition (DPRP) status for providing excellent care for diabetics. City Health Works employs health coaches to lead peer on peer network of communities to improve the quality of life. Our Health Home program offers a wide range of services for Medicaid patients with complex medical and behavioral needs. They have a dedicated care management program that coordinates access to needed services. The Institute for Family Health works with the social worker program at Mount Sinai (PACT) with the goal of reducing the rate of hospital readmissions. This is just a sample of the significant assets and resources in our diverse PPS.

While we anticipate workforce issues to be a challenge, we will re-train and educate providers like PCPs, CDEs, and home care workers to boost access and provider capacity. The expertise from navigators and care managers from 2.c.i will also be tapped for this project since there is an overlap in target population.



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

The first challenge will be related to IT issues. Currently, IT systems are not uniform and there are various sources of medical information that will need to be integrated to ensure that 1) we will be able to target and coordinate care for those who will most benefit from this project, and 2) to ensure ongoing QI processes. DSRIP provides opportunities to enhance IT infrastructure to support care coordination and disease management. We will implement a common data sharing platform and a continuous well-coordinated QI component within and between the various components of the overall program.

Another challenge will be around training and recruitment of sufficient numbers of CDEs and other staff. In addition to existing networks of CDEs and related staff, it's going to be critical to draw upon the resources and expertise of our diverse network of community providers. We will also create a standardized and comprehensive training to educate new and existing providers in our PPS.

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

We continue to build multiple avenues for collaboration with other PPSs, both directly and through our partners. By way of cross-PPS meetings, we will work with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop common approaches and protocols in the area of diabetes and diabetes prevention, share data, and collaborate on project development. For example, we are currently building a strategic relationship with the Bronx Lebanon Health Center PPS to facilitate joint planning on this project, achieve economies of scale, and establish shared protocols. In addition, our workforce and union stakeholders overlap with other PPSs, providing an additional avenue to connect across PPSs around shared protocols and practices.

Using the MIX and through state DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models.

With the breadth and depth of our partners, many of whom are active in several PPSs, MSPPS is well-poised to engage other PPSs in the area of diabetes, diabetes prevention, and prevention of diabetes complications. Our partners are key to driving performance and standardization across the system. The goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.



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.

Capital funding is necessary to support the costs of developing the IT infrastructure necessary to stand up this project and to ensure that different providers can communicate, and share information that respects patient privacy and confidentiality. Capital funding will be critical in purchasing hardware, like computers and printers, and upfront software costs. These capital needs include providing tablet and laptops to frontline care workers providing care to CVD patients in the community and facilities that allow seamless sharing of patient care data. We may also need to purchase new equipment to implement this project, such as laboratory testing materials depending on the needs of our participating partners. Some of our partners have already requested funding to support the purchase of a point-of-care HbA1c analyzer. Some partners may also wish to renovate or rebuild existing space to better accommodate the needs of this project. For example, one of our partners expressed interest in renovating and expanding their existing diabetes clinic. We anticipate capital requests for building or expanding existing clinics and urgent care centers. At this time, our intent is to provide a high level overview of needs. More detailed capital asks will be described in the Capital Restructuring Financing Program application due February 20, 2015.



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
The Institute for Family Health	NYS Hospital Medical Home Initiative	April 2013	December 2014	The Hospital-Medical Home Demonstration is a health care quality and safety improvement program for Medicaid members in New York State. The focus of the Hospital-Medical Home Demonstration is to improve health care provided to Medicaid members in sites that train residents to become primary care physicians.



- 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.

Institute for Family Health (IFH) is receiving funding through the NYS Hospital Medical Home Initiative funded through a Medicaid waiver. While this initiative has multiple diabetes-related quality objectives and has specific goals tied to diabetes, Project 3.c.i will provide opportunities to expand the services currently offered, and to expand the number of IFH sites that offer comprehensive and evidence-based diabetes care. This is an expansion of this project for IFH (bringing it to scale across their sites) as well as a significant expansion of this approach and strategy to a broader integrated delivery system and set of partners, some of which do not have integrated programs for diabetes care spanning outside of their organization and multiple external partners.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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



Domain 4 Projects

4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings (Focus Area 3) (This project targets chronic diseases that are not included in Domain 3, such as cancer)

Project Objective: This project will help to increase access to high quality chronic disease preventative care and management in both clinical and community settings for chronic diseases that are not included in Domain 3 projects, such as cancer.

