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Using this document to submit your DSRIP Project Plan Applications

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

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

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

Domain 2 Projects

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

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

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

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

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

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

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

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

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

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

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

CCB's IDS project addresses community needs #1, 2, 3, 4, 5 and 13 in our Section 3.8 summary table.

According to the CNA, Twenty-five percent of Brooklyn's population is in fair-poor health, 24% in poverty, and there are significant disparities in care for preventable hospitalizations and premature death for minority populations (65% of Brooklyn residents). Chronic conditions, particularly respiratory, and cardiovascular, and diabetes, drive preventable admissions, cause premature death and are closely correlated with poverty, poor housing conditions and food insecurity, especially in North-Central Brooklyn, Crown Heights, East New York, East Flatbush-Flatbush, and Coney Island.

Behavioral health problems, especially substance abuse, result in high utilization and underlie many of the preventable admissions, as more than half of individuals have a co-morbid chronic condition. Coney Island, Williamsburg/Bushwick, Crown Heights, East New York, Borough Park, Sunset Park, and Flatbush are hot-spots on many or all of these metrics.

Brooklyn faces primary care shortages-- much of the borough is a designated health professional shortage area or medically underserved area. Outpatient care sites including FQHCs and clinics are unevenly distributed and insufficient in areas with moderate to high Medicaid populations such as Greenpoint, Canarsie, and East New York.

With half of the borough's population covered by Medicaid, an integrated, systematic approach to addressing to gaps in health services, care delivery and social needs is required. The IDS will focus on high-risk communities and patients through expanded access to services and better care coordination. Our commitment to deploying of a new model of care that integrates physical, behavioral and social needs into a coordinated care plan and creates a team-based approach to care management is demonstrated in our IDS approach. Fundamentally, the IDS is built on shared technology, common standards of care, and an integrated quality management program.

We will leverage our existing experience and a centralized governance and infrastructure, via the CCB Central Services Organization, to rapidly deploy and evaluate selected interventions that meet DSRIP goals. Target neighborhoods include: Coney Island, Borough Park, Sunset Park, East Flatbush-Flatbush, Greenpoint, East New York, Williamsburg/Bushwick, and Crown Heights, and target populations include those with: frequent ED and hospital visits, chronic disease (e.g. cardiovascular, asthma) or mental/behavioral health needs, social challenges that increase risk (e.g. homelessness, criminal justice involvement), and other populations that might benefit from care management services (e.g. disabled and developmentally disabled).

CCB's IDS project will specifically address gaps by:

-- Expanding access to care via new primary care sites, more hours, and a larger, better trained workforce;

-- Expanding community-based care management and peer services;

-- Disseminating existing technology (Dashboard) across the IDS to ensure seamless coordination and communication;

-- Providing PCMH-specific expertise and project management support to implement the foundation of high performing primary care practice as defined by 2014 NCQA Level 3 standards;

-- Developing a robust support infrastructure to support providers and social organizations, including a call center, patient registries, reporting, and protocols; and

-- Engaging with MCOs to rapidly move to value based payments and provide contracting, analytics, performance reporting to support the transition.

This IDS project underpins all our projects, creating a solid foundation for the future of Brooklyn's delivery system. CCB will leverage Maimonides' track record of success in population health management and in leading Brooklyn wide community-based efforts.

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.

To support all projects, CCB will expand upon Maimonides existing population health infrastructure for deployment across all participants, including community providers. Existing assets and resources that will be mobilized are:

--IT. Maimonides has developed a web-based, easily accessible care coordination and population health management solution (Dashboard) that provides:

(1) interoperable connections to existing clinical systems (EHRs) within the PPS as well as the RHIO (Healthix);

(2) an integrated data warehouse, business intelligence engine and risk stratification algorithms for quality and outcome reporting and predictive analytics and

(3) a care coordination application designed for integrated clinical and social care teams to collaborate patient care across the full continuum.

This solution is currently in use with the Brooklyn Health Home and over 50 Health Home partners and will be extended to all participants, including health care and social service agencies, independent of their use of EHRs.

--Care Management. The Dashboard identifies the care team, manages consent, permits secure messaging, provides alerts at critical care transitions and provides tools for interdisciplinary care planning. Currently, participating Health Homes employ 826 Care Managers and 191 Care Navigators and work with over 35 care management agencies. All resources work with a customized set of protocols to provide services to high risk, health home-eligible patients. We'll leverage protocols, staff, and existing relationships, where appropriate, to provide care management services across projects.

--Training. In conjunction with 1199 SEIU and Center for Urban and Community Services, the Brooklyn Health Home has innovative training programs in place to transform the existing workforce into a high functioning care management team. We will leverage and enhance this training to meet the needs of an IDS.

We will also rely heavily on the 10 in-network FQHCs along with our primary care practices (a least 65 practices) which have already achieved some level of PCMH certification.

We have worked with network participants on a project-by -project basis to identify other project-specific assets and resources that can be redeployed and have noted those in the individual project sections.

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.

We will confront various challenges as we implement DSRIP and become a sustainable enterprise. We will address these challenges with an inclusive, transparent governance structure and key services provided by a central services organization (CSO).

A major challenge is social factors that impact care—poverty, long work days, language/cultural diversity, lack of family and social contacts, and stressors on minority and behavioral health populations. These are barriers to engaging patients and sustaining strong patient-provider relationships fundamental to effective care.

To address this, CCB will recruit and train peers as advocates, coaches and outreach workers to engage chronically ill populations, communicate health information in a culturally competent manner, build trust and connect patients with support services, primary care and care management to assist with medical and behavioral service needs. CCB will integrate behavioral

health services into primary care to increase access to services that can reduce anxiety, substance abuse and depression and improve outcomes.

To address provider engagement and low PCP supply, CCB will expand the primary care workforce in Canarsie, Flatbush, Greenpoint, Williamsburg/Bushwick and other high need locations and provide technical assistance via the CSO to help providers achieve level 3 NCQA 2014 standards. CCB will add care managers to practices, improve patient monitoring and evidence base health education practices (e.g. Stanford Model) to improve self-management. The CSO will provide analytics and capabilities via the Dashboard to help providers meet NCQA reporting requirements and conduct population management.

Building the workforce will require significant recruitment and training. CCB will work with aligned PPSs to develop a joint recruitment strategy and leverage its existing curricula and strong relationship with 1199's training fund, community colleges other organizations to add new curriculum and expand existing high quality training programs.

CCB must ensure that DSRIP interventions and resources are deployed efficiently. We will organize Participants into local Hubs which will be responsible for local program implementation. Hubs will be governed by a local board with CSO support to ensure a bidirectional flow of communication/information and real-time performance data to inform rapid cycle evaluation.

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.

Joint planning is critical to creating a focused approach to population health management and achievement of the DSRIP goals in Brooklyn. CCB, HHC and Lutheran PPSs have conducted joint planning and will continue to do so during the implementation phase across all projects. Joint planning discussions encompass six increasing levels of coordination and integration:

1. Project Planning;
2. Requirements (Clinical & IT);
3. Borough-wide PPS Hub Partners;
4. Infrastructure (Training, Administration & IT);
5. Funding & Incentives; and
6. Governance & Oversight.

To date CCB and HHC have aligned all projects and Lutheran has aligned with 5 projects, including the IDS. Joint project planning has been initiated, with the intent of arriving at similar clinical interventions and IT requirements. The PPSs hope to continue to align along Hub geographic definitions and broader infrastructure needs regarding training, administration and IT. It is envisioned that joint planning will also encompass building primary care capacity, shared funding and incentive structures, whereby PPSs are aligned on payment methodologies and incentives for providers. Governance and oversight principles will also be aligned as feasible to support shared policies and procedures.

Coordination and alignment is critical to the IDS project, in particular, because it ensures that efforts undertaken by CCB to develop into an IDS (e.g. shared clinical protocols) is accomplished in a way that complements, rather than conflicts, with other emerging IDSs. This will generate less confusion within the existing provider workforce and partners who are supporting each PPS and, ultimately, enable better health care for all individuals in Brooklyn Medicaid.

CCB has actively pursued and is continuing to pursue collaboration with the other emerging PPSs in Brooklyn.

2. <u>System Transformation Vision and Governance</u> (Total Possible Points – 20)

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

Maimonides and its partners view DSRIP as a powerful change agent enabling fundamental transformation in the way low income residents of Brooklyn participate in the health care system. Maimonides has already begun implementation of a comprehensive population health management strategy and action plan for shifting the healthcare paradigm in Brooklyn. Full implementation of this strategy will result in deployment of integrated care teams that leverage advanced IT systems to coordinate care for medically and socially complex patients across Brooklyn, and integration of physical, behavioral and social services that addresses underlying issues driving overuse of inpatient services in our health care system.

Since 2005, Maimonides has led the development of an integrated care model to patients with chronic disease, particularly those with serious mental illness (SMI). Over the last 5 years, with the assistance of HEAL NY (funding to create an health information exchange) and CMMI (funding to create innovative care models for those with serious mental illness), Maimonides:

-- Built strong partnerships with behavioral health, social services and community-based organizations (who have committed to continue the transformation journey through the DSRIP governance structure);

-- Developed the Dashboard, an IT infrastructure that permits seamless communication across partners for care planning and coordination; and

-- Hired and organized a care management workforce to provide services via Health Homes.

Leveraging DSRIP funds, CCB will continue execution against the population health strategy by focusing on development of a primary care practice support infrastructure, training and engaging more providers, deployment of a broader range of clinical programs and development of a shared governance infrastructure to support the IDS. Our strategy includes: specific changes to strengthen the ambulatory health care system by development of comprehensive protocols shared across all providers and social service organizations to improve care outcomes and transitions and divert patients from hospital care to community-based care; development of a CSO to support project implementation, building new primary care practices (targeting Bed-Stuy, Williamsburg-Bushwick, East New York, Carnarsie, and Crown Heights), and bolstering primary care practices through implementation of PCMH Level 3 standards and embedding care managers/ navigators within practices who can engage patients and coordinate care.

Based on our Health Home experience, we estimate that our DSRIP project efforts will specifically target ten percent of patients who are most susceptible to over utilizing health care services. We will also provide better access to higher quality and coordinated care across all attributed patients. Estimates for the actively engaged population will be included in our final speed/scale tables to be submitted January 12.

Full implementation of DSRIP, which will occur by DSRIP Year 4, will result in a shift from inpatient care to more efficient care delivered in ambulatory settings. As discussed in the CNA section, if CCB successfully eliminates all potentially avoidable admissions and readmissions, as a proxy, we estimate that 104 Medicaid beds will be eliminated across Brooklyn. We anticipate that staff that support these beds can either be redeployed to other areas of the hospital or to ambulatory settings, as described in our Workforce Section. We anticipate a dramatic shift away from ED use, as individuals are able to seek comprehensive care solutions from their primary care provider.

By DSRIP Year 5 we will have achieved an integrated, collaborative, and accountable service delivery structure that will enable partnerships with Medicaid MCOs. These partnerships will leverage the capabilities of MCOs while providing sustainable funding for the infrastructure and resources started with HEAL and CMMI and completed with DSRIP funding. We will use metrics and reporting refined in DSRIP Years 2 through 4 to build value propositions for discussion and negotiation. As the CCB evolves into a fully-functional IDS, with the support of the State, CCB will be successful in expanding value-based purchasing arrangements which will sustain DSRIP efforts and transform care delivery.

Key milestones and implementation timeframes associated with DSRIP implementation and achievement of a successful IDS include:

DSRIP Planning and “Quick Hits” Deployment Milestones (Deployed across DSRIP Year 1)

1: Deployment of the Dashboard across all key participants and development of an IT plan to enhance Dashboard capabilities and assist providers in improving access to direct information exchange;

2: Deployment of a communication plan (e.g. website, marketing) to allow participants and public to have insight and input into DSRIP implementation;

3: Development of a comprehensive training plan with union participants to retrain workers to enhance skills, develop career ladders and manage redeployment;

4: Final development of evidence-based protocols across all projects and in collaboration with participants;

5: Development and implementation of a financial services plan, including distribution of DSRIP funds for implementation and incentives;

6: Development of a sustainability plan for continuation of services for financially frail providers and create longer-term path for maintaining DSRIP gains;

7: Development of a reporting infrastructure to enable a rapid-cycle evaluation process to drive continuous quality improvement.

DSRIP Deployment and Testing Milestones (Deployed across DSRIP Years 2 - 4)

8: Full staffing of trained care managers and care navigators deployed, as appropriate, throughout CCB's service area;

9: Deployment against all projects, with 75% deployment by Year 3 and 100% deployment by Year 4;

10: Final deployment IT plan, including Dashboard, to all participants;

11: Development of new primary care provider sites in underserved neighborhoods and recruitment of providers to serve in those sites;

12: Achievement of PCMH Level 3 standards by all Primary Care providers;

13: Testing and refinement, through CSO and committee structure, of protocols and processes to review initial outcomes and make needed changes for improved performance;

14: Piloting DSRIP successes with MCOs to test and refine payment structures and partnership strategies;

15: Development of a comprehensive plan for bed reduction and rationalization, across hospitals and nursing homes.

DSRIP Full Deployment (DSRIP Years 4 - 5)

16: Continued refinement and adjustments to protocols and processes to review outcomes and enhance performance through CSO and committee structure;

17: Comprehensive assessment of the cost to deliver services and corresponding quality metrics across CCB participants;

18: Planning for and development of a new governance structure to support negotiation of value-based purchasing arrangements and further integration of MCOs into governance structure;

19: Detailed discussions with MCOs on value-based purchasing arrangements;

20: Development of the contracting mechanisms required to implement new purchasing arrangements (e.g.- standing up one or more ACOs) and deployment of value-based purchasing strategies.

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.).

CCB's governance strategy will evolve to meet the needs of the IDS as it moves from a group of Participants with a shared vision and goals to one that is clinically integrated and financially sustainable.

We have developed a strong governance structure, described in detail in Section 2 Governance, which has been designed to govern DSRIP project implementation, performance accountability and financial incentive distribution, which are key milestones noted in above. Our structure consists of representatives from all CCB participant groups. Broad participation by Participants in governance is foundational to enabling the CCB to move from groups of Participants implementing against 10 projects and into a well-performing IDS over the course of the DSRIP project.

CCB's governance structure has been explicitly designed to truly transform CCB participants into an IDS. The Planning Steering Committee has agreed that:

-- CCB's clinical governance must agree to and effectively implement against a group of evidence-based clinical protocols, with a governance structure that can rapid review and enhance protocols while simultaneously ensuring compliance and managing Participant performance;

-- CCB's IT governance must ensure that all Participants must effectively share information via the Dashboard, RHIO, and EHR systems and all Participants must use a standardized approach for reporting performance and receiving continuous feedback against performance;

-- CCB's business and executive governance must ensure that the CCB is on a path of sustainability through the evolution toward a risk-based contracting strategy with multiple MCOs that will support DSRIP initiatives and enter into risk-based contracts.

The first two components can be accomplished within the DSRIP operational structure set forth in Section 2, Governance. Milestones associated with deployment of our operational governance structure include:

1: Execution of the Master Services Agreement between and among Maimonides, the CCB CSO, and CCB Participants by the time DSRIP Year 1 starts;

2: Final formation of Executive and Sub-Committees populated from existing planning committees. The planning phase Steering Committee will evolve into an Executive Committee for implementation. The current Care Model and Program Planning Committee will evolve into a Care Delivery and Quality Sub-Committee. The current Business, Operations, Analytic and Technology Committee will evolve into the Business and Operations Sub-Committee and the IT Sub-Committee;

3: Formation of a sustainability work group, reporting to the Business and Operations Sub-Committee, to support regular assessments on the stability of CCB Participants, to develop a sustainability plan and inform early discussions with MCOs;

4: Formation of a formal workforce work group, reporting to the Business and Operations Sub-Committee to support a broad workforce strategy including deployment of a training plan.

Planning for the third initiative, risk based contracting, can occur in the DSRIP operational structure, but implementation against that strategy, including entering into risk-based contracts, will require CCB's governance structure to evolve during the course of the DSRIP period.