Project Description: The delivery of high-quality chronic disease preventive care and management can prevent much of the burden of chronic disease or avoid many related complications. Many of these services have been shown to be cost-effective or even cost-saving. However, many New Yorkers do not receive the recommended preventive care and management that include screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. This project is targeted on increasing the numbers of New Yorkers who receive evidence based preventative care and management for chronic diseases.

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

1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services.
2. Offer recommended clinical preventive services and connect patients to community-based preventive service resources.
3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.
4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management.
5. Adopt medical home or team-based care models.
6. Create linkages with and connect patients to community preventive resources.
7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts.
8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services.

Partnering with Entities Outside of the PPS for this Project

Please provide the name of any partners included for this project outside of the PPS providers. This may



include an entity or organization with a proven track record in addressing the goals of this project.

Entity Name

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

1. 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.

While MSPPS will concentrate on disease prevention and management for cardiovascular disease and diabetes management through Projects 3.b.i and 3.c.i, it is of equal priority to implement aggressive programming to prevent and manage other chronic conditions affecting all individuals within our service area. Data from our CNA show a significant need to increase screenings and preventive care to diagnose and manage conditions that if left untreated, develop into chronic conditions requiring high levels of care. When asked about the level of difficulty Medicaid patients face when trying to access routine primary care/preventive care services, 46% of respondents answered “difficult.” This data also indicated that Medicaid beneficiaries are often non-compliant with medication regimens.

According to HEDIS measures, cancer screening rates can also be improved in our service area, particularly for breast (67%), cervical (69%), and colorectal cancers (52%). Among females in NYC, the top cause of cancer is breast cancer (118.8 per 100,000). Among males in NYC, colorectal cancer is the third leading cause of cancer (53.5 per 100,000).

Our PPS is also interested in seeing the rate of children (aged 3-6) and adolescents (aged 12-21) who receive the recommended number of well child visits move closer towards the Prevention Agenda objectives. This will increase immunizations that will prevent the population from contracting Hepatitis, HPV, and other serious diseases.

Our CNA shows that more can be done to prevent, diagnose, and manage a broad range of conditions. For example, the rate of new Hepatitis C diagnoses in 2009 was 129.7 per 100,000 NYC residents, with some of the highest rates in Harlem, Chelsea, East Elmhurst, Ocean Hill, and Bedford-Stuyvesant. Hepatitis C is more prevalent in males, and most new diagnoses occur in people between the ages of 50-59. If left untreated, hepatitis C can lead to severe liver disease, cirrhosis, liver cancer, and death.

Chlamydia is also a major health concern for women in our service area. In 2012, the NYC chlamydia case rate for women between the ages of 15-44 was nearly double the statewide average, with prevalence rates especially high in Brooklyn at 2,139.30 per 100,000 women. Screening rates for chlamydia can also be improved in our service area particularly in Brooklyn and Queens, as the average rate in NYC is 70%.



As described in Projects 2.b.iv, 2.c.i, 3.b.i, 3.c.i, and 4.c.ii, we will hire new employees or leverage and retrain existing care coordination staff of various backgrounds to provide health coaching and psycho-social support in disease self-management to risk-stratified, targeted populations of patients. A heavy emphasis will be placed on assessing preventive care needs and providing access to such services. Services will be based on a needs assessment and treatment will follow a personal care plan that addresses patient preference, as well as disease specific health goals, including necessary screenings, immunizations, and preventive care.

We will use electronic health records with clinical decision supports and registry functionality as developed for Project 2.a.i (integrated delivery system) to support care coordination efforts. We intend to increase the clinical capacity to send reminders to patients for preventive and follow-up care. Population health databases, currently utilized by behavioral health and FQHC partners within our PPS, will be integrated into the delivery system platform to enable communication and data sharing.

In addition, the MSHS, as well as other hospitals, FQHCs, and community-based providers within the MSPPS network, have implemented quality improvement (QI) teams, which will be leveraged to provide technical support to other members of our PPS to systematically address preventive screening services and/or connection to specialized disease management programs.

- 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.*

We intend to target the entire population in the MSPPS service area through a population health approach that emphasizes preventive care. However, based on the results of our CNA we anticipate that the patient populations outlined below will be prioritized for screenings and interventions:

- Individuals who were born between the years of 1945 and 1965 for Hepatitis C;
- High-risk groups such as injecting drug users (IDUs), hemophiliacs, people diagnosed with HIV, people who have chronic hemodialysis, incarcerated individuals, and people at risk of occupational exposure to HCV-infected blood through invasive procedures or blood product transfusions for Hepatitis C;
- Women ages 15-44 years of all ethnicities will be targeted for chlamydia screening due to high rates of infection throughout our service area;
- Women ages 40-64 of all ethnicities will be targeted for breast cancer screening;
- Women ages 21-64 of all ethnicities will be targeted for cervical cancer screening;
- Adults between the ages of 50-75 years old will be targeted for colorectal cancer screening, especially among those with annual incomes that fall below \$25,000;
- Children ages 3-6 years and adolescents ages 12-21 years will be targeted to promote the utilization of preventive care services and well child visits; and
- Adults prescribed specific chronic disease medications (e.g. cholesterol lowering, antihypertensive, and diabetic medications) will be targeted for medication management and adherence.



- 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.

Currently, MSHS is engaged in a HealthFirst Pay for Performance HEDIS/QARR reimbursement and patient incentive program, along with 35 other hospitals. This program strives to increase the delivery of high quality chronic disease prevention and management services to its members. The Brooklyn Hospital Center (TBHC), a key partner in the MSPPS, also participates in this program and has been rated in the top ten hospitals. TBHC is also the administrator for the NYSDOH's Integrated Breast, Cervical and Colorectal Cancer Screening Program, which is aimed at providing screenings to individuals with no or low insurance coverage.

Mount Sinai St. Luke's/Roosevelt and Mount Sinai Beth Israel have been rated in the top five hospitals for the Medicaid population meeting clinical benchmarks for adult cancer screening services (breast, cervical, colorectal), chlamydia screening, as well as child and adolescent preventive visits. Our FQHCs also participate in multiple MCO QARR programs.

We intend to enhance and expand our current reimbursement and patient incentive model programs by hiring and retraining existing providers to expand our care coordination, team-based approach and continue the clinical integration of primary care practices, specialty practices, and diagnostic centers. This will allow us to also incorporate NYS Prevention Agenda objectives, as well as offer breast and cervical cancer screening to our community. We intend to establish similar P4P models with other Medicaid managed care programs like Affinity, Fidelis, Wellcare, Emblem Health, Amerigroup, and HealthPlus.

We will also provide feedback to clinicians (hospital and community based) in our network about clinical benchmarks and incentivize quality improvement efforts through financial and non-financial efforts as allowed by employee agreements at the sites. Each member of our PPS will receive adult preventive service report cards/dashboards metrics and metrics to measure patient experience and patient satisfaction.

The MSHS currently has a number of physician practices, which are certified NCQA Level 3 PCMHs, including MSPPS partners William F. Ryan Community Health Network and Community Healthcare Network. In addition, TBHC has four NCQA Level 3 PCMHs, and two NCQA Level 2 PCMHs. CHN runs 11 primary care practices across four boroughs and provides access to screening services either directly or by referral. Our P4P QI teams and MSPPS MSO will provide technical support to other members of our PPS to expand the number of practices that are NCQA certified PCMHs.

Through the MSPPS Health Homes, we offer comprehensive care management, care coordination and health promotion, referrals to community and social support services, and use of health IT to link services as needed for our patients throughout the healthcare system through a coordinated team based approach. We are poised to expand this team-based approach and clinical care coordination to increase access to adult and pediatric preventive services by hiring and retraining staff who will be linked to the community.



City Health Works, a key provider in the MSPPS, partners with hospitals and primary care providers to manage teams of culturally-competent, community health workers. CHW links providers to patients in community settings and delivers accessible, evidence-based, high-quality care that holistically addresses the health of the population. MSPPS will expand this community health navigation model through Project 2.c.i and integrate Project 4.b.ii goals and objectives.

For adults prescribed chronic disease medications, a number of MSPSS providers offer tele-monitoring which effectively supports medication adherence and patient self-management skills. The PPS's comprehensive call center will also be an important resource for linking individuals with health screening and promotion resources.

- 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 in implementing this project will be ensuring access to adult and pediatric preventive services and that patients are properly linked from primary care to specialists who perform preventive procedures. We will address this by expanding office and diagnostic hours to weekends and evenings. Through Projects 2.a.i, 2.b.iv, and 2.c.i, we will also expand care teams and increase care coordinators and patient navigators to increase patient capacity and access to necessary services.