We anticipate value-based purchasing arrangements with our IDS will rely on the CCB's ability to provide centralized financial, analytical and performance improvement services to advance the IDS's capability to manage population health and on CCB providing the common, supporting infrastructure to enable value-based contracting vehicles for the IDS (e.g. development of Accountable Care Organizations (ACOs) through the CCB PPS). As such, our ultimate governance structure will evolve and likely involve multiple structures based on how different Participants leverage the CCB to support their evolution to value-based purchasing.

Milestones for achieving a dynamic governance structure that not only sustains DSRIP outcomes but also enables value-based purchasing include: 5: Identification of contracting vehicles to undertake risk-based contracting, including creation of one or more ACOs; 6: Identification of governance structures within each of the contracting vehicles that will successfully manage administration and performance of each risk-based contract; 7: Development of contracts with network providers for each ACO in place; 8: Detailed discussions with multiple MCOs on value-based purchasing arrangements; 9: Contracts with multiple MCOs; 10: Administration of financial risk pools and payment plans through DSRIP.

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

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

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

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

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

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

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

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

Yes	No
☒	☐

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

CCB will need capital funds to support our integrated delivery system, enhance our IT and data analytics capabilities, expand primary care access, and support population health management

efforts. Examples of specific capital needs that may be required include:
-- Acquiring a data warehouse and related software to support communication among and between CCB Participants (partner organizations), ongoing assessment of population health indicators and ongoing evaluation of CCB's provider network.
-- Developing, renovating , and/or improving accessibility and efficiency of new or existing primary care space for both adults and pediatrics.
-- Establishing urgent care and/or primary care services at select nursing home(s).
-- Acquiring, renovating and securing equipment for CSO Office space.
-- Developing a call center to connect providers, patients and caregivers to care management.
-- Restructuring of hospital/other inpatient beds to make room for observational units or ambulatory space.
These improvements will develop the services needed to meet DSRIP project objectives, facilitate population health management, and address current provider shortages.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Methodist	Community Based Care Transitions Program	2012	2014	The Medicare Community based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
Glen Island Center for Nursing & Rehabilitation	Community Based Care Transitions Program	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Dominican Sisters Family Health Service, Inc./Family Home Health Care, Inc.	Community Based Care Transitions Program	2013	2016	Same as above…
Concern for Independent Living, Inc.	Community Based Care Transitions Program	2014	2016	Same as above…
PSC Community Services, Inc.	Community Based Care Transitions Program	2015	2015	Same as above…
South Beach Psychiatric Center /Kingsboro - OMH Initiatives	Community Based Care Transitions Program	2015	2015	Same as above…
NAMI-NYC Metro	Community Based Care Transitions Program	2015	2019	Same as above…
Amber Court of Brooklyn	Community Based Care Transitions Program	2011	2016	Same as above…
Higher Ground, IPA	Community Based Care Transitions Program	2015	2020	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Ridgewood Bushwick Senior Citizens Council, Inc.	Community Based Care Transitions Program	2015	2019	Same as above…
Cobble Hill Health Center, INC	Community Based Care Transitions Program	2011	2013	Same as above…
Heights and Hills, Inc.	Community Based Care Transitions Program	2012	2014	Same as above…
Family Care Certified Services a Division of Tri-Borough Certified Health Systems of New York	Community Based Care Transitions Program	2015	2020	Same as above…
Integra Managed Care, Inc	Community Based Care Transitions Program	2015	2019	Same as above…
Program Development Services, Inc.	Community Based Care Transitions Program	2015	2019	Same as above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Community Based Care Transitions Program	2015	2016	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
PROACTIVE CARE IPA, LLC	Community Based Care Transitions	2015	2015	Same as above…
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.
The Health Home program, particularly the experience and capacity of our participating Health

Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

FIDA enrollees are likely to participate in this project given that this project targets those with high needs. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement services provided under FIDA plans. In addition, this project will extend to all of our actively engaged population, not just those enrolled in FIDA.

CCB Participants receiving BIP funds will be critical to our project implementation efforts, and we will learn from and leverage their experience in improving care for Medicaid populations. DSRIP funding, however, will not be provided to these providers if doing so would supplant or duplicate BIP funding.

CCB Participants who have VAP designation are important to our project implementation efforts, and we will learn from and leverage their experience in improving care for Medicaid populations. DSRIP funding, however, will not be provided to these providers if doing so would supplant or duplicate VAP funding.

The Brooklyn Health Home Health Care Innovation Award under HCIA will not overlap for the same reasons as described in our response to Project 3.a.i and 4.a.iii. The Community based Care Transitions program will not overlap for the same reasons as described in our response to Project 2.b.iii and 2.b.iv. Money Follows the Person will not overlap for the same reasons as described in our response to Project 3.g.i and 2.a.iii. VillageCare's HCIA will not overlap for the same reasons as described in our response to Project 2.a.iii, 2.b.iii, 2.b.iv, 3.b.i, 3.d.ii, and 4.c.ii. The Medicare Shared Savings Program will not overlap for the same reasons as described in our response to Project 2.a.iii.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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

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

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

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

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

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

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

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

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

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

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

government units (such as SPOAs and public health departments).

9. Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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

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

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

The Maimonides-led PPS, Community Care of Brooklyn (CCB) has chosen Health Home At-Risk Project to comprehensively address chronic conditions and social determinants of health for Health Home at risk populations. Through this project, CCB will increase the availability of care management services to individuals with complex medical and social needs who are not Health Home eligible, but are at risk for increased severity and co-morbidities. This project addresses community needs #5, 6, 7, 8, 12 and 13 in our Section 3.8 CNA summary table.

In Brooklyn, the CNA notes that chronic conditions are the largest driver of potentially preventable admissions, particularly for respiratory, cardiovascular, and diabetes. Brooklyn PQIs for circulatory conditions accounted for almost 25% of such PQIs in the State. In many neighborhoods with disease-specific PQI rates among the highest in the borough, there are fewer than 3 health centers with specialty services for chronic disease. For cardiovascular, this is true in Coney Island/Sheepshead Bay, Crown Heights, Williamsburg/Bushwick, and in East Flatbush-Flatbush, for diabetes in Crown Heights and East-Flatbush, and for asthma in Coney Island/Sheepshead Bay, Crown Heights, East New York, Williamsburg and Bushwick.

CNA survey respondents noted that community members had a lack of resources to assist with their basic social needs, and that providers often fail to recognize or address these needs, looking instead to the “quick but possibly ineffective medical solution." Pervasive poverty, long work days, assimilation problems for immigrants, and housing shortages were cited as stressors that reduce the priority of health concerns, and exacerbate existing diseases and co-morbidities. Outreach is generally well received, but materials and workers are not always linguistically and culturally appropriate.

High functioning Medical Homes that integrate care managers into the care team are critical to addressing these gaps. CCB’s Health Home At Risk intervention program will provide additional well trained care managers to strengthen primary care team capabilities to monitor and manage at risk patients, and to refer higher need eligible patients to our two partner Health Homes. CCB will greatly expand outreach to engage this population, increasing the sites where peer outreach workers or care managers are deployed (e.g., EDs, and hospital discharge departments, Foster Care agencies, transitional housing, Adult Homes, Riker’s Island, Community-based Organizations(CBOs)). Care managers will assess patients and work with them and other primary care team members to create comprehensive care management plans.

To improve efficient use of care management resources and increase collaboration, CCB will strengthen links among Health Homes, PCPs and Managed Care Organizations through its advanced technology, the Dashboard, described below. Newly recruited or redeployed care managers will receive in depth training from CCB's Health Home partners, the Brooklyn Health Home and Coordinated Behavioral Care (leveraging existing training programs, described below), to address chronic illness management, cultural competence, motivational interviewing and knowledge of CCB social support providers.

CCB will collaborate with Health Homes to ensure quality services through new uniform evidence-based service standards for education, training, supervision, evaluation, continuous quality improvement, and IT. Policies and procedures developed by the Brooklyn Health Home, as well as the analytics it uses to assess Health Homes, will be a model for CCB. CCB will include the standards in all contracts and will enforce/audit implementation of the standards to ensure high quality Health Home services.

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.

CCB will target services to Medicaid beneficiaries and uninsured patients who need care management services but are not yet Health Home eligible--we estimate that roughly 10% of our utilizing attributed population would fall into this category. Final estimates for the actively engaged population will be included in our final speed/scale tables to be submitted January 12.

Specifically, given the needs identified above in the CNA, the At Risk Health Home population will include individuals with single chronic diseases, including diabetes, CVD, asthma, COPD, neurogenerative diseases, moderate depression, and others as determined via PCP and care team assessment, who would benefit from care management services, for example, the physically disabled and developmentally disabled. CCB will focus its efforts in neighborhoods with high rates of these conditions, and with limited resources, as identified in the CNA (noted by disease burden above, including Borough Park, Flatbush, Crown Heights, East New York, and Williamsburg/Bushwick).

Given the CNA's focus on social determinants, CCB's program will train care managers to look beyond immediate medical problems to identify social factors that elevate risk and pose barriers to improved outcomes, such as housing and food insecurity, substance use disorder, and criminal justice involvement. CCB will partner with MCOs to ensure that patients connect with their PCPs.

This project supports and integrates with several other DSRIP projects, including 3.a.i (Primary Care Behavioral Health Integration), 2.a.iii (ED Triage), 2.b.iv (Care Transitions), 3.b.i (CVD), 3.d.i (Asthma), and 3.g.i (Palliative care). At risk patients identified through these projects, and who are not Health Home eligible, will also be included in the target population.

CCB will also provide care management services to children.

CCB's CSO, as described in our Organization application, will be critical to enabling the data analytics and tracking capabilities that will help us best target this project to those with the highest need.

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.

CCB's greatest assets in implementation of this project are our two partner Health Homes and its NCQA recognized Medical Homes which together provide a strong foundation and have a wealth of experience on which we will build our Health Home At-Risk project.

CCB's two partner Health Homes have 826 care managers employed via contracting agencies. Both Health Homes are represented on CCB's Project Advisory Committee and have been highly participatory in shaping this project intervention. In addition to helping to develop uniform performance standards and provide technical assistance as noted above, CCB will use the Health Homes' existing 35 contracted downstream care management agencies to rapidly recruit, train and deploy hundreds of care managers into network primary care practices and other sites noted above to support this project and the other DSRIP projects listed above. The Health Homes' strong partnerships with community assets, including, mental health and substance abuse providers multi-service agencies, transitional housing providers, social service agencies, primary care providers, specialists, and hospitals, built up over the past 3 years, will help to quickly integrate the new care managers into their organizations and address social barriers to care (addressing a key gap identified in the CNA). For example, our network will include FEGS, CAMBA, Housing Works and VNSNY. We will also leverage the comprehensive reporting and quality improvement processes already in place in our partner Health Homes.

CCB has extensive existing training programs on which to build the expanded workforce. Working with 1199, Maimonides, through its CMMI grant, has already developed an extensive training program for Brooklyn Health Home care managers on the basics of chronic illness and care management, cultural competency, patient activation tactics including behavioral activation, CBT, and problem solving therapy and on team-building among providers. The CBC Health Home also has strong training program resources so that together the two Health Home partners can bring a high functioning care management workforce up to scale quickly.

CCB's web-based Dashboard is a cutting-edge care management platform that can link Health Homes, PCPs, and community organizations as they care for patients, and is already in use by the two Health Homes in our PPS. The Dashboard can be rapidly deployed to additional care management staff to support the expansion to the At Risk Health Home population. Through the Dashboard, users will create the comprehensive care management plan, access an enrollment application to electronically capture patient demographics, and dynamically manage patient consent to all stakeholders on the Health Home consent form. An integrated business intelligence solution uses the data warehouse to provide real-time reporting for the Health Home, including required reports (NYS Patient Tracking Sheet and CMART reports) as well as population level analytics.

Finally, given the needs identified in the CNA, a CCB priority will be to build on its existing high functioning NCQA Level 3 PCMHs and use their expertise and experience to move up to 2014 standards and to provide support to other participating PCPs to reach NCQA 2014 Level 3 Medical Home recognition by the end of DSRIP Year 3.

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.

CCB's program is designed to address the challenges we expect to face in achieving this project's goals:

For example, EDs and inpatient discharge units, important engagement sites for this project, have posed past challenges for Health Home representatives due to space/workload issues, lack of incentives, and lack of staff knowledge on Health Home services. CCB will build off the Brooklyn Health Home's experience in successfully engaging hospital staff by launching a focused education campaign to get provider buy-in and improve understanding of the positive impact Health Home services have on their patients. A clinical 'champion' at each hospital will oversee the education program and guide care managers to ensure they are responsive to clinician and patient needs, and to prevent duplication of effort.

In addition, the lack of key information about at risk patients at the point of care, and the lack of resources to monitor/follow up with such patients pose formidable obstacles, as noted in the CNA. We will overcome this traditional barrier through investment in a well-trained workforce (we expect to train or re-train thousands of care managers) and by connecting providers and CBOs to HIE and our web-based Dashboard, a proven smart technology solution to care management planning, which has already been deployed in many sites within our PPS.

Finally, gaining information sharing consent from patients, particularly those with behavioral health needs, is challenging. Through this project, CCB will be able to serve patients who are not consented and thus continue to gain their trust, help them with their medical and social needs, and eventually, we hope, obtain their consent. For those who are health home eligible, CCB will identify patients at their usual source of care (medical or social), as our experience shows that this increases the consent rate, and will pursue patient-engagement through peers and CBOs who provide support services to at risk populations.

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

The Brooklyn-based PPS's, including CCB, HHC, and Lutheran, have collaborated to select the Health Home At risk project and align key interventions related to its implementation. During the January-April 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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.

CCB will need capital funds to support our Health Home At-Risk project, specifically to acquire a data warehouse and related software to support communication among and between CCB Participants (partner organizations) who are implementing this project. This will support the use of collaborative shared care plans by the interdisciplinary care team, and the use of risk stratification for targeting potential at risk patients.

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

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be)

participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Jewish Board of Family & Children's Services (JBFCS) /CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Bailey House	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as above…
NAMI-NYC Metro	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services /Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
Apicha Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2015	Same as above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as above…
Family Services Network of New York, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Outreach Development Corporation	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
FEGS Health and Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
The Resource Training and Counseling Center, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
SCO Family of Services /Member of the Children's Collaborative and the Advance Care Alliance	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Village Center for Care	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

The MSSP program targets Medicare patients served through ACOs. We will build on the experience of these Participants to establish our care management and coordination model, but our project is aimed at improving care for a broader population of Medicaid patients. DSRIP funding will not duplicate or supplant MSSP funding for populations that overlap.

VillageCare's efforts under this award will help inform CCB's planning around medication and treatment adherence, but will apply to a far broader population and will be implemented at our other relevant Participant sites. DSRIP funding will not supplant or duplicate the funding that has been provided to VillageCare under the HCIA.

Bridges to Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization and other out-of-home care. CCB's project will supplement these important services, but DSRIP funding will not be provided to Bridges to Health participating providers if doing so would supplant or duplicate funding.

DISCO service providers and enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider, not plan level, and is distinct from and will supplement DISCO services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in DISCO plans.

DSRIP funding will not be provided to Money Follows the Person participating providers if doing so would supplant or duplicate MFP funding. These providers, however, will serve as experts on facilitating transitions from nursing homes to the community.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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.iii ED Care Triage for At-Risk Populations

Project Objective: To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Project Description: Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

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

1. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
    a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
    b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
    c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
    a. Patient navigators will assist the presenting patient to receive a timely appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
    b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
    c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. Use EHRs and other technical platforms to track all patients engaged in the project.

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

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

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

The Maimonides-led PPS, Community Care of Brooklyn (CCB) has chosen ED Care Triage Project because of the need in Brooklyn to reduce preventable use of the ED, increase use of primary care and other community-based services, and because we recognize that the ED is a critical new point of engagement for high need populations. This project addresses community needs #3, 4, 6, 7, 8, and 12 in our Section 3.8 summary table.

The CNA notes that nearly three quarters of Medicaid ED visits in Brooklyn were preventable in 2013, amounting to over 347,000 preventable ED visits. Medicaid beneficiaries in northern/central Brooklyn account for the majority of these preventable visits—with rates of 30-54 PPV/100 beneficiaries. The CNA indicates that community and provider perceptions make the ED a rational choice for "one stop shopping," as patients seek to avoid long PCP wait times and the need for multiple visits.