Another anticipated challenge is outreach and education to the patient population. Engaging patients in their care, as well identifying and treating conditions before they become chronic, will be difficult and will require all providers and PPSs working together. Using culturally appropriate media and communications, we will build awareness of chronic disease prevention. Cultural competency training programs will improve our capacity to build trust and engage patients in the community. Additional trainings that increase sensitivity to health literacy and disease self-management skills for patients will be developed and implemented. As described in other projects, we will hire and re-train existing staff, particularly those that are bilingual and reflect the diversity of our service area.

The lack of integrated health IT also presents a challenge. Significant investments are needed to create a shared data infrastructure. Functioning HIE will require innovative payment models and policy changes. Early and continued engagement with MCOs and policy/regulatory changes will facilitate integration and collaboration among previously competitive parties.

Finally, we anticipate that it may be challenging to offer affordable preventive services to our entire patient population. Many PPS providers have sliding fee scales and programs for the uninsured/underinsured to decrease out-of-pocket costs for clinical and community services. For example, TBHC's Integrated Cancer Screening program provides screenings for the uninsured and underinsured in collaboration with NYSDOH. These sliding scale and low-cost programs may need to be expanded for the residually uninsured. Through the MSPPS MSO and governing entity, we will engage in discussions with payers to advocate for coverage and to subsidize prevention



activities to promote healthy behaviors.

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

We continue to build multiple avenues for collaboration with other PPSs, both directly and through our partners. By way of cross-PPS meetings, we will work with PPSs in the same service area to identify overlap in partners and projects. Our goal is to develop common approaches and protocols, share data, and collaborate on project development. For example, we are currently building a strategic relationship with the Bronx Lebanon Health Center PPS to facilitate joint planning, achieve economies of scale, and establish shared protocols. We also have engaged with NYC DOHMH to collaborate on projects that both MSPPS and HHC share. In addition, our workforce and union stakeholders overlap with other PPSs, providing an additional avenue to connect across PPSs around shared protocols and practices.

We will also work with other PPSs to coordinate project implementation in the same clinic sites where possible. Using the MIX and through State DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models. We anticipate hosting speakers to inform providers on payment and care delivery changes.

With the breadth and depth of our partners, many of whom are in multiple PPSs, MSPPS is well poised to engage other PPSs. These partners are key to driving performance and standardization across the system. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where patients seek services, they have access to the best care possible.

- 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.

To successfully implement this project we will focus on having a detailed implementation plans, including at the project/provider level. Other specific milestones will be determined during the Implementation Plan phase and supplemented with the state identified Domain 1 and 4 metrics and milestones. This collaborative implementation process will be guided by the achievement of key milestones, including:

- Convene a Learning Collaborative
- Developing best practice for coordinating with other PPS's using the MIX
- Establishing Quality Improvement (QI) Teams to manage implementation pieces that require technical support
- Establish a shared work plan and timeline for project implementation
- Schedule a Speaker Series to inform providers on national best practices, payment and care delivery



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.

Capital funding will be used to purchase equipment, particularly screening tools to ensure that preventive services can be accessible to members of our PPS, and that our project partners are well equipped to care for the target population. We will assess the specific needs of our project partners during the implementation-planning phase. We also anticipate needing funds for clinic/site renovations, particularly for the expansion of primary care sites in our PPS. Investments in IT infrastructure will also be critical, specifically to support the cost of hardware, like computers and tablets, and start up software costs.

At this time, our intent is to provide a high level overview of needs. More detailed capital asks will be described in the Capital Restructuring Financing Program application due February 20, 2015.

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.

Entity Name
See response in 1.c.



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.

According to the NYSDOH/AIDS Institute Statewide Coordinated Statement of Need (SCSN), NYC - the heart of the MSPPS service area - is the epicenter of the US HIV/AIDS epidemic. CNA data show that in 2010, NYC reported more AIDS cases than any other state, except for California. Although NYC only represents 2.6% of nation's population, almost 8% of people living with HIV/AIDS in the US reside in NYC. In addition, 15.2% of AIDS deaths nationwide occur in NYC.

Data show that in 2011, there were a total of 154,386 individuals, including the incarcerated, that are diagnosed and living with HIV/AIDS in NYC. Statewide, a total of 131,632 persons diagnosed and living with HIV/AIDS in 2009. In NYC, it is estimated that 34,880 persons are HIV infected are unaware of their HIV status.

More recent data show that in 2013 there were 116,452 people living with HIV/AIDS in NYC, of which, 58.3% had an AIDS diagnosis. In our service area, Manhattan has the largest proportion of residents with HIV/AIDS (26.9%), followed by Brooklyn (24.7%), the Bronx (23.2%), and Queens (14.8%). The majority of this population are male (60%). Communities of color disproportionately represent NYC residents living with HIV/AIDS compared to white residents; 44.4% are African American, 32.4% are Hispanic, and 20.7% are white. More than half of these individuals are living in poverty (52.9%).

Additional data on HIV in NYC that demonstrates a need to increase early access to, and retention in, HIV care, include:

In 2012, 3,141 new HIV diagnoses in NYC were made;

Among the newly diagnosed, racial/ethnic disparities persist - African Americans and Hispanics consistently account for the vast majority of all concurrent diagnoses (81% in 2012);

Neighborhoods with the highest rates of HIV diagnoses are in Central Brooklyn, Chelsea-Clinton, and Harlem;

In 2012, there were 1,899 new AIDS diagnoses. Since 2008, about one-fifth of those diagnosed with HIV were concurrently diagnosed with AIDS, reflecting the late identification of disease; Each year since 2008 through 2012, males had more new HIV diagnoses than females.

Since 2008, the percentage of new HIV diagnoses among men who have sex with men (MSM) has been increasing;



Since 2012, 74% of new HIV diagnoses among females have been attributed to heterosexual transmission;
In 2012, four out of five individuals with an “injecting drug user” (IDU) HIV risk factor were male, while four-fifths of those with heterosexual risk were female;
Since 2009, the number of new HIV (non-AIDS) diagnoses was higher among MSM under age 30 than among those in older age groups;
In 2012, there were 1,578 deaths among persons with HIV/AIDS in NYC;
An estimated 14%, or 18,709 individuals living with HIV in NYC, were not diagnosed by the end of 2012;
An estimated 16%, or 17,636 NYC residents diagnosed with HIV, had never been linked to care in 2012;
An estimated 18%, or 12,171 of NYC individuals living with HIV, presumed to have ever been on antiretroviral therapy (ARVs) were not virally suppressed in 2012;
More than a third (34.5%) of HIV+ NYC residents have an unmet health care need; and The HIV epidemic continues to disproportionately impact persons 50 years old and over.

To address the health care needs of this population, Project 4.c.ii will develop new resources and programs, including improved access to care, expanded HIV testing, expanded access to Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP), increased disease self-management, expanded culturally and linguistically appropriate care, solidified linkages to substance abuse programs such as needle exchange services, and expanded peer navigation services to improve access to and retention in care. Seven PPSs are engaged in joint planning via a non-binding charter affirmed by our PPS. We intend to continue the collaboration through implementation planning and operations to address major gaps in access to, and retention in, HIV care.

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

Based on CNA data, key target populations for this project include:

1. HIV-infected individuals who are undiagnosed;
2. HIV+ individuals who have been diagnosed but are out of care (both fully engaged and never fully engaged);
3. HIV infected individual who are connected to care but have unsuppressed viral loads; and High-risk individuals who are not HIV infected (i.e., individuals eligible for PrEP and nPEP).

Within the HIV + population, we will focus on sub-populations, including individuals with co-occurring behavioral health diagnoses (e.g., mental health and/or substance abuse comorbidities), new and undocumented immigrant populations, transgender women, and other subgroups as identified below. We will focus primarily on African Americans, Hispanics, and MSM, who are disproportionately affected by HIV/AIDS in our service area.



We will also target high-risk negatives who are not engaged in primary care, individuals living in poverty, and those predominantly from communities hardest hit by the epidemic, including, but not limited to, Chelsea-Clinton, East & Central Harlem, and Central Brooklyn.

Additional target populations include:

- Communities of color, particularly African American and Hispanic residents
- Substance users
- Individuals with mental illness
- Mentally impaired chemical abusers (MICA)
- Men who have sex with men (MSM)
- Women
- Children
- Adolescents/young adults
- Heterosexuals
- Perinatally infected
- Senior citizens
- Incarcerated populations/formerly incarcerated
- Immigrants and the undocumented
- Homeless and individuals with housing instability
- Transgendered population

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

Provider-based and community-based resources that will be mobilized for this project include:

- HIV initiatives occurring within MSPPS hospitals and Federally Qualified Health Centers (FQHCs), including the Institute for Family Health, Community Healthcare Network, William F. Ryan Health Center, and Betances.
- MSPPS providers with a focus on the HIV-positive population, including Amida Care, Select Health, AIDS Service Center, Housing Works, GMHC, Harlem United, Harm Reduction Coalition, APICHA Community Health Center, Latino Commission on AIDS, iHealth, United Health Plan, and the National Black Leadership Commission on AIDS.
- TBHC is recognized by the NYSDOH as a Designated AIDS Center (DAC) and provides services at two locations in Brooklyn to over 1300 clients.
- The MSPPS behavioral health network of mental health and substance abuse providers with a focus on the HIV positive population, including Article 31 and Article 32 sites, co-located mental health and substance abuse services available within Article 28 clinics, and needle exchange programs. These providers include the Institute for Family Health, Community Healthcare Network, Argus, Housing Works, Lower East Side Harm Reduction Center, FROST'D, Positive Health Project, and Harm Reduction Coalition. Additional Article 31 and 32 clinics may be needed to meet the needs of our population, as well as available needle exchange programs within the community.



- Enhanced continuous quality improvement (CQI) infrastructure at various points of service delivery along the HIV continuum, also known as a “Cascade of HIV Treatment.” Of particular need are Spanish speaking providers and healthcare workers (e.g. nursing, case managers).
- Health Homes participating in the MSPPS, including the Mount Sinai Health Home, CCMP, QCCP, and CBC.
- Long term care partners with expertise in HIV/AIDS care, including ArchCare at Terrence Cardinal Cooke Health Care Center, and home care providers with medication adherence programs.

Additional external partners and resources that will be leveraged include:

- Governor’s End of AIDS Taskforce
- NYC DOHMH Bureau of HIV Prevention and Control
- NYSDOH/AIDS Institute
- AIDS Education and Training Centers
- HARPs (behavioral health)
- HRSA Ryan White funded 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.

Data show that the most significant barriers to HIV/AIDS services in NYC are poverty, housing, nutrition, case identification, access to primary and comprehensive care, connection to supportive services, and outreach and education. These challenges, and the solutions to address them, are described more specifically below:

1. Target Population: Individuals may not trust or feel welcomed by providers/health centers, and are often homeless or lead unstable lives. To address this, we will work with community-based organizations that have experience with outreach, community engagement, and peer education models. We will increase cultural competency training for medical providers and health services staff.
2. Resource Alignment: To ensure that the desired health outcomes are achieved, resources must be aligned to support needed services. We will work closely with colleagues to align our work, including designing incentives that enhance and promote collaboration between existing resources and organizations with expertise.
3. Community-Based Collaboration: Clinical providers and community-based organizations often work in silos, hindering collaboration and integration. We will reach across organizations to share information and conduct activities to engage and retain HIV-infected individuals at all points across the continuum of care, thereby eliminating existing silos.



4. Creation of Peer Educator Workforce: Currently there is no social determinants of health (SDOH) certification of peer educators to provide reimbursable enrollments, linkage, and retention services as part of the care team. This project will utilize peer training experience of PPS members to create a credentialed peer workforce that can be integrated into the care team, eligible for Medicaid reimbursement, and contribute to reductions in hospitalizations.

5. Evolving shortage of HIV experienced providers: Current HIV practitioners are aging and retiring. Young physicians replacing them generally lack the knowledge necessary to treat the disease. There is also a lack of incentives to treat HIV patients. It will be increasingly important to include HIV education and cultural competency in basic medical training and also provide HIV education to primary care doctors who are not currently HIV experts. We also need to create ways to acknowledge the complexity of issues in caring for HIV patients

- 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.

MSPPS has engaged with multiple PPSs in joint planning for this project, including HHC, CCB, BPHC, Lutheran Medical Center, and Bronx Lebanon Hospital Center. We are committed to working collaboratively together throughout implementation. We have preliminary consensus around a subset of sector projects that each PPS will implement and also around a subset of interventions to achieve the goals of these sectors. Throughout implementation planning, we anticipate this collaboration to continue including finalizing milestones, developing resources and shared materials, and agreeing on common protocols.

We will also work with other PPSs to coordinate project implementation in the same clinic sites where possible. Using the MIX and through State DSRIP learning collaboratives, we will coordinate with PPSs and partners to share ideas and learn from others. We are excited to engage our partners and other PPSs together in an innovation collaborative that focuses on national best practices and models.