According to the CNA access to primary care is limited: 23% of Brooklyn residents reported that in some point in the last year they needed health services but did not get them. 25% of Brooklyn CNA survey respondents reported that primary care was not sufficiently available, 13% said they used the ED because the doctor's office/clinic was closed, and 12% said they could not get a timely appointment. Behavioral health patients, in particular, face stigma and other barriers to care. Adding to access barriers is a lack of urgent care in Williamsburg-Bushwick and East Flatbush-Flatbush, and only 1 urgent care site in Borough Park, Sunset Park, Canarsie, Coney Island and Greenpoint. There is a shortage of PCPs in Brooklyn; much of the borough is a health professional shortage area or medically underserved area. Shortages are most stark in Greenpoint, Canarsie, and East New York.

Initial analysis of SDOH data indicates there are thousands of individuals who used the CCB EDs at least twice for low severity causes in 2012. Hospitals cite a lack of ED staff with sufficient time to follow up with such patients and insufficient knowledge about available community services, and resources to divert patients.

To address these issues, CCB will:

1. Create a new clinical position in our EDs with responsibility for managing follow-up and referral for patients who have been medically screened and deemed non-emergent. The clinical manager, assisted by a patient navigator, will connect patients to a PCP and Health Home Care Manager, as needed to ensure a follow-up appointment is scheduled. Patients with identified behavioral health problems will be connected with an onsite Health Home representative for appropriate assessment, follow-up care and enrollment.

2. Work with PCMHs to ensure expanded hours of operation and open access scheduling, so patients can be directed to open facilities during extended hours. This project will include all of

our 6 acute care partner hospitals and many of our PCP and urgent care practices.

3. Add urgent care sites and primary care capacity to address inappropriate ED use in all hospitals, especially in shortage areas and areas with high preventable ED use, as identified in the CNA and in Community Health Care Association of New York State report recommendations (e.g. Williamsburg-Bushwick, East Flatbush-Flatbush).

4. Divert patients with serious mental illness (SMI) away from the ED through use of Parachute NYC. Parachute seeks to stabilize SMI patients in the community via mobile crisis teams, crisis respite centers, and peer support hotlines.

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 project will target frequent users with low severity problems, and high risk subpopulations including mental/ behavioral health populations, and those with social and economic barriers to care. PPS hospital partner data and CNA data (described above) suggests the intervention will be most effective by focusing on these frequent utilizers. For example, initial analysis at one CCB hospital demonstrated that 15% of Medicaid patients accounted for 40% of ED visits. Among ED users with low severity ESI scores (Level 3, 4 and 5), some of the most frequent diagnoses were minor injuries, digestive system issues, or other conditions that could be treated in a primary care setting.

CCB will use SDOH data to quantify the number of chronic ED users for low severity problems We will specifically target individuals that used the ED at least twice in the 12 month period for low severity issues. We anticipate engaging at least 85% of this population in a manner that complies with the SDOH definition of active engagement. Final estimates for the actively engaged population will be included in our final speed/scale tables to be submitted on January 12. We will prioritize outreach to individuals who visited the ED 5 or more times for low severity diagnoses and the low severity users who have a behavioral health diagnosis.

CCB will implement this project in all of our 6 acute care hospital EDs in our service area, which serve the key geographic areas identified above with high PPV rates.

And, as noted in the CNA, many in the target population struggle with social and economic factors such as 16 hour workdays, lack of insurance, and immigration status that drive inappropriate ED use. Both our ED Triage and At Risk Health Home projects will therefore aim to link those with limited access to regular care because of housing, work schedule, inability to afford care, or other social issues, to PCMHs and care management services. These two projects are closely aligned in their goals and key populations of focus.

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

To successfully implement this project, CCB will use many existing assets and resources. For example, to better connect patients to community-based care, CCB will use the care

management infrastructure, and strong relationships especially with existing

mental and behavioral health providers, that have been built up over the past 3 years by the Brooklyn Heath Home and Coordinated Behavioral Care (CBC). Some of these collaborating service providers include CUCS, the Jewish Board of Family and Children Services, FEGS, VNSNY, Catholic Charities and many others. Through this project, and concurrently with many of the other projects we have selected, CCB will also expand the integrated virtual co-location care model and extensive training program that has already been implemented for Health Homes. These resources will be critical to building up and implementing CCB's interconnected suite of projects.

Importantly, CCB's innovative technology, the Dashboard, will be extended to all CCB providers, and accessible to providers in the EDs and primary care providers to identify patients who are in care coordination programs and identify their care team and comprehensive care management plan. Providers and care teams receive real-time alerts notifying them when their patient is registering in the ED, enabling actions that if appropriate would redirect them to their PCP and prevent an inpatient admission. Using the assessment tools built into the Dashboard and the Messages application, patients can be triaged and quickly referred to their primary care provider.

The Parachute Program is already operating in Brooklyn, and will be expanded in both the scope of the patient population it serves and its respite bed and mobile crisis intervention capacity. The City's Parachute Program is not RHIO connected, so this capacity will be developed through connection to the CCB Dashboard.

Finally, CCB partners believe that high functioning PCMHs are the foundation of a transformed delivery system that meets patients' needs and service expectations. Using internal expertise and collaborating with NYC REACH, CCB will provide support and technical assistance to participating PCPs to reach PCMH NCQA 2014 Level 3 Medical Home certification by the end of DSRIP Year 3.

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.

CCB's program is designed to address the challenges we expect to face in achieving this project's goals:

As noted in the CNA, some patients use EDs for convenience -'one stop shopping' -and 24/7 access. To address, CCB will assist PCMHs to expand the range of on-site services where feasible and reduce wait times via open access scheduling. It will also add both primary practices and urgent care centers in neighborhoods (e.g. Williamsburg/Bushwick) with poor public transportation and high ED use.

As noted in the CNA, many inappropriate ED visits are by individuals with behavioral health diagnoses. CCB will address this challenge in three ways: 1) linking patients to Health Home services, 2) culture change and 3) stabilizing patients in the community.

1) Although behavioral health patients are usually eligible for Health Home services, many are not yet enrolled due to lack of consent or ineffective engagement. CCB's ED Triage project is designed to identify these beneficiaries at the point of care, assess, and link them to care

management via the At Risk Health Home program (2.a.iii) where consent is not a requirement, and care managers can gradually build trust and obtain consent.

2) PCPs and other providers often lack the knowledge and are uncomfortable treating patients with behavioral health disorders. Provider and staff education, culture change and resources to support changes have been shown to permit mainstreaming these patients. These strategies will be an integral part of the CCB DSRIP Program, as described under project 3.a.i.

3) The Parachute Program, described above, though proven to be effective in stabilizing mentally ill patients in the community, has not seen a high demand. CCB will educate ED and primary care practitioners, psychiatrists and other mental and behavioral health workers about the program, the population targeted, and its safety and effectiveness in stabilizing patients without the ED. CCB will also link patients, to Health Home care managers, who can ensure that patients get the social and community service supports they need.

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

The Brooklyn-based PPSs, including CCB, HHC, and Lutheran, have collaborated to select this project and align some of the specific interventions related to its implementation. During the January-April 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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

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

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

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

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

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

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

a. Will this proj

Yes	No
☒	☐

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

CCB will require capital funds to support this project, specifically our implementation of the Parachute program, improved and expanded urgent care access, and other alternatives to EDs. Examples of specific capital needs that may be required include:
-- Developing (or expanding) a community respite center to support implementation of Parachute program. The Center would provide non-medical support for individuals post-acute care discharge. Capital funding would be used for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions for the site.
--Investing in mobile crisis vehicles, another core component of the Parachute program, which would allow CCB to offer timely assistance to individuals in crisis in the community.
-- Developing, renovating , and/or improving accessibility and efficiency of new or existing urgent care sites for both adults and pediatrics.
--Renovating and purchase equipment for an emergency department to create an observation unit (as an alternative to hospital admission for targeted patients).
These efforts and their accompanying capital needs are critical to diverting and triaging inappropriate ED use, CCB's goal under this DSRIP project.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
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Glen Island Center for Nursing & Rehabilitation	Community Based Care Transitions Program	2015	2019	Same as above…
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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Community based Care Transitions program targets Medicare patients. We will build on the experience of these Participants to establish a new, evidenced-based standard care transitions model for the Medicaid population in each of our hospitals, extending the model to a broader population of Medicaid patients.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

FIDA enrollees are likely to participate in this project given that this project targets those with high needs. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement services provided under FIDA plans. In addition, this project will extend to all of our actively engaged population, not just those enrolled in FIDA.

VillageCare's efforts under this award will help inform CCB's planning around medication and treatment adherence, but will apply to a far broader population and will be implemented at our other relevant Participant sites. DSRIP funding will not supplant or duplicate the funding that has been provided to VillageCare under the HCIA.

CCB will build on existing implementation of the Parachute/mobile crisis program, but CCB's project will expand use of, and access to, mobile crisis/Parachute services for our engaged population. DSRIP funding will not be provided to participating providers if doing so would supplant or duplicate funding.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient

information was provided.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

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

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

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

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

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

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

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

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

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

The Maimonides led PPS Community Care of Brooklyn (CCB) has chosen Project 2.b.iv because of the need to reduce the number of avoidable readmissions in Brooklyn, and to fill communication gaps during care transitions and ensure transitioning patients get the services they need in the community (e.g. home care and care management). This project addresses community needs #2, 3, 5, 6, 7, 8, and 12 in our Section 3.8 summary table. This project also complements and strengthens linkages to many of our other projects, especially the At Risk Health Home project.

In 2012, there were 8,878 potentially preventable readmissions in Brooklyn; 2,870 were at the 6 Brooklyn-based acute hospitals participating in CCB. The observed/expected ratios of Potentially Preventable Readmissions for CCB hospitals ranged from .83 (Community Hospital of Brooklyn) to 1.17 (Interfaith), an average ratio of 1.03; Kingsbrook had a rate of 1.10, Wyckoff 1.09, Methodist .98, and Maimonides .87.

Based on data from four CCB hospital(s), cardiovascular conditions including heart failure, Septicemia/infections, renal failure, pneumonia, and COPD have among the highest volumes of readmissions. The CNA also noted that 2,573 of Brooklyn readmissions were for patients with behavioral health diagnoses and 22% of patients with behavioral health diagnoses were readmitted.

Brooklyn also has a primary care shortage , described in the CNA; access issues drive readmissions, and make safely transitioning patients into the community challenging. Post-discharge services and transition programs are limited, often do not extend for 30 days, and often exclude or cannot support behavioral health populations. The CNA notes that patient needs for care coordination, linkages, and follow up to PCPs, CBOs, MCOs, and Health Homes are not being met.

To address, CCB will implement a standardized care transitions model at each of the 6 acute care CCB hospitals. Patients will be screened using the evidence-based LACE tool (a validated predictor for risk of readmission) modified to include social factors that increase risk, and those at risk of readmissions will be assigned a Transitional RN who will work with embedded hospital care managers, the patient's clinical team and Health Home care manager (if applicable) to develop a 30 day care transitions plan. CCB will also increase PCP capacity by increasing efficiency, extending work hours and opening new practices in shortage areas.

The plan will indicate the level of outreach (telephonic/in-person) and the timeframe for patient contacts. The RN will educate patients pre-discharge on their transition plan using the LACE discharge checklist and the teach-back method. High risk individuals will receive a home visit by the embedded or Health Home care manager, who reports to the Transitional RN. Eligible patients will be referred to care management services through the Health Homes or Health Home At-Risk project to facilitate a care coordination plan beyond the 30 day period, and to ensure on-going community and social supports are in place. Existing Health Home care manager protocols will be strengthened to include visits to hospitalized patients, and home visits following discharge as appropriate.

All transition patients will be enrolled in the Dashboard, an IT platform to enable care team communication. PCPs will receive real-time alerts as patients are admitted and discharged, and will access the patient's shared care plan and discharge plan through the Dashboard. CCB will

also strengthen supportive resources (e.g. consulting pharmacists, more frequent use of Home Care).
Finally, the 6 key CCB hospitals will implement the Critical Time Intervention (CTI), an empirically-based intensive case-management model targeted to individuals with mental/behavioral health conditions, and designed to prevent homelessness and adverse outcomes in these populations following discharge.

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 will include patients with diagnoses that are the most frequent source of readmissions at CCB partner hospitals and highlighted in the CNA, including: heart conditions, COPD, renal or pulmonary disease; patients with behavioral health conditions; and patients who are identified as frequent users of the ED. In addition, patients with previous admissions and those identified at higher risk of readmission using the LACE tool and known social factors (e.g. homelessness, criminal justice history, substance abuse) will be in the target population. Final estimates for the actively engaged population will be included in our final speed/scale tables submitted on January 12. Patients who are eligible for Health Homes, or who are eligible for the At Risk Health Home project will be actively engaged as will three other important subpopulations: the physically and developmentally disabled, dual eligible enrollees, and patients with behavioral health or serious mental illness diagnoses. CCB will implement these programs at all of our 6 acute care hospitals, serving a wide range of Brooklyn neighborhoods, and will build linkages to community sources of care in the neighborhoods identified in the CNA as highest need (e.g. Borough Park, Williamsburg, Bushwick, North Central Brooklyn, Flatbush-East Flatbush, and Crown Heights).

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

To successfully implement this project, CCB will use many existing assets and new resources generated through our other selected DSRIP projects. For example, CCB will leverage the existing expertise, referral networks, and community supports being provided through its two Health Home programs that are also active PPS partners. As noted in CNA Section 3.2 and 3.3, CCB includes a broad range of social service and community Participants who will be linked, through Health Home care managers, with our transition patients to ensure smooth and safe transitions.This intensive care management infrastructure, and the comprehensive training that has been developed for these care managers, will be critical for the success of CCB's care transitions model and for many of our other projects. CCB is in discussions with these partners to improve links between discharge planners and Health Homes and maximize their effectiveness in enrolling/retaining the population this project serves.
The 6 acute care CCB hospitals in Brooklyn already have elements of a care transition program

from which CCB can build and learn. Methodist has implemented the Bridge program, Maimonides elements of the BOOST program and Naylor models, and Kingsbrook, Wyckoff and Community Hospitals have programs to incorporate social services and case management into discharge planning. Maimonides has already implemented the CTI program for behavioral health patients, and has seen early success. Maimonides has contracted with Center for Urban Community Service to provide intensive training to care managers participating in the model, and will use this training curriculum for CCB's CTI program.

The Dashboard, a web-based care management tool, is another critical asset, and it is currently configured to support this project, specifically for identifying patients in need of care coordination when admitted to the hospital or presenting in the ED, tracking those patients in a distinct program group, and enabling care teams to quickly coordinate services for the patient. CCB will leverage Maimonides' existing palliative care program, and CCB partners including MJHS' and VNSNY's expertise, as leaders in palliative and hospice care, to promote it as a resource that is integral to successful care transitions for patients with advanced progressive illnesses, and to train and educate PCPs and their staff on these important services through CCB project 3.g.i.

CCB will strengthen communication and optimize the extensive resources of our partner long term care providers, many of whom were identified in the CNA, to improve care transitions. Through our skilled nursing facilities, home care and special needs managed care programs like MLTCs, PACE, and FIDA programs, we can expand our reach and scope of services to at risk patients through home and community based services, rehabilitative services beyond the 30 day transition period.

As discussed under the ED triage project response, CCB will leverage and expand the Brooklyn Parachute program for mentally is individuals to provide mobile treatment units, crisis respite centers, and peer support lines that has been shown to reduce hospitalizations . Finally, CCB's provider support call center will provide centralized advanced clinical back up for providers and patients, as described in our Organizational application.

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.

CCB's program is designed to address the challenges we expect to face in achieving this project's goals:

Inadequate coordination and follow-up between hospital physicians and discharge planners and home care agencies, PCPs, SNFs, and social service agencies has been a recurring challenge in care transitions models. CCB's care transitions model and its Dashboard will materially improve the flow of information and coordination among providers and social support services, as described above.

Social determinant barriers to care also remain a challenge, including language barriers, income, and health literacy, as noted in the CNA and quantified in Section 3.5 of this application. Traditionally, the integration of social and health care services has been impeded by a lack of a patient assessment tool that includes social issues, cultural competency, and knowledge of the

resources to assist the patient to access needed supports. Our care transition model addresses each of these through: assessment tools that address social factors; cultural competency training; use of Health Homes to link social and clinical services seamlessly; and creation of a web-based tool that lists/describes social service organizations, specific contacts, referral instructions, and provides online referral forms to enable real time referrals. This latter initiative will be developed under project 4.a.iii.

Workforce challenges are also likely to occur, particularly in recruiting staff that have experience and training on working with mental health and behavioral health patients. As described above, CCB will develop a training program for CTI (working with the Center for Urban Community Service) and for care managers (working with 1199) that is focused on these populations.

Finally, discharge planners and physicians lack knowledge and experience in assisting patients with end of life planning, and informing them of palliative care resources. CCB will provide palliative care training for PCPs as part of its palliative care project 3.g.i.

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.

Although hospitals are affiliated with different PPSs, patients are admitted and readmitted to hospitals irrespective of PPS alignment based on a variety of factors. Therefore, to be successful in this project, we must coordinate our efforts across PPSs. The Brooklyn-based PPSs, including CCB, HHC, and Lutheran, have collaborated to select this project and align some of the specific interventions related to its implementation. During the January-April 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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

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

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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.

To support our Care Transitions project, CCB expects capital needs related to the development of post-acute care supports for transitioning patients. Examples of specific capital needs that may be required include:
-- Developing (or expanding) a community respite center to support implementation of Parachute program. The Center would provide non-medical support for individuals post-acute care discharge. Capital funding would be used for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions for the site.
-- Potentially expanding or developing an intermediate care facility for certain transitioning patients post discharge. Capital funding would be used for new construction, repairs, and renovation of fixed assets, equipment costs, and other asset acquisitions for the site.
--Renovating and purchasing equipment for an emergency department to create an observation unit (as an alternative to hospital admission for targeted patients).
These efforts and their accompanying capital needs are critical to ensuring safe transitions and reducing readmissions, CCB's goal under this DSRIP project.

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

Yes	No
☒	☐

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.

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

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Community based Care Transitions program targets Medicare patients. We will build on the experience of these Participants to establish a new, evidenced-based standard care transitions model for the Medicaid population in each of our hospitals, extending the model to a broader population of Medicaid patients.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

FIDA enrollees are likely to participate in this project given that this project targets those with high needs. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement services provided under FIDA plans. In addition, this project will extend to all of our actively engaged population, not just those enrolled in FIDA.

Bridges to Health addresses the complex needs of children in foster care and their families,

reducing the need for hospitalization and other out-of-home care. CCB's project will supplement these important services, but DSRIP funding will not be provided to Bridges to Health participating providers if doing so would supplant or duplicate funding.

The Balancing Incentives Program (BIP) funds will not overlap for the same reasons as described in our response to Project 2.a.i. VillageCare's HCIA will not overlap for the same reasons as described in our response to Project 2.a.iii, 2.b.iii, 4.c.ii, 3.d.ii, and 3.b.i.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

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

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

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

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

Domain 3 Projects

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

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

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

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

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

There are three project areas outlined in the list below. Performing Provider Systems (PPSs) may implement one, two, or all three of the initiatives if they are supported by the Community Needs Assessment.
Any PPS undertaking one of these projects is recommended to review the resources available at http://www.integration.samhsa.gov/integrated-care-models.

A. PCMH Service Site:

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

B. Behavioral Health Service Site:

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

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

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

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

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

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

The Maimonides led PPS, Community Care of Brooklyn (CCB) has chosen Project 3.a.i because of the great need in Brooklyn to expand access to both primary and behavioral health care, to allow early rapid treatment, address co-morbidities, and improve care coordination across settings. This project addresses community need #2, 3, and 6 in our Section 3.8 summary table.

The CNA found that behavioral health care is a critical need in Brooklyn: In 2012, of the almost 220,000 Brooklyn Medicaid enrollees with behavioral health-related service utilization throughout the year, nearly a third had an inpatient admission. The CNA shows behavioral health utilization concentrated in Williamsburg/Bushwick, Crown Heights, Brownsville/East New York, Sunset Park, Borough Park, Flatbush, and Coney Island/Sheepshead Bay, and inpatient admissions in north-central Brooklyn. Many of these neighborhoods are hot-spots for serious mental illness; up to 12% of residents report severe psychological distress (in Coney Island), well above the Brooklyn average of 6.1%, and the NYC average of 5.5%. More than half of adult behavioral health clients under age 65 and almost 90% of those over 65 had at least one co-morbid chronic condition. CNA focus groups were concerned about anxiety, depression, and

substance abuse, and emphasized the link between behavioral and physical health.

The CNA questions the adequacy of behavioral/mental health resources. Brooklyn has only 536 general psychiatrists, a rate of 21.1/100,000 (the NYC rate is 49/100,000), and much of the borough is a health professional shortage area or medically underserved area. The most stark primary care physician shortages are in Greenpoint, Canarsie, and East New York.

To address these gaps, CCB will pursue primary care–behavioral health integration through all three 3.a.i initiatives, including hospital and community-based PCPs and mental and behavioral health providers in high need areas: Borough Park, central Brooklyn, Bushwick, northern Brooklyn, Flatbush and others.

Specifically, CCB will pursue physical co-location of primary care into behavioral sites and vice versa, where feasible; virtual co-location via a shared care plan platform (the Dashboard) where physical co-location is not feasible; and the Collaborative Care Model (aka IMPACT). At behavioral sites where physical co-location is not feasible, CCB will implement increased medical monitoring, medication management, chart review, and standing orders, along with the Dashboard to improve care and address the gaps noted above. CCB will ensure that all patients with serious mental illness treated under the project are referred to Health Homes.

CCB will expand implementation of the Collaborative Care Model to all PCMH Level 3 sites. Through this evidence-based model, CCB will screen patients, and treat those with mild/moderate depression or substance abuse using multi-disciplinary care teams comprised of the patient, PCP, care manager and consulting psychiatrist.

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.

CCB aims to screen patients that visit our PPS primary care sites using PHQ 2 and 9 and/or SBIRT. We will estimate the actively engaged population by using SDOH 12 month claims data (March 2013- February 2014) to count the numberof patients using primary care at CCB's participating primary care sites. We will take State Department of Health screening targets for the PHQ2 and PHQ9, used for the NYS Collaborative Care grant program currently underway and in which Maimonides participates, (85% screened with PHQ2; 15% screen positive requiring a PHQ9 screening) to estimate those who will be screened with the PHQ9. Final estimates for the actively engaged population will be included in our final speed/scale tables to be submitted January 12.

Co-location (both virtual and physical) will serve those > age 12 receiving primary care and/or mental or behavioral care from a participating PPS provider (PCMHs and CCB's Article 31, 32, or 16 facilities). Given CNA findings, co-location will specifically focus on those patients with serious mental illnesses (SMI), serious emotional disturbance, substance use, or with high

behavioral health service utilization, and will focus in high need neighborhoods (e.g. Brownsville/East New York, Sunset Park, Borough Park, Flatbush, and Coney Island/Sheepshead Bay).

Collaborative Care/IMPACT will engage patients > 12 years receiving care at a PPS PCP, and will screen this population for undiagnosed depression and alcohol or drug use. At the outset, PCPs will principally treat those with mild, moderate depression or with substance abuse disorder, and refer those with more serious substance abuse disorders. Over time, with training, PCPs will increasingly manage patients with substance abuse and personality disorders. CCB will partner with MCOs to ensure that patients connect with their PCPs.

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.

Key assets and resources that CCB will employ to achieve this project include:
1. Experience and expertise from existing physical co-location models at Maimonides, South Beach Psychiatric Center, Village Care, and FEGS . The lessons learned in implementation will be applied as CCB expands this model.

2. Maimonides' long history of virtual co-location work with key CCB partners. Funded through HEAL and CMMI grants, we have developed an integrated care model for the SMI population using interdisciplinary care teams, jointly established clinical and care management protocols, standards of practice, and a comprehensive referral network. Central to the model is the IT Dashboard, providing a collaborative platform to support virtual co-location by allowing users to share patient information and a care plan, coordinate care, and track and report on patient progress and program effectiveness. The platform is in use and supports integrated care teams to conduct clinical assessments and build and share interdisciplinary care plans that include medical, behavioral and social issues. This scalable model, including the Dashboard, will be deployed throughout the PPS.

3. An extensive training program developed by 1199 and Maimonides for care managers that focuses on the SMI population and includes care team training with the physician. This training curriculum, implemented through CMMI, focuses on chronic illness, care coordination, motivational interviewing, critical time intervention, and patient activation and engagement techniques, and will be deployed across many of CCB's projects.

4. Our partner Health Homes' experience working with these populations. Discussions during the planning process with these partners have helped CCB identify specific areas for improvement to strengthen care management services and linkages to primary care teams. This intensive care management infrastructure is particularly important for behavioral health population, and will be integrated into all co-located sites. These assets also align across many of CCB's selected projects.

5. Maimonides' experience implementing the IMPACT model in some of its primary care sites;

these sites are at nearly 99% depression screening as a result. All patients with PHQ-9 scores between 10 and 20 are assigned care managers for follow up treatment and tracking. Funds already supporting this project will not be duplicated; instead, Maimonides will use this expertise to help lead IMPACT implementation at additional sites implementing the model, with DSRIP funds supporting this broader effort.

Additional resources CCB will require and deploy, as noted above, include new care management staff, expanded access to PCPs (described in IDS Section) expansion of the Dashboard to new sites, and expansion of training to CCB personnel.

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.

CCB's program is designed to address the challenges we expect to face in achieving this project's goals:

The CNA notes, and CCB anticipates that it will be difficult to engage PCPs in managing patients with behavioral health problems, given stigma, and the lack of PCP training and confidence in treating these patients. CCB is using an experienced implementation consultant to assist practices adopting the IMPACT model, including how to use a consulting psychiatrist, how to integrate a depression care manager into the team, and use of measurement-based stepped care. This 6 month training/support program is key to overcoming this challenge. In the face of psychiatrist shortages, as noted in the CNA, this model will also "extend" existing capacity as CCB builds psychiatrist capacity.

CCB recognizes that mentally ill individuals may be especially difficult to engage, and culturally-appropriate patient education materials are not readily available for this population. CCB will develop new materials for patients and train providers and staff in motivational interviewing. Staff training in problem-solving therapy, cognitive behavioral therapy, and cultural competency will also aid implementation.

Regulatory/reimbursement challenges present real and perceived barriers to physical co-location; CCB is pursuing regulatory relief for these issues, as described in the organizational application.

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.

Because of the limited availability of inpatient psychiatric beds in Brooklyn, communication across PPSs is key. The Brooklyn-based PPSs, including CCB, HHC, and Lutheran, have collaborated to select this project and align some of the specific interventions related to its implementation. During the January-April 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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
☒	☐

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

To support our Behavioral Health and Primary Care Integration project, CCB expects capital needs related to co-location of services. Examples of specific capital needs that may be required include:

-- Renovations and/or expansions to allow co-location of behavioral health services at larger, established PCP practices. -- Renovations and/or expansions of behavioral health clinics and community mental health centers to allow co-location of primary care services. These efforts and their accompanying capital needs are critical to successfully implementing co-location.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Jewish Board of Family & Children's Services (JBFCS)/ CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Bailey House	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as above…
NAMI-NYC Metro	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services /Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
Apicha Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2015	Same as above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Family Services Network of New York, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Outreach Development Corporation	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
FEGS Health and Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
The Resource Training and Counseling Center, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
SCO Family of Services /Member of the Children's Collaborative and the Advance Care Alliance	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Village Center for Care	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

CCB's Dashboard will sit on top of the EHR platforms at each Participant site; the Dashboard does not duplicate EHRs, but rather helps consolidate important patient information in an actionable manner, and provides additional information that is not found in EHRs from the RHIO/Healthix. As such, CCB's project does not duplicate or supplant this EHR incentive funding.

CCB will build on the experience of our partners who have already begun work to improve behavioral health care under HRSA BHI grants. However, this CCB project will extend to many

additional MH/BH and primary care settings, and will include additional interventions such as the IMPACT model not covered by this funding. DSRIP funding will not be provided to HRSA BHI participating providers if doing so would supplant or duplicate funding.

CCB's Collaborative Care intervention will greatly expand this model in Brooklyn, extending services to new patients and in new primary care provider settings. CCB will also expand the scope of the program to address other disease states. CCB Participants who are currently involved in this initiative will serve as "best practice" experts as we expand the program. CCB will ensure that DSRIP funding will not be provided to providers participating in the Collaborative Care Initiative if doing so would supplant or duplicate CCI Medicaid funding.

The Brooklyn Health Home Health Care Innovation Award will not overlap for the same reasons as described in our response to Project 2.a.i and 4.a.iii. Bridges to Health will not overlap for the same reasons as described in our response to Project 2.a.iii, 2.b.iv, and 3.d.ii. The Comprehensive Care Management program will not overlap for the same reasons as described in our response to Project 4.a.iii. The Parachute/mobile crisis program will not overlap for the same reasons as described in our response to Project 2.b.iii. The Hospital Medical Home Demonstration Project will not overlap for the same reasons as described in our response to Project 3.b.i and 3.g.i. SAMHSA grant initiatives will not overlap for the same reasons as described in our response to Project 4.a.iii and 4.c.ii. The Health Home program will not overlap for the same reasons as described in our responses to all Projects, excepting 3.g.i.

We will continue to survey our network to ensure DSRIP funds do not duplicate other funding and to clarify dates.

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

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

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

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

application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

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

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

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

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

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

Improve Medication Adherence:

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

Actions to Optimize Patient Reminders and Supports:

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

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

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

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

Addressing cardiovascular disease (CVD) is a high priority in Brooklyn. This project addresses community needs #2, 3, and 7 in our Section 3.8 summary table. Heart disease is the leading cause of mortality among the white, black, and Hispanic populations. The age-adjusted mortality rate for heart diseases was 195.4/100,000. It is the second leading cause of premature death in Brooklyn, with an age-adjusted death rate of 201/100,000, surpassing the City (184/100,000) and State (180/100,000). Community members have highlighted CVD needs as critical—for example, 40% and 23% of Brooklyn CNA respondents indicated that high blood pressure and heart disease, respectively, are of great concern. There is high CVD-related utilization in Brooklyn, and many preventable hospitalizations for Medicaid beneficiaries. In 2012, there were 3,694 potentially preventable hospitalizations for circulatory conditions (PQI S02 Circulatory Composite), accounting for 23.3% of all such admissions in the State. In 2012, there were also 862 potentially preventable hospitalizations for hypertension (PQI 07). Several neighborhoods, including Coney Island-Sheepshead Bay and Borough Park, have been disproportionately affected by CVD, with relatively high utilization rates.

CVD needs in Brooklyn have been significant, in part, because of primary care provider shortages and gaps in care and patient engagement. While the CNA reported 493 cardio pulmonary specialist providers in Brooklyn, it revealed that specialty CVD services are not located in many areas of greatest need, including Coney Island. Relatedly, there is limited access to specialists like cardiologists to treat semi-emergent issues outside the ER, care managers to fully implement PCMH care teams, and care navigators and CHWs to engage and activate patients. Communication between PCPs and emergency rooms is often limited to those relatively few providers with advanced technology and participating in an HIE.

The economic and social needs of Medicaid beneficiaries have hindered Brooklyn's ability to improve CVD outcomes, and providers lack deep knowledge of available community resources. While Maimonides has an existing IT solution (Dashboard) for care coordination, many CBOs and providers in Brooklyn are not connected to the RHIO and do not use an EMR.

CCB's strategy to improve the management of CVD and meet this project's goals will be helping primary practices attain 2014 PCMH Level 3 recognition, employing CVD management strategies from the Million Hearts Initiative, and implementing other evidence-based CVD management strategies in community and ambulatory settings. Specific project components include increasing frequency and available community based locations for blood pressure measurement and addressing lifestyle changes, medication adherence, health literacy, and patient efficacy in self-management through use of peer and CBO supports. Care coordination teams will include PCPs, care managers, peer educators, and CHWs, all of whom will be trained to work with the patient in a culturally competent manner.

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

This project will aim to actively engage attributed adults with a CVD-related diagnosis, including hypertension, congestive heart failure, angina, acute myocardial infarction, and others. Using SDOH data, CCB will look to actively engage adults attributed to CCB that have a CVD diagnosis and at least one PCP visit. CCB estimates, based on initial SDOH data, that it will actively engage approximately 80% of individuals with CVD diagnosis on an annual basis through its participating PCMH care coordination teams. Final estimates for the actively engaged population will be included in our final speed/scale tables to be submitted January 12.

CCB will work with MCOs to find and engage patients assigned to a participating PCMH who have not yet received disease management services. CCB will place a priority on provider outreach related to intervening with patients and documenting self-management goals in the medical record in neighborhoods where the percentage of beneficiaries with CVD utilization is higher than the state average, according to the CNA, such as Coney Island-Sheepshead Bay, Borough Park, and Brooklyn Heights. Many of these neighborhoods also have lower-income, less-educated, and/or immigrant families. For example, the CNA reported highest

observed/expected PQI ratios for circulatory composite in neighborhoods such as Coney Island-Sheepshead Bay, where an estimated 40% of the population speaks English "less than well." CVD management strategies will be sensitive to the socio-cultural needs of these communities.

- 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.

CCB will engage at least 80% of PCPs and employ strategies from the Million Hearts initiative, using the guide, "Hypertension Control: Action Steps for Clinicians" as a framework for CVD management. Activities include:
-- Implementing standardized hypertension and cholesterol protocols within the PPS and across Brooklyn, such as the American Medical Group Foundation's Provider Toolkit to Improve Hypertension Control.
-- Making blood pressure measurements available on drop-in basis without a copay, and in community settings.
-- Training additional clinic personnel on taking blood pressure measurements. -- Identifying patients with repeated elevated blood pressure readings who lack hypertension diagnosis, and scheduling visits.
-- Creating hypertension and high cholesterol registries.
-- Leveraging the Maimonides IT Dashboard to facilitate the development of a 'real time' care plan as well as referrals and information sharing among providers and Health Home care management staff. It will also use best practice alerts, e.g. to complete tobacco control 5 A's.
-- EHR capabilities will be enhanced, such that by the end of DY3 EHR systems used by safety net providers will meet Meaningful Use and PCMH Level 3 standards, and EHR data will be shared with local health information exchanges and then, in turn, fed into the Dashboard.
-- CCB will also create a registry for use at provider and PPS level to facilitate population management.
-- Instituting a patient engagement strategy that addresses social determinants of health, particular in "hot spot" communities. For instance, use peer educators in one-on-one sessions, link patients to the YMCA's wellness program and other CBOs, use the peer-led Stanford Self-Care group model, optimize patient supports including for home-based self-monitoring, and facilitate referrals to NYS Smoker's Quitline.

CCB will also mobilize strong provider- and community-based resources to achieve the strategies above, including 49 cardio pulmonary specialists in Brooklyn and CBOs that disseminate information to the community such as YMCA, the United Way, and the American Heart Association. CCB includes Brooklyn Health Home and Coordinated Behavioral Care Health Home, that both provide training for care managers and contract with agencies with expertise in providing care management services for individuals with chronic conditions. At least 65 of the PCPs in CCB have attained some form of NCQA PCMH recognition and will be more prepared to implement project components. As a part of CCB's ramp up to 2014 NCQA standards, new care managers will be added to care teams to expand capacity to manage and support CCB projects, including supporting CVD patients at risk of co-morbidities.

In conjunction with CVD disease management, the IDS (2.a.i) and Health Home at-risk (2.a.iii) projects will support efforts to move to 2014 NCQA standards.

- 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.

CCB anticipates addressing the following challenges: -- Some PCPs may have challenges adhering to evidence-based guidelines, attaining 2014 PCMH recognition, and hiring additional care management staff, given professional shortages identified in the CNA. CCB will convene early-adopter and influential clinicians across Brooklyn to build consensus on guidelines and methods. CCB will consider offering provider incentives to facilitate timely implementation of project components. CCB's CSO will also institute training to ensure that providers understand and support the PPS's clinical protocols. Finally, the CSO will conduct continuous quality improvement to assess fidelity to the standards and institute corrective actions. -- Many MCO policies are contrary to project goals. Current MCO policies often disallow fixed-dose combination pills (recommended under the Million Hearts initiative) and 90-day refills (recommended to improve medication adherence). CCB will work with MCOs to institute policy changes to address these challenges. -- There is a lack of patient education about long-term negative effects of hypertension and unmanaged CVD and, according to the CNA, a need to address other socio-economic needs in tandem with CVD needs. This project and Project 2.a.iii will enable CCB to invest in peer educators and care managers to be deployed in health centers, community centers, and religious organizations to educate and promote self-management of CVD and co-occurring needs, including socioeconomic needs. CCB will implement the Stanford Chronic Disease Self-Management Program.

- 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.

CCB and HHC have collaborated to select this project and align some of the specific interventions related to its implementation. During the January-April 2015 implementation planning period, we intend to collaborate further with HHC and other Brooklyn-based PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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)

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

Yes	No
☒	☐

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

To support our Cardiovascular Disease Management project, CCB will require capital to invest in patient monitoring equipment in order to allow medical monitoring of our most complex patients. This equipment is critical to ensuring the best care for our patients with Cardiovascular Disease, thereby reducing expensive inpatient utilization for this population.

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Jewish Board of Family & Children's Services (JBFCS)/ CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Bailey House	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as above…
NAMI-NYC Metro	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services /Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as above…
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Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as above…
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SCO Family of Services /Member of the Children's Collaborative and the Advance Care Alliance	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as above…
Village Center for Care	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…

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Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Please refer to the table at the end of this application for additional entities.				

- 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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

CCB will rely on the expertise from our Partner hospital(s) participating in the Hospital Medical Home Demonstration Project as we seek to expand care coordination, care teams and care team communication, and smooth care transitions. This DSRIP project will expand these services to a much larger population and to all of our Participant hospitals and many other Participant sites, and will not supplant or duplicate this funding.

VillageCare's efforts under this award will help inform CCB's planning around medication and treatment adherence, but will apply to a far broader population and will be implemented at our other relevant Participant sites. DSRIP funding will not supplant or duplicate the funding that has been provided to VillageCare under the HCIA.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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.

- **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.

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

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

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

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

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

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

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

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

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

The Maimonides-led PPS, Community Care of Brooklyn (CCB), chose Project 3.d.ii because poor housing, high rates of smoking, and poor understanding among residents of underlying causes, leads to high asthma prevalence in Brooklyn that can be addressed through home-based self-management. This project addresses community needs #2, 3, and 8 in our Section 3.8 summary table.

CNA primary/secondary data identify asthma as a serious concern for residents; 6% of beneficiaries had asthma-related service utilization in 2012, on par with NYC and NYS. The highest rates (6.7%-10.0%) are in Williamsburg-Bushwick, Sunset Park, and Downtown.

A high number of hospitalizations/ED-visits for asthma are preventable. Asthma ED-visit rates for the general population and children 0-4 years are higher in Brooklyn than in NYC and NYS. Among beneficiaries ages 18-39, PQIs for asthma are heavily concentrated in Bushwick and Brownsville. The highest number of Prevention Quality Indicators (PQI) respiratory composite hospitalizations are in North/Central Brooklyn (rates as high as 1.82 observed/expected admissions).

CNA data revealed environmental conditions contributing to asthma prevalence. High preventable respiratory PQI hospitalizations in Bedford-Stuyvesant-Crown-Heights, Williamsburg-Bushwick, and Flatbush correspond to housing violation rates are as high as 108.6 per 1000 rental units (11%) in these areas. CNA focus groups cited asthma prevalence as “huge” and attributed it to poor housing and air-pollution. Brooklyn is home to one of the largest Chinese communities in the U.S.; smoking rates are higher in this community than others, resulting in asthma/serious respiratory problems.

Few resources in Brooklyn address the need for home-based services. Woodhull Hospital has a highly regarded program directed towards North-Brooklyn communities. To meet our attributed population’s needs we will contract with a CBO long experienced in asthma home-services and others to scale-up a multi-faceted evidence-based home-based education/self-management program. The program’s workforce draws from communities served, speaking the same languages and understanding cultural backgrounds of residents. Community health workers (CHWs) conduct home visits while educating patients/families about managing asthma; identify home-environmental triggers; link families to Integrated Pest Management (IPM)/mitigation programs; discuss importance of medication use; demonstrate delivery devices; and create an Asthma Action Plan in coordination with PCPs. CCB will leverage the innovative care-planning tool (Dashboard) Maimonides has implemented to incorporate/share information from home visits, and provide alerts when patients with Asthma visit the ED or admitted. Based on a.i.r.NYC documented results, a 40% reduction in ED visits/asthma-related hospitalizations is achievable among our engaged 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.

The target population for this project will be beneficiaries attributed to CCB with an asthma diagnosis. We will prioritize actively engaging patients who either have had three or more PCP visits or an emergency department visit or hospital discharge with asthma as the primary diagnosis in the past year or were referred by their PCP. Based on a.i.r. nyc's experience over the past 10 years, we expect that approximately one-half of families will refuse a home visit. We anticipate that we will actively engage a proportion of both adults and children with newly diagnosed or preexisting asthma, with a special emphasis on children. Our proposed number of actively engaged individuals will be reflected in the January 12 scale and speed submission, which will use updated attribution data expected to be released by the state. Priority outreach will be directed toward patients residing in asthma hotspots – Williamsburg/Bushwick, Sunset Park, (where there will be a special focus on the Chinese population due to higher smoking rates) and Downtown.

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.

CCB is fortunate to have a.i.r.NYC as a PPS partner. A.i.r.NYC is a Community-Based Organization that has provided evidence-based home-based services to families since 2001. It incorporates home health education, home environmental assessment, integrated pest management services, connections to pro bono legal services to assist with housing issues, referrals to social service organizations, and assistance with developing an Asthma Action Plan. A.i.r.NYC's evidence-based program has demonstrated consistent, positive results that include an over 40% reduction in hospitalizations, ED visits, and school absenteeism rates, and reduced asthma symptoms. A major strength of the model is the recruitment and training of community residents from the targeted neighborhoods who speak the languages of families and are culturally sensitive in the outreach/engagement process.

CCB will continue to collaborate with the HHC PPS, to use their experience and protocols as developed by Woodhull Medical Center in serving the North Brooklyn Community. Their program, which also uses a family-centered chronic care health model and an asthma care team, received the U.S. Environmental Protection Agency's (EPA) 2010 National Environmental Leadership Award in Asthma Management.

In addition, CCB will work with the HHC-PPS and Lutheran-PPS to scale up workforce capacity and create economies of scale. For this project we expect to hire home-based care managers.

NYDOHMH has also volunteered to offer assistance with the development and implementation of environmental assessment tools and training, the creation of education materials, the optimization of electronic health record use, and the coordination of care to support the goals of project 3.d.ii.

The Dashboard, an Internet-based care coordination platform, enables users to store and share information among all members of the care team, regardless of location and organization. The

Dashboard allows members of the care team to collaborate on a single integrated care plan and communicate patient needs.

For the home-based model, the Dashboard will be a critical tool to gather findings in the patient's home, document the Asthma Action Plan, identify barriers to care, create a registry and communicate information dynamically about acute asthma exacerbations and opportunities for preventing avoidable ER visits. It alerts providers and care managers upon patient admission and discharge from ED or inpatient service as part of project 2.b.iv (Care Transitions) and 2.b.iii (ED Triage). It allows care managers embedded in PCMHs as part of part of 2.a.iii (At Risk HH), to directly refer asthma patients to a.i.r.NYC and support programs like smoking cessation, as well as integrate data collected during asthma home-visits into patient's individual Asthma Action Plan that can be completed through an enhanced patient engagement application and sent securely to the care team. Results can be loaded into the data warehouse to support the reporting requirements.

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

Asthma Action Plans are time consuming to complete and require input by multiple individuals. CCB will establish protocols for the development of Asthma Action Plans outlining responsibilities of community healthcare workers (CHWs) during home visits. They will also assist with scheduling PCP appointments to complete the plan.

Identifying and mitigating home environmental triggers is a challenging process for affected families, resulting in preventable hospitalizations/ED visits, as noted in CNA. In a.i.r NYC 's model, CHWs identify/educate families about triggers during visits and link families to resources needed to address them including free legal services and Integrated Pest Management (IPM).

CNA data identify asthma as a serious concern for residents, yet families are unaware of exacerbating symptoms and act too late to prevent incidents causing ED visits. CHWs will educate families about signs/symptoms; emphasize importance of consistent medication use to control symptoms; and demonstrate use of medication delivery-devices.

Recruiting/training staff to implement the program at appropriate scale to address population needs is challenging. CCB, a.i.r.NYC, and other PPSs will scale up borough-wide recruitment using professional recruiters, and media to reach out to qualified community residents. We will use a.i.r. NYC's proven training capabilities/programs including the National Lung Association's program to ensure we have a knowledgeable well trained work force that can effectively engage patients and families.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that

serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

Community Care of Brooklyn, along with the PPS of the New York City Health and Hospitals Corporation (HHC), and Lutheran have collaborated to select the Asthma Home-Based Self-Management project and align key interventions related to its implementation. During the January-March 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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

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

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

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

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

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☒	☐

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

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

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Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

VillageCare's efforts under this award will help inform CCB's planning around medication and treatment adherence, but will apply to a far broader population and will be implemented at our other relevant Participant sites. DSRIP funding will not supplant or duplicate the funding that has been provided to VillageCare under the HCIA.

Bridges to Health addresses the complex needs of children in foster care and their families, reducing the need for hospitalization and other out-of-home care. CCB's project will supplement these important services, but DSRIP funding will not be provided to Bridges to Health participating providers if doing so would supplant or duplicate funding.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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

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

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

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

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

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

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

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

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

The Maimonides-led PPS, Community Care of Brooklyn (CCB), chose Project 3.g.i because of the need for greater access to palliative care can be achieved most effectively by integrating

palliative care within the PCMH. This project addresses community need #11 in our Section 3.8 summary table.

Palliative care is specialized care focusing on providing relief from the symptoms, pain, and stress of any serious illness. The goal is to improve quality of life for patients/families and can be used alongside curative care. According to CNA primary data, chronic pain was reported by over 19% of residents and was the 4th most common self-reported health problem overall, but there are only 12 facilities in Brooklyn serving Medicaid and the Uninsured that provide specialty pain management services. Twenty-three facilities offer hospice services. In 2011 NYS recognized this need and passed the Palliative Care Access Act, requiring health providers to offer palliative care to all patients that could benefit.

Data from the Dartmouth Health Atlas indicates that among Medicare beneficiaries, and those with both Medicaid and Medicare (dual eligibles) the utilization rate for hospice in the hospital referral regions (HRR) including Brooklyn is incredibly low, at 1/3 the national average, 9.1 compared to 28 days. There is a national gap between the desire for palliative care and its administration; 75% of Americans approve of a living will, but only 20% have advanced directives (Compassion and Support survey).

CCB palliative care clinical experts identified PCP lack of knowledge about care resources and the lack of time/expertise to discuss this subject with patients, as principal causes of the low use of palliative care/hospice services.

To address these needs, CCB will integrate palliative care into PCP practices that have/will have achieved PCMH certification using a care model that trains PCPs and care team members to assess patients, educate them about palliative care support services, and create care plans that encompass pain/symptom relief, spiritual support, and advanced directives, and how to use tools like Conversations on Compassionate Care and MOLST, to assist patients/families. MOLST is a NYSDOH approved physician order form that facilitates conversations between patients and qualified health professionals that define the patient's goals for care; ensure shared, informed medical decision-making; and review treatment options. These tools will be available in the Dashboard, our web-based platform for interdisciplinary care planning. Palliative care specialists will also train/consult with PCMH teams and Health Home care managers. CCB's Central Services Organization, will work with Medicaid Managed Care plans to expand networks, coverage for services, and incentivize participating providers.

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

CCB estimates that at least 80% of patients with at least one visit to the PCP will be receptive to active engagement in palliative care services. This population includes: patients with at least one of a set of chronic conditions including, but not limited to, advanced cancer, AIDS/HIV with

high viral load, Chronic Obstructive Pulmonary Disease (COPD), Class 3/4 heart failure, advanced cancer, all dementias, multiple sclerosis, Parkinson's, Amyotrophic Lateral Sclerosis (ALS), Cirrhosis, and End Stage Renal Disease (ESRD). In addition we will prioritize outreach to patients with at least 1 hospitalization/ED visit in a year and/or 3+ outpatient visits in 3 months or the equivalent of 12 total outpatient visits in a year. We will also focus early efforts in neighborhoods with high concentrations of dual eligibles (e.g. Willamsburg, Borough Park and Coney Island). Final estimates for the actively engaged population will be included in our final speed/scale tables to be submitted January 12.

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 key partners and leaders in hospice and palliative care, including Metropolitan Jewish Hospice and Homecare (part of MJHS), Visiting Nurse Service of New York, Calvary Hospice, and Compassionate Care Hospice. CCB will contract with them to provide training and consultation services to CCB in designing and implementing the program. Dr. Russell Portenoy, Chief Medical Officer of MJHS Hospice, a renowned palliative care specialist, will serve as special advisor to the program.

CCB has two participating Health Homes (HH), the Brooklyn Health Home and Coordinated Behavioral Care, that will provide care planning and care management support to patients and PCPs throughout this intervention. The CSO will contract with its palliative care specialists to provide training to the HH care managers.

CCB will leverage its Dashboard, which will be deployed throughout the PPS. This web-based system enables real time communication, patient information sharing, and care planning among care management, social service, and clinical providers. It also facilitates patient monitoring. In addition, assessment tools and clinical guidelines approved by the CCB Care Delivery and Quality sub-committee will be available via the Dashboard.

CCB will also leverage the New York Legal Assistance Group, a free civil legal service for low income individuals to access its Total Life Choices (TLC) program, which educates New Yorkers about the tools available to address serious lifetime incapacity and end-of-life issues and assists them in making appropriate plans.

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

PCMH-specific challenges: 1) Insufficient time to incorporate palliative care discussions in 20-minute PCP visit and lack of information about patient resources. CCB will train nurses, care

managers, and the PCP team in screening, assessment, and resources to reduce burden on PCPs. 2) Lack of staff to support patients/care-givers between PCP visits. CCB will add more care managers to its partner PCP practices to assist patients and caregivers.

Work Force challenges: Lack of MDs and mid-level providers with palliative specialty training, and care manager staff willing to do home visits. CCB will launch a recruitment effort to attract community residents who are capable, with training, to meet care manager position requirements or 'coach' roles. CCB will also provide financial incentives to MDs and midlevels who wish to become palliative care specialists. CCB will employ telehealth solutions for remote symptom management to create efficiencies by reducing travel time, while increasing contact with patients and care givers.

Cultural competency: Varying belief systems, misconceptions, and cultural sensitivity are barriers to palliative care. With partners MJHS, the 1199 training fund, and other experts, CCB will develop a curriculum that reaches various ethnic/religious groups and trains PCMH staff to address end of life issues with cultural competence.

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.

Community Care of Brooklyn, along with the PPS of the New York City Health and Hospitals Corporation (HHC), have collaborated to select the Integration of Palliative Care into the PCMH Model project. In doing so, we are seeking opportunities to develop standard education/training (a "core curriculum") across CCB, HHC, and community providers/social services, among others, as well as to align key interventions related to project implementation.

During the January-March 2015 implementation planning period, we intend to collaborate further with our Brooklyn PPS colleagues to ensure alignment and coordination of standardized protocols, development of workforce strategy, workforce training efforts, and selection of culturally competent patient education resources to support this project.

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

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

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

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

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

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

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

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

Yes	No
☐	☒

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

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
St. Mary's Healthcare System for Children (Includes the following: St. Mary's Hospital for Children, St. Mary's Community Care Professionals; Extraordinary Home Care d/b/a St. Mary's Home Care)	Money Follows the Person	2014	2014	Money Follows the Person is a federally funded State Medicaid program that provides enhanced reimbursement for select services to persons who transition to community based care after having been in a nursing home for more than six months.
Methodist	Hospital Medical Home Demonstration Project	2013	2015	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Kingsbrook Jewish Medical Center	Hospital Medical Home Demonstration Project	2014	2014	Same as above…
Maimonides Medical Center	Hospital Medical Home Demonstration Project	2013	2015	Same as above…

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

DSRIP funding will not be provided to Money Follows the Person participating providers if doing so would supplant or duplicate MFP funding. These providers, however, will serve as experts on facilitating transitions from nursing homes to the community.

CCB will rely on the expertise from our Partner hospital(s) participating in the Hospital Medical Home Demonstration Project as we seek to expand care coordination, care teams and care team communication, and smooth care transitions. This DSRIP project will expand these services to a much larger population and to all of our Participant hospitals and many other Participant sites, and will not supplant or duplicate this funding.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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

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

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

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

application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

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

Domain 4 Projects

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

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

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

Project Requirements: The PPS must show implementation of three of the four sector projects in their project plan. The implementation must address a specific need identified in the community assessment and address the full service area population. For each sector project, specific potential interventions are identified on the Preventive Agenda website under "Interventions to Promote Mental Health and Prevent Substance Abuse" (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/interventions.htm).

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

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

Entity Name
HHC PPS; Bronx Partners for Healthy Communities PPS; Bronx Lebanon PPS

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.

The Maimonides-led Community Care of Brooklyn (CCB) selected this project based on CNA and SDOH data documenting significant disease prevalence and service gaps. This project addresses community need #10 and 13 in our Section 3.8 summary table. In Brooklyn, high rates of substance use, addiction, poor mental health, and serious psychological distress contribute to high, and often preventable, health system costs. The CNA found high rates of psychological distress, with 6.1% of Brooklyn Medicaid beneficiaries reporting serious distress, compared to 5.5% of beneficiaries in NYC overall. Depression affects 20% of Brooklyn residents.

Brooklyn's CNA data also show that in 2012, 59,184 beneficiaries had alcohol or drug use-related service utilization, also reflected in elevated emergency department visits and inpatient admissions. While MEB health needs affect all communities, immigrant, lower-income communities in Bushwick-Williamsburg and Downtown-Heights have over 9.8% condition-related utilization.

Gaps in care are pronounced, with more than half (59.2%) of CNA respondents identifying substance abuse services as unavailable. These gaps are compounded by provider shortages in substance abuse and mental health services—for example, 536 general psychiatrists in Brooklyn, a rate of 21.1 per 100,000, versus 49 per 100,000 in NYC—together with insufficient provider training and pronounced silos between provider-types that prevent coordination. According to providers, the system is highly fragmented, and providers fail to fully coordinate mental health and substance use (MHSA) activities to adequately address co-occurring conditions. Also of particular concern is the lack of targeted attention to adolescents.

To close these gaps, CCB, together with HHC and Bronx Partners for Healthy Communities (BPHC), is undertaking sector Projects 1-3 with the goals of: Promoting evidence-based practices in MHSA care; Breaking down silos in care to enable health professionals to collaborate; and Targeting adolescents.

Under Sector Project 1, the PPSs have established, and committed via a Charter, to a City-Wide MHSA Workgroup that will bring together a cross-section of MHSA providers to develop infrastructure and programs to transform MHSA services across the City, and develop a methodology to assess programs' impact on MHSA service utilization and care.

Collaborating with State and City agencies as appropriate, the Workgroup will identify and promote evidence-based programs that extend the reach of education, screening, and early intervention into existing health service footprints. In one program, the Workgroup will adapt or develop culturally-sensitive educational materials that inform adolescents about the nature of and risk factors for MHSA diseases; the fact that diseases frequently co-occur; and early warning signs.

Under Sector Project 2, the PPSs will adapt the Collaborative Care model to better meet the needs of adolescents. The group will evaluate successful adaptations of the model, such as Reaching Out to Adolescents in Distress (ROAD).

Under Sector Project 3, all activities and programs will consider cultural and linguistic factors,

including: differences in views regarding mental health and use of substances; intra-cultural issues; circumstances such as trauma/violence; and, language access-related issues. The resources and program that the Workgroup develops will be shared with borough-level MHSA councils of providers, who will adapt to local needs.

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

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

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

Specific targeted sub-populations include adolescents from ages 12-25, a critical group for prevention and early intervention efforts given that up to 20% of adolescents experience an episode of major depression by age 18, yet few receive evidence-based treatment for their depression. In Brooklyn, 44% of Medicaid beneficiaries (approximately 544,000 persons) are between 0-19, and key experts consulted in the CNA reported significant gaps in MHSA care in Brooklyn for the adolescent portion of this group.

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

Lastly, CCB expects to engage dual-eligibles (154,000 persons within Brooklyn) and Medicaid patients with MH and SA diagnoses in geographic areas with heightened need for and utilization of MH and SA services based on CNA and focus group data, including Crown Heights, Bushwick-Williamsburg, Borough Park, and Coney Island. For example, according to Census data, in Bushwick-Williamsburg, 19.9% of residents are non-U.S. citizens, 37.2% of persons over 25 years of age have less than a high school education, and 32.2% speak English "less than well." Accordingly, CCB will work to ensure that all programs and approaches are culturally appropriate and sensitive to socio-economic needs in the population.

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

Brooklyn has a significant foundation of MHSA providers and community programs upon which to build. There are 536 general psychiatrists in Brooklyn and approximately 4,900 social workers. While there are fewer of these professionals on a per-patient basis in Brooklyn than City-Wide—a key gap noted above and addressed through CCB's workforce section—the borough has certain provider organizations with particular depth and expertise, including the

Kingsboro Psychiatric Center and the Parachute NYC-Brooklyn Crisis Respite Center, which provides alternatives to hospitalization for persons experiencing crisis. There are also 186 mental health residential programs and over 90 mental health outpatient programs including Assertive Community Treatment programs, which offer an intensive and integrated approach to community mental health service delivery. Brooklyn also has 100 mental health programs that specifically target youth, including 51 outpatient programs and 29 support programs such as Home and Community Based Services waiver programs. The four Health Homes operating in Brooklyn also target this population to provide much needed care management services.

There are approximately 110 alcohol and drug use programs and services, the vast majority of which are outpatient programs. Brooklyn's broader mental health support infrastructure is also extensive, with supportive case management programs and 23 targeted case management programs serving over 3,700 patients with mental health needs.

Despite this strong base of providers, as documented in the CNA and focus group interviews, there are provider shortages in many areas, including psychiatrist shortages, and a need for enhanced skills to treat co-occuring conditions. Many of these programs have operated in silos, and on a City-wide basis there has been no central leadership to promote much-needed MHSA reforms. Through the MHSA Workgroup, CCB will bring together key leaders across these provider-types to develop and disseminate key resources—such as training materials and educational programs, particularly those targeting adolescents, and means of assessing progress. There are various successful models of CBO-activities targeting adolescents upon which to build, including the Turnaround for Children program, the Peer Health Exchange's peer-based mentoring, YMCA wellness programs, and middle- and high-school-based health curricula that could be expanded to more robustly address MHSA prevention and early intervention. In developing educational models for adolescents and adults (e.g., parents, teachers) on MHSA needs, CCB will develop and support partnerships among health professionals, CBOs, and/or middle- and high-schools that have strong experience in this arena, including the aforementioned programs.

CCB's MHSA project activities will also enhance existing and new sites implementing the Collaborative Care/IMPACT model under Project 3ai. As implemented in NYC, the Collaborative Care model almost exclusively targets adults, with less demonstrated efficacy in treating adolescents and does not include use of SBIRT. CCB, in collaboration with partner PPSs and stakeholders, will explore opportunities to develop and pilot adolescent-targeted adaptations of the Collaborative Care model using developmentally sensitive materials and structured involvement of adolescents and parents in education and treatment (e.g. the ROAD model). These activities will enhance mental health and substance abuse workers' capacity to address adolescent needs through the IMPACT model, with key ties to workforce training efforts.

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

There is a lack of patient education and engagement about risk factors, causes, and treatments for MHSA disorders. In many immigrant and minority communities in Brooklyn, such as Williamsburg-Bushwick, the CNA reported significant socio-cultural obstacles to care (e.g., misunderstanding of diseases, stigma, insufficient social supports). In certain communities or situations, parents may also be reluctant to actively engage in MEB health promotion efforts due to their own biases or illness. MEB health promotion programs will need to emphasize cultural-acuity, particularly for ethnic minorities and immigrant populations in order to effectively serve the target population. CCB will link with community programs (e.g. the Arthur Ashe Institute) that have resonance and efficacy in local communities to address these concerns, looking for peer leaders and others to help incentivize patient engagement and break down pronounced socio-cultural barriers to care.

There are also challenges in targeting adolescents, given that not all adult-appropriate MHSA models can be seamlessly applied to the adolescent group. Thus, in developing adolescent-specific adaptations of the Collaborative Care model, the PPSs will build on practices that have demonstrated success in reaching adolescents with similar demographics and needs, including peer-mentor programs and programs that utilize social media outlets to disseminate messages.

Further, as MHSA care is often siloed among providers, we anticipate certain challenges in coordinating and integrating care. The Workgroup specifically addresses this challenge by breaking down silos and, through collaboration with state and city agencies, promoting inter-disciplinary education and training on prevention efforts, screenings to assess all co-occurring conditions, and development of comprehensive treatment plans. CCB will also work to support care integration through its activities under the IDS project and through its EHR efforts, and will share those lessons with Workgroup members.

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

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

Since Fall 2014, CCB has participated in various MHSA joint-planning sessions with HHC and BPHC to achieve consensus on the selected Sector Projects 1-3 with the goals of: Promoting evidence-based practices in MHSA care; Breaking down silos in care to enable health professionals to collaborate and address the population's full range of MHSA needs; and Targeting adolescents with MHSA programming.

Through the City-wide MHSA Workgroup, and guided by the Workgroup Charter, the PPSs will bring together a cross-section of MHSA providers to develop appropriate infrastructure and programs to transform MHSA services across the City. The Workgroup will research and propose evidence-based models to implement across NYC and its boroughs, with the models subject to borough-specific tailoring with sensitivity to social and cultural factors. Further, the PPSs will also collaborate to review and expand upon existing Collaborative Care trainings to more

appropriately address adolescent groups. And, consistent with Sector Project 3, all resources and programs will be designed with sensitivity to cultural acuity for the unique demographics in Brooklyn.

During the 2015 implementation planning period, we will collaborate further with PPS partners and stakeholders through the Workgroup, ensuring alignment and coordination of standardized protocols, development of workforce strategies, workforce training efforts, and selection of culturally responsive patient education resources to support this project.

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

Implementation milestones are as follows:

Leadership & Coordination: Organize structure for City Workgroup meetings, identify participants & organizers (Q1/Q2 DY1); convene meetings (Q3/Q4 DY1)

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

Adolescent Programs: Review evidence-based models for adapting Collaborative Care model to adolescents (Q3/Q4 of DY1); develop curriculum (Q3/Q4 DY2); share curriculum with PPSs (Q1/Q2 DY3). Identify DoE contact; develop/implement curriculum & methodology for performance measurement (Q1/Q2 DY3)

Adult Programs: Review & revise educational materials and outreach initiatives targeting ethnic groups and high impact neighborhoods, as needed (Q3/Q4 DY2); launch initiatives (Q1/Q2 DY3)

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

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

Yes	No
☐	☒

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

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Jewish Board of Family & Children's Services (JBFCS)/ CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
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Coordinated Behavioral Care IPA/Center for Urban Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2015	Same as above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as above…
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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
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Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

HARP service providers and behavioral health enrollees are likely to participate in this project. This DSRIP project, however, is being implemented at the Participant/provider level, not plan level, and is distinct from and will supplement HARP services. In addition, this project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

Our partner's experience with enhancing HIV treatment and prevention through the SAMHSA grant will be valuable to inform this DSRIP project, but DSRIP funds will not be provided to this provider if doing so would supplant or duplicate SAMHSA funding.

Experience implementing the Comprehensive Care Management program will help inform CCB's efforts to better care for the SUD population. However, our projects will offer services to a larger population (our actively engaged) and in additional sites. DSRIP funding will not be provided to participating providers if doing so would supplant or duplicate funding.

The Brooklyn Health Home Health Care Innovation Award is an important foundation for much of CCB's work, and has involved collaboration between many of our Participants. The IT Dashboard, developed under this award, will be expanded to all CCB participants, and the care model using interdisciplinary care teams and enhanced care coordination will be extended to our engaged population under this project. DSRIP funding will not supplant or duplicate the funding that has been provided to the BHH under the HCIA.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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.iiIncrease 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
HHC PPS; Bronx Partners for Healthy Communities PPS; Lutheran Medical Center PPS; Bronx Lebanon PPS; New York Hospital of Queens PPS; Mount Sinai Hospitals Group PPS; AmidaCare

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.

CCB selected this project based on CNA and SDOH data documenting significant HIV/AIDS disease prevalence and a lack of resources supporting access to and retention in care. This project addresses community needs #9 and 13 in our Section 3.8 summary table. The specific
interventions described below were chosen for their proven ability to impact the objectives of this Project and to collaboratively address the identified gaps in HIV care access; diagnosis and effective linkage to care; and retention and improvements to quality of care.

HIV/AIDS is the fifth leading cause of premature death in Brooklyn. Premature deaths in Brooklyn due to AIDS account for approximately one-third of all such deaths in NYC. Brooklyn residents who have AIDS or HIV positive have a 58.3% rate of viral load suppression, a key factor in reducing transmission of HIV.

The highest number and prevalence of People Living with HIV/AIDS (PLWHA) in Brooklyn is in the United Hospital Fund neighborhoods Bedford Stuyvesant–Crown Heights and East Flatbush– Flatbush, where, across neighborhoods, between 1.7 and 3.1% of beneficiaries also have condition-related utilization. Four of the ten UHF neighborhood districts have higher HIV infection rates than NYC, with Bedford-Stuyvesant the highest at 77.1 per 100,000 persons, far higher than the NYC and Brooklyn rates of 41.2 and 38.7, respectively. The rate of new HIV diagnoses among black/African American people living in Brooklyn is more than five times the rate among whites in the borough, and the rate of new HIV diagnoses among Latinos in Brooklyn is over 2.5 times that of whites.

There are 97 HIV prevention and Ryan White programs in Brooklyn, with 25 Ryan White/CDC Prevention-funded HIV programs providing services at 276 service sites; 25 non-profits provide counseling, health education, case management, and other HIV/AIDS-related services. Yet, although treatments have improved, HIV funding has shifted to medical

management, with diminished resources available for key supportive services.

To address gaps in HIV care and patient retention, CCB along with six other NYC PPSs, engaged in joint planning to address gaps in access to, and retention in, HIV care. Together with HHC, we have identified the following seven common sectors from the 13 project requirements: Sector 1) Decrease HIV and STD morbidity and disparities and increase early access to and retention in HIV care; Sector 2) Increase peer-led interventions around HIV care navigation, testing, and other services; Sector 3) Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations; Sector 4) Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health; Sector 5) Assure cultural competency training for providers, including gender identity and disability issues; Sector 7) Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care; and Sector 9) Promote interventions directed at high-risk individual patients, like therapy for depression.

CCB's interventions are aligned with HHC's PPS and include implementing the following programs to respond to the gaps in care and patient retention identified in the CNA, including need for more peer-based and culturally sensitive supportive services, better integrated care, and patient retention and tracking techniques: Integration of HIV Screening and Improved Linkage System, including Increasing Viral Load Suppression (Sector 1); PrEP for High Risk Negatives (Sectors 1 & 9); NY Links Peer Support Program (Sectors 1, 2, 4, 7, & 9); Social Marketing, Consistent Messaging and Appointment Procedures (Sectors 1, 3, 4, 7, & 9); Virologic FastTrack and additional tracking and identification of key social co-factors (Sectors 4 & 9); and Improve Cultural Competency (3-tiered approach) (Sector 5).

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.*

Target populations for this project are HIV-infected individuals newly diagnosed, those who have been diagnosed but have fallen out of care, and those at high-risk of becoming infected (i.e., individuals eligible for PrEP). There are 26,945 persons living with HIV/AIDS in Brooklyn, approximately 23% of all such persons in NYC, according to the CNA. CCB will actively engage patients with HIV/AIDS diagnoses that have had at least one primary care visit over a year. However, we will also target beneficiaries that have not had such visits and may be harder to engage through this project, making peer- and community-level engagement strategies such as those in Project 2 (Increase peer-led interventions) and Project 3 (Launch educational campaigns) particularly important.

Our target population includes several sub-populations that have historically experienced significantly higher rates on infection including the black/African American and Latino populations, with particular focus on those living in Bedford Stuyvesant–Crown Heights, East Flatbush–Flatbush, and Williamsburg-Bushwick.

The target population includes persons with co-occurring diagnoses, according to the CNA, such as mental health or substance abuse conditions, and social factors such as homelessness and previous incarceration that play a strong role in their ability to access care and maintain care routines. In addition, primary data suggests many of these same populations are now facing increased Hepatitis C incidence and prevalence. This diversity and the level of co-factors and co-morbidities within the target population lend to the complexity of this Project, and are a central organizing point for collaborative efforts within CCB, as well as with the PPS HIV Collaborative.

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.

CCB has a range of HIV/AIDS service-related resources to build upon in this project, including City-wide resources that it can jointly engage with HHC, with which CCB is closely collaborating. There are three HIV Special Needs managed care plans in Brooklyn, specifically targeting the needs of this patient group. Over 100 HIV/AIDS programs in Brooklyn are operated by CBOs, healthcare agencies, non-profit groups, private industry, and government agencies dedicated to ending the AIDS epidemic. These include, at the federal and State levels: Ryan White Part A and CDC prevention programs (71 funded agencies); 8 Ryan White Part C and 10 Part D programs; There are 122 total Ryan White Programs in Brooklyn. DOH/DOHMH initiatives including the NYLinks project; and Governor Cuomo's End of Aids Campaign. There are 53 total HIV Prevention/Outreach and Social Service Programs.

CCB also plans to leverage community-based providers with a strong history of serving a range of socio-medical needs for HIV/AIDS patients, including Housing Works, CAMBA,Village Centers for Care, AmidaCare, GMHC, God's Love We Deliver, Planned Parenthood, and religious organizations that provide HIV care support. These organizations have been at the forefront of a comprehensive, integrated approach to the provision of HIV/AIDS care.

The PPS HIV Collaborative will draw upon these resources, and PPS-specific resources, and will expand and enhance these efforts through its selected sector projects.

Despite this rich community resources and infrastructure, the CNA reflected that much of HIV funding goes primarily towards medical management services, with fewer resources becoming available for supportive services including those that address the psychosocial ramifications of being infected with HIV infection. Further, many of the existing community-based organizations have a narrow footprint, targeting only select populations based on factors such as ethnicity or sexual orientation. This finding suggests that CCB should focus on increasing, standardizing and raising awareness for such support services within Brooklyn's diverse communities and ensuring that all populations in need receive care and services. CCB's chosen projects address these deficits by promoting support groups, peer supports and outreach, educational campaigns, and case management services.

CCB and six other PPSs in NYC, including HHC, engaged in joint planning through our HIV Collaborative to maximize the impact of DSRIP investments to achieve project goals. To fortify this partnership, CCB has agreed to a city-wide non-binding charter that formalizes our joint

planning group's working relationship and specifies the collaboration and identification of mutual resources that can support efforts to increase early access to and retention in HIV care. Via this charter, we are dedicated to our commitment to work together through implementation planning and operations to address major gaps in access to, and retention in, HIV 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.

HIV/AIDS is a chronic disease that disproportionately impacts ethnic/racial minorities. Some of the challenges we anticipate relate to these factors and will be addressed through this project.

First, CCB must effectively address social co-factors that constrain successful access and retention in care. These include cultural perceptions and stigma of the disease that act as barriers to access and retention in care. CCB will implement a multi-layered cultural competency campaign to more effectively identify needs; work with a wide array of non-medical service providers to address various needs; create peer support programs; and implement evidence-based patient education/participation and social marketing.

Second, meeting this project's goals will require effective pooling of resources across the PPS collaborative – particularly knowledge, experiences, perspectives and funding. Such pooling will improve project design and implementation and help better address the needs of targeted sub-populations. To address this challenge, CCB will work closely with other PPSs, including HHC, during the planning and implementation phases to ensure effective allocation of DSRIP funding and to establish regular ongoing communication patterns. The established Collaborative, guided by its Charter, creates a formal structure for such knowledge-sharing and joint engagement.

Third, effective partner communication of project activities will be essential to success. Such communication will ensure common understanding and implementation at the service level. To address this challenge, CCB will work closely with other PPSs, including HHC, during the planning and implementation phases through the Collaborative to ensure effective communication patterns are established.

Fourth, patients must remain engaged in care to allow for project objectives to be realized, a challenge given the experience to-date with patient attrition. In response, CCB will implement interventions across our PPS partners that focus on the integration of HIV Screening and improved linkage systems for services; peer support programs; virology fast track plus; and evidence-based patient education/participation and social marketing.

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.

Community Care of Brooklyn, along with six other PPSs, including the PPS of the New York City Health and Hospitals Corporation (HHC) and Lutheran, have collaborated to select the HIV Access and Retention in Care project. The PPSs identified a core group of common sectors from the Project Requirements, and developed a common list of interventions designed to address those sectors. CCB and HHC aligned further on a discrete list of interventions to meet project goals (mentioned previously).

As described in Section C, CCB will continue our commitment to further collaboration with our

Brooklyn PPS colleagues through the HIV Collaborative to address major gaps in access to, and retention in, HIV care. Our continued joint planning through the January-March 2015 implementation planning period will ensure alignment and coordination of resource allocation, standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project.

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

Consistent with application requirements, the PPS HIV Collaborative will continue to meet in early 2015 to complete the detailed Implementation Plan, which will be submitted by March 1, 2015. We have identified a number of key milestones in this implementation planning process, including: -- Convening a PPS HIV Collaborative Planning Committee (Q1/Q2, DY1); -- Establishing a work plan and timeline for project implementation (Q3/4, DY1); -- Developing agreed upon milestones for project implementation (Q3/4, DY1); -- Agree upon project commonalities and shared resources (Q3/Q4, DY1); -- Agree upon a data sharing system to address reporting and implementation needs (Q3/Q4, DY2)

2. <u>Project Resource Needs and Other Initiatives</u> (Not Scored)

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

Yes	No
☐	☒

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

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

Yes	No
☒	☐

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

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

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NADAP	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
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Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as above…
Please refer to the table at the end of this application for additional entities.				

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.

CCB surveyed our Participants to gather this information. We have included the initiatives and programs most relevant to our project's objectives. The specific initiatives/programs that may overlap with this project are listed below.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects. This project will build on this work, but will serve a different and larger group of Medicaid patients, including those who are not eligible for Health Home services.

Our partner's experience with enhancing HIV treatment and prevention through the SAMHSA grant will be valuable to inform this DSRIP project, but DSRIP funds will not be provided to this provider if doing so would supplant or duplicate SAMHSA funding.

VillageCare's efforts under this award will help inform CCB's planning around medication and treatment adherence, but will apply to a far broader population and will be implemented at our other relevant Participant sites. DSRIP funding will not supplant or duplicate the funding that has been provided to VillageCare under the HCIA.

We will continue to survey our provider network to ensure DSRIP funds do not supplant or duplicate other Federal or State funding, including to clarify dates when insufficient information was provided.

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

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

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

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HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
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MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
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Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Apicha Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
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The Resource Training and Counseling Center, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
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Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…

Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…

Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
Catholic Charities Community Services	HARP	2015	2019	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	HARP	2015	2019	Same as Above…
Mental Health Association of New York City	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	HARP	2015	2019	Same as Above…
Center for Behavioral Health Services	HARP	2015	2019	Same as Above…
NAMI-NYC Metro	HARP	2015	2019	Same as Above…
St. Christopher's Inn	HARP	2015	2019	Same as Above…

CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC.	HARP	2015	2015	Same as Above…
FEGS Health and Human Services	HARP	2015	2015	Same as Above…
The Resource Training and Counseling Center, Inc.	HARP	2015	2019	Same as Above…
Pesach Tikvah Hope Development Inc.	HARP	2015	2019	Same as Above…
Saint Joseph's Medical Center	HARP	2015	2015	Same as Above…
Greenwich House, Inc.; applied	HARP	2014	2014	Same as Above…
Medical Arts Sanitarium, Inc.	HARP	2015	2015	Same as Above…
SUS Mental Health Programs, Inc.	HARP	2015	2019	Same as Above…
CAMBA, Inc.	HARP	2015	2019	Same as Above…
Maimonides Medical Center	HARP	2015	2019	Same as Above…
Federation of Organizations	HARP	2015	2015	Same as Above…
Interborough Developmental & Consultation Center	HARP	2015	2019	Same as Above…
Housing Works, Inc	HARP	2015	2019	Same as Above…
Exponents	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
PSC Community Services	FIDA	2015	2019	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.

Job Path Advance Care Alliance	FIDA	2015	2019	Same as Above…
St. Christopher's Inn	FIDA	2015	2019	Same as Above…
God's Love We Deliver, INC	FIDA	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	FIDA	2015	2019	Same as Above…
Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	FIDA	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	FIDA	2015	2019	Same as Above…
CenterLight Healthcare Inc	FIDA	2015	2019	Same as Above…
Amber Court of Brooklyn	FIDA	2015	2015	Same as Above…
Greenwich House, Inc.	FIDA	2014	2019	Same as Above…
CAMBA, Inc.	FIDA	2015	2019	Same as Above…
Program Development Services, Inc.	FIDA	2015	2019	Same as Above…
Metropolitan Center for Mental Health	FIDA	2015	2019	Same as Above…
Ridgewood Bushwick Senior Citizens Council, Inc.	FIDA	2015	2019	Same as Above…

Visiting Nurse Service of New York	FIDA	2015	2019	Same as Above…
Integra Managed Care, Inc	FIDA	2015	2019	Same as Above…
CenterLight Health System	FIDA	2015	2019	Same as Above…
Interborough Developmental & Consultation Center	FIDA	2015	2019	Same as Above…
BHRAGS home care corp	FIDA	2015	2015	Same as Above…
PROACTIVE CARE IPA, LLC	FIDA	2015	2015	Same as Above…
Sovereign Phoenix - IPA	FIDA	2014	2019	Same as Above…
Planned Parenthood	NYS DOH Vital Access Provider (VAP)	2014	2015	Providers with a VAP designation may qualify for supplemental financial assistance to support their longer-term financial viability through time-limited grants or supplemented rates. Grants, for example, support efforts to increase primary care capacity, improve chronic disease management, integrate palliative care services into PCPs, smooth care transitions, or advance community wellness and education.
New York Methodist Hospital	NYS DOH Vital Access Provider (VAP)	2014	2016	Same as Above…
CenterLight Healthcare Inc	NYS DOH Vital Access Provider (VAP)	2015	2017	Same as Above…

Kingsbrook Jewish Medical Center (Cinergy Collaborative)	NYS DOH Vital Access Provider (VAP)	2014	2016	Same as Above…
CenterLight Health System	NYS DOH Vital Access Provider (VAP)	2015	2017	Same as Above…
St. Mary's Healthcare System for Children (Includes the following: St. Mary's Hospital for Children, St. Mary's Community Care Professionals; Extraordinary Home Care d/b/a St. Mary's Home Care)	Money Follows the Person	2014	2014	Money Follows the Person is a federally funded State Medicaid program that provides enhanced reimbursement for select services to persons who transition to community based care after having been in a nursing home for more than six months.
Maimonides	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. The Brooklyn Health Home Health Care Innovation Award focuses on seriously mentally ill patients, and provides enhanced care coordination, multi-disciplinary care teams, and enhanced communication through an IT "Dashboard".
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2013	2019	Same as Above…
CAMBA, Inc.	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works, Inc	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…

CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2016	2017	Same as Above…
APICHA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
JBFCS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
VNSNY	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Ohel	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
FEGS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
PRFI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
CAMBA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
NADAP	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…

HELP PSI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.
God's Love We Deliver	Balancing Incentives Program Grant	2014	2015	The Balancing Incentive Program is a Federally funded State Medicaid program to increase access to non-institutional long-term services and supports (LTSS) creating a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children (Includes the following, listed above: St. Mary's Hospital for Children, St. Mary's Community Care Professionals; Extraordinary Home Care d/b/a St. Mary's Home Care)	Balancing Incentives Program Grant	2014	2015	Same as Above…
Jewish Association for Services for the Aged	Balancing Incentives Program Grant			Same as Above…

CenterLight Healthcare Inc	Medicare Shared Savings Program 2012	2014	2019	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.
ProHEALTH Care Associates, LLP	Medicare Shared Savings Program 2012	2013	2019	Same as Above…
Glen Island Center for Nursing & Rehabilitation	Medicare Shared Savings Program 2012	2015	2019	Same as Above…
Higher Ground, IPA	Medicare Shared Savings Program 2012	2015	2019	Same as Above…
Visiting Nurse Service of New York	Medicare Shared Savings Program 2012	2013	2019	Same as Above…
CenterLight Health System	Medicare Shared Savings Program 2012	2014	2019	Same as Above…
Sovereign Phoenix - IPA	Medicare Shared Savings Program 2012	2015	2018	Same as Above…

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
CenterLight Healthcare Inc	Medicare Shared Savings Program 2012	2014	2019	The Medicare Shared Savings Program is a Federally funded program that supports Accountable Care Organizations (ACOs) and their participants as they facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

ProHEALTH Care Associates, LLP	Medicare Shared Savings Program 2012	2013	2019	Same as Above…
Glen Island Center for Nursing & Rehabilitation	Medicare Shared Savings Program 2012	2015	2019	Same as Above…
Higher Ground, IPA	Medicare Shared Savings Program 2012	2015	2019	Same as Above…
Visiting Nurse Service of New York	Medicare Shared Savings Program 2012	2013	2019	Same as Above…
CenterLight Health System	Medicare Shared Savings Program 2012	2014	2019	Same as Above…
Sovereign Phoenix - IPA	Medicare Shared Savings Program 2012	2015	2018	Same as Above…
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.
Little Flower Children and Family Services of NY	Bridges to Health	2010	2014	The State Bridges to Health program supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.
SCO Family of Services/Member of the Children's Collaborative and the Advance Care Alliance	Developmental Disabilities Individual Support and Care Coordination Organization (DISCO)	2015	2015	New York's DISCO program will provide enhanced care coordination to developmentally disabled Medicaid populations through qualified managed care plans.
St. Mary's Healthcare System for Children (Includes the following: St. Mary's Hospital for Children, St. Mary's Community Care Professionals; Extraordinary Home Care d/b/a St. Mary's Home Care)	Money Follows the Person	2014	2014	Money Follows the Person is a federally funded State Medicaid program that provides enhanced reimbursement for select services to persons who transition to community based care after having been in a nursing home for more than six months.

2.b.iii ED Care Triage for At-Risk Populations

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Bailey House	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
NAMI-NYC Metro	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Apicha Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2015	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as Above…
Family Services Network of New York, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Outreach Development Corporation	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
FEGS Health and Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Resource Training and Counseling Center, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
SCO Family of Services/Member of the Children's Collaborative and the Advance Care Alliance	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

Village Center for Care	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…

Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
Catholic Charities Community Services	HARP	2015	2019	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	HARP	2015	2019	Same as Above…
Mental Health Association of New York City	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	HARP	2015	2019	Same as Above…
Center for Behavioral Health Services	HARP	2015	2019	Same as Above…
NAMI-NYC Metro	HARP	2015	2019	Same as Above…
St. Christopher's Inn	HARP	2015	2019	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC.	HARP	2015	2015	Same as Above…
FEGS Health and Human Services	HARP	2015	2015	Same as Above…
The Resource Training and Counseling Center, Inc.	HARP	2015	2019	Same as Above…
Pesach Tikvah Hope Development Inc.	HARP	2015	2019	Same as Above…

Saint Joseph's Medical Center	HARP	2015	2015	Same as Above…
Greenwich House, Inc.	HARP	2014	2014	Same as Above…
Medical Arts Sanitarium, Inc.	HARP	2015	2015	Same as Above…
SUS Mental Health Programs, Inc.	HARP	2015	2019	Same as Above…
CAMBA, Inc.	HARP	2015	2019	Same as Above…
Maimonides Medical Center	HARP	2015	2019	Same as Above…
Federation of Organizations	HARP	2015	2015	Same as Above…
Interborough Developmental & Consultation Center	HARP	2015	2019	Same as Above…
Housing Works, Inc	HARP	2015	2019	Same as Above…
Exponents	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
PSC Community Services	FIDA	2015	2019	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Job Path Advance Care Alliance	FIDA	2015	2019	Same as Above…
St. Christopher's Inn	FIDA	2015	2019	Same as Above…
God's Love We Deliver, INC	FIDA	2015	2019	Same as Above…

Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	FIDA	2015	2019	Same as Above…
Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	FIDA	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	FIDA	2015	2019	Same as Above…
CenterLight Healthcare Inc	FIDA	2015	2019	Same as Above…
Amber Court of Brooklyn	FIDA	2015	2015	Same as Above…
Greenwich House, Inc.; applied	FIDA	2014	2019	Same as Above…
CAMBA, Inc.	FIDA	2015	2019	Same as Above…
Program Development Services, Inc.	FIDA	2015	2019	Same as Above…
Metropolitan Center for Mental Health	FIDA	2015	2019	Same as Above…
Ridgewood Bushwick Senior Citizens Council, Inc.	FIDA	2015	2019	Same as Above…
Visiting Nurse Service of New York	FIDA	2015	2019	Same as Above…
Integra Managed Care, Inc	FIDA	2015	2019	Same as Above…
CenterLight Health System	FIDA	2015	2019	Same as Above…

Interborough Developmental & Consultation Center	FIDA	2015	2019	Same as Above…
BHRAGS home care corp	FIDA	2015	2015	Same as Above…
PROACTIVE CARE IPA, LLC	FIDA	2015	2015	Same as Above…
Sovereign Phoenix - IPA	FIDA	2014	2019	Same as Above…
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.
Visiting Nurse Service of New York	Mobile Crisis/Parachute Program CMMI Health Care Innovation Award (HCIA)	1986	2019	The Mobile Crisis/Parachute program provide coordinated care and psychiatric treatment to the SMI population and those in psychiatric crisis, and is funded by NYC DOHMH and under a CMS Health Care Innovations Award.
Community Access	Mobile Crisis/Parachute Program CMMI Health Care Innovation Award (HCIA)	2013	2015	Same as Above…

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
HELP/PSI Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
HeartShare St. Vincent's Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Bailey House	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
NAMI-NYC Metro	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
MercyFirst	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Graham Windham	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Apicha Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Coordinated Behavioral Care IPA/Center for Urban Community Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2015	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2015	Same as Above…
Family Services Network of New York, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Outreach Development Corporation	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
FEGS Health and Human Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Resource Training and Counseling Center, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
SCO Family of Services/Member of the Children's Collaborative and the Advance Care Alliance	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

Village Center for Care	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…
Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2019	Same as Above…

Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…

Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…

Catholic Charities Community Services	HARP	2015	2019	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	HARP	2015	2019	Same as Above…
Mental Health Association of New York City	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	HARP	2015	2019	Same as Above…
Center for Behavioral Health Services	HARP	2015	2019	Same as Above…
NAMI-NYC Metro	HARP	2015	2019	Same as Above…
St. Christopher's Inn	HARP	2015	2019	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC.	HARP	2015	2015	Same as Above…
FEGS Health and Human Services	HARP	2015	2015	Same as Above…
The Resource Training and Counseling Center, Inc	HARP	2015	2019	Same as Above…
Pesach Tikvah Hope Development Inc.	HARP	2015	2019	Same as Above…
Saint Joseph's Medical Center	HARP	2015	2015	Same as Above…

Greenwich House, Inc	HARP	2014	2014	Same as Above…
Medical Arts Sanitarium, Inc.	HARP	2015	2015	Same as Above…

SUS Mental Health Programs, Inc.	HARP	2015	2019	Same as Above…
CAMBA, Inc.	HARP	2015	2019	Same as Above…
Maimonides Medical Center	HARP	2015	2019	Same as Above…
Federation of Organizations	HARP	2015	2015	Same as Above…
Interborough Developmental & Consultation Center	HARP	2015	2019	Same as Above…
Housing Works, Inc	HARP	2015	2019	Same as Above…
Exponents	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
PSC Community Services	FIDA	2015	2019	The New York and CMS joint FIDA initiative will serve dual eligible individuals (Medicare-Medicaid enrollees) through qualified managed long term care plans, providing a better care experience by offering a person-centered, integrated care initiative that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.
Job Path Advance Care Alliance	FIDA	2015	2019	Same as Above…
St. Christopher's Inn	FIDA	2015	2019	Same as Above…
God's Love We Deliver, INC,	FIDA	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	FIDA	2015	2019	Same as Above…

Brooklyn Bureau of Community Service d/b/a Brooklyn Community Services/Part of CBC IPA	FIDA	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	FIDA	2015	2019	Same as Above…
CenterLight Healthcare Inc	FIDA	2015	2019	Same as Above…
Amber Court of Brooklyn	FIDA	2015	2015	Same as Above…
Greenwich House, Inc.	FIDA	2014	2019	Same as Above…
CAMBA, Inc.	FIDA	2015	2019	Same as Above…
Program Development Services, Inc.	FIDA	2015	2019	Same as Above…
Metropolitan Center for Mental Health	FIDA	2015	2019	Same as Above…
Ridgewood Bushwick Senior Citizens Council, Inc.	FIDA	2015	2019	Same as Above…
Visiting Nurse Service of New York	FIDA	2015	2019	Same as Above…
Integra Managed Care, Inc	FIDA	2015	2019	Same as Above…
CenterLight Health System	FIDA	2015	2019	Same as Above…
Interborough Developmental & Consultation Center	FIDA	2015	2019	Same as Above…

BHRAGS home care corp	FIDA	2015	2015	Same as Above…
PROACTIVE CARE IPA, LLC	FIDA	2015	2015	Same as Above…
Sovereign Phoenix - IPA	FIDA	2014	2019	Same as Above…
God's Love We Deliver	Balancing Incentives Program Grant	2014	2015	The Balancing Incentive Program is a Federally funded State Medicaid program to increase access to non-institutional long-term services and supports (LTSS) creating a "no wrong door" policy for LTSS recipients. Funding supports service enhancements such as remote patient monitoring.
St. Mary's Healthcare System for Children (Includes the following, listed above: St. Mary's Hospital for Children, St. Mary's Community Care Professionals; Extraordinary Home Care d/b/a St. Mary's Home Care)	Balancing Incentives Program Grant	2014	2015	Same as Above…
Jewish Association for Services for the Aged	Balancing Incentives Program Grant			Same as Above…
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.
Little Flower Children and Family Services of NY	Bridges to Health	2010	2014	The State Bridges to Health program supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…

Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
Catholic Charities Community Services	HARP	2015	2019	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Center for Urban Community Services	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc.	HARP	2015	2019	Same as Above…
Mental Health Association of New York City	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	HARP	2015	2019	Same as Above…
Center for Behavioral Health Services	HARP	2015	2019	Same as Above…
NAMI-NYC Metro	HARP	2015	2019	Same as Above…
St. Christopher's Inn	HARP	2015	2019	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC.	HARP	2015	2015	Same as Above…
FEGS Health and Human Services	HARP	2015	2015	Same as Above…

The Resource Training and Counseling Center, Inc.	HARP	2015	2019	Same as Above…
Pesach Tikvah Hope Development Inc	HARP	2015	2019	Same as Above…
Saint Joseph's Medical Center	HARP	2015	2015	Same as Above…
Greenwich House, Inc.	HARP	2014	2014	Same as Above…
Medical Arts Sanitarium, Inc.	HARP	2015	2015	Same as Above…
SUS Mental Health Programs, Inc.	HARP	2015	2019	Same as Above…
CAMBA, Inc.	HARP	2015	2019	Same as Above…
Maimonides Medical Center	HARP	2015	2019	Same as Above…
Federation of Organizations	HARP	2015	2015	Same as Above…
Interborough Developmental & Consultation Center	HARP	2015	2019	Same as Above…
Housing Works, Inc	HARP	2015	2019	Same as Above…
Exponents	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Community Counseling and Mediation (CCM)	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2015	2019	This SAMHSA grant, under the Federal Minority AIDS Initiative Continuum of Care Pilot, supports (co-located and integrated primary care in Bridging Access to Care's mental health clinic) (enhanced HIV treatment and prevention under CCM's program).
Bridging Access to Care; Sept.	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2014	2018	Same as Above…
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	Collaborative Care Initiative			The New York State Medicaid Collaborative Care Depression Program provides Medicaid PMPM payments to participating providers for depression services rendered to eligible patients.

Apicha Community Health Center	Collaborative Care Initiative	2015	2015	Same as Above…
Glen Island Center for Nursing & Rehabilitation	Collaborative Care Initiative	2015	2019	Same as Above…
PSC Community Services, Inc.	Collaborative Care Initiative	2015	2019	Same as Above…
Kingsbrook Jewish Medical Center	Collaborative Care Initiative	2014	2014	Same as Above…
Center for Alternative Sentencing & Imployment Services, Inc. (CASES)	Collaborative Care Initiative			Same as Above…
SUS Mental Health Programs, Inc.	Collaborative Care Initiative			Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Collaborative Care Initiative	2017	2017	Same as Above…
Maimonides Medical Center	Collaborative Care Initiative	2015	2019	Same as Above…
PROACTIVE CARE IPA, LLC	Collaborative Care Initiative	2015	2015	Same as Above…
American Dental Offices, PLLC	Medicare/Medicaid EHR Incentive Programs	2015	2020	The EHR Incentive Programs provide funding to qualified hospitals and health professionals to adopt, implement, upgrade and/or meaningfully use health information technology and report on quality metrics.
Planned Parenthood of New York City, Inc	Medicare/Medicaid EHR Incentive Programs	2015	2019	Same as Above…
Maimonides	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. The Brooklyn Health Home Health Care Innovation Award focuses on seriously mentally ill patients, and provides enhanced care coordination, multi-disciplinary care teams, and enhanced communication through an IT "Dashboard".

National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2013	2019	Same as Above…
CAMBA, Inc.	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works, Inc	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2016	2017	Same as Above…
APICHA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
JBFCS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
VNSNY	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Ohel	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
FEGS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…

PRFI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
CAMBA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
NADAP	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
HELP PSI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Little Flower Children and Family Services of NY	Bridges to Health	2010	2014	The State Bridges to Health program supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	HRSA Behavioral Health Integration (BHI)	2014	2015	HRSA Behavioral Health Integration grants support health centers to improve behavioral health services and capacity, and to employ integrated models of primary and behavioral health care.
Brooklyn Plaza Medical Center	HRSA Behavioral Health Integration (BHI)	2014	2015	Same as Above…

Visiting Nurse Service of New York	Comprehensive Care Management (CCM)	2001	2015	The Comprehensive Care Management program, funded by NY HRA, provides coordinated care to the SUD population receiving public assistance, including assessments and referal to treatment, and employment services.
Visiting Nurse Service of New York	Mobile Crisis/Parachute Program CMMI Health Care Innovation Award (HCIA)	1986	2015	The Mobile Crisis/Parachute program provide coordinated care and psychiatric treatment to the SMI population and those in psychiatric crisis, and is funded by NYC DOHMH and under a CMS Health Care Innovations Award.
Community Access	Mobile Crisis/Parachute Program CMMI Health Care Innovation Award (HCIA)	2013	2015	Same as Above…
Methodist	Hospital Medical Home Demonstration Project	2013	2015	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Kingsbrook Jewish Medical Center	Hospital Medical Home Demonstration Project	2014	2014	Same as Above…
Maimonides Medical Center	Hospital Medical Home Demonstration Project	2013	2015	Same as Above…

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Visiting Nurse Service of New York	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…

Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
Methodist	Hospital Medical Home Demonstration Project	2013	2015	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Kingsbrook Jewish Medical Center	Hospital Medical Home Demonstration Project	2014	2014	Same as Above…
Maimonides Medical Center	Hospital Medical Home Demonstration Project	2013	2015	Same as Above…
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.

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

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…

Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…

Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.
Little Flower Children and Family Services of NY	Bridges to Health	2010	2014	The State Bridges to Health program supports in home services for foster children who have emotional problems, developmental disabilities or are medically fragile.

4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure Across Systems

(Focus Area 3) Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
CAMBA, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…

Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…
Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…
Catholic Charities Community Services	HARP	2015	2019	New York's HARP program will provide enhanced 1915(i) waiver services (such as enhanced substance use disorder services) to high need behavioral health Medicaid populations through qualified managed care plans.
South Beach Psychiatric Center/Kingsboro - OMH Initiatives	HARP	2015	2019	Same as Above…

Coordinated Behavioral Care IPA/Center for Urban Community Services	HARP	2015	2019	Same as Above…
Coordinated Behavioral