With the breadth and depth of our partners, many of whom are in multiple PPSs, MSPPS is well poised to engage other PPSs. These partners are key to driving performance and standardization across the system. We recognize that patients have and will seek care within and outside any network developed by our PPS. Our goal is to raise the bar for not only our PPS, but with other providers in our area to ensure that regardless of where Medicaid patients seek services, they have access to the best care possible.



- 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.

Our PPS has chosen to focus on eight sector projects consistent with partner PPSs listed above: # 1, 2, 3, 4, 5, 6, 7 and 13. There are currently seven PPSs affirmed to join a HIV Collaborative in NYC, committed to via a non-binding charter, and are dedicated to working together through implementation. We will continue to meet with our collaborators 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 shared work plan and timeline for project implementation
- Reaching consensus on project milestones
- Reaching agreement on shared resources

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 HIV project will be established to expand upon existing networks and programs across the PPS. In order to ensure that all partners are able to acquire appropriate resources, enhance training programs, and support system restructuring for the project to succeed, the HIV project has identified a number of needs that require capital funding, including:

- Renovation and expansion of existing HIV clinic sites to accommodate service expansions, including access to nPEP, PrEP and HIV/Hep. C/STI screenings.
- Renovation and expansion of HIV clinic sites in order to accommodate co-location and integration of peer navigators, Health Home care managers, and behavioral health providers.
- Expansion of mobile medical van to provide HIV/Hep. C/STI screenings and to function as a bridge to medical care.
- IT equipment including computers, video conferencing, mobile devices, and related technology in order to expand data sharing across and between all PPS providers.



- 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
HELP/PSI	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
Long Island Association for AIDS Care	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
EAC, INC.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).



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Fortune Society, Inc.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
Harlem United Community AIDS Center, Inc.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
Housing Works, Inc.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
St. Luke's-Roosevelt Institute for Health Sciences	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates(at or above 270 per 100,000).
Greenhope Services for Women, Inc.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).
Samaritan Village, Inc.	SAMSHA Targeted Capacity Expansion (TCE) Grant	2013	2017	This program supports substance use treatment and HIV- and AIDS-related services in minority communities with the help of faith- based organizations in states with the highest HIV prevalence rates (at or above 270 per 100,000).



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Housing Works	HIV Viral Load Suppression initiative	March 2014	February 2016	The HIV Viral Load Suppression project offers a high level of care coordination to help clients achieve and maintain suppressed Viral Load. This is a privately funded initiative.
AIDS Service Center NYC	HIV Peer Training Initiative	2013	2017	This citywide program supports peer-delivered HIV/Hep C prevention education, screening, linkage to and retention in care for people living with and at risk for HIV. This is not a Medicaid initiative, it is funded by NYSDOH.
William F. Ryan Community Health Network	Access to PrEP			This program provides targeted outreach and enrollment into PrEP services for at-risk individuals, sero-discordant couples, etc. that may benefit from PrEP, and support services for those currently on PrEP. This is not a Medicaid initiative, it is funded by NYSDOH.
Callen-Lorde Community Health Center	New York State Dept. of Health, AIDS Institute, Transgender HIV services	2014	2018	This program provides targeted HIV prevention and care related services to individuals of transgender/gender non-conforming experience through integrated Medical Case Management to provide gender-affirming medical adherence, treatment education, and social services support.

- 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.

Our proposed sector projects under Project 4.c.ii will supplement existing efforts of the initiatives identified above. To meet the needs of the expanded target patient population, these existing initiatives will require additional resources. For example, augmentation of treatment adherence services and resources to existing programs will result in increased viral suppression, reduced healthcare costs, and overall improved health outcomes.

Our current system reform efforts seek to improve the overall health status of individuals with HIV/AIDS as outlined in the HIV Cascade. Our proposed projects will reduce emergency room utilization, hospitalizations and length of stay for HIV infected individuals and will result in



reduced healthcare costs and improved health outcomes. Our current projects target improvements within the HIV Cascade:

- Increase the number of individuals who know their HIV status
- Increase the number of HIV infected individuals ever linked to care
- Increase the number of HIV infected individuals retained in care
- Increase the number of HIV infected individuals started on anti-retroviral therapy
- Increase the number of HIV infected individuals with suppressed viral load

The DSRIP program, through implementation of our identified sector projects, will assist in achievement of improved outcomes related to the HIV Cascade. DSRIP addresses reduced cost and efficiencies while our other programs also include measures of improved psychosocial and clinical outcomes.

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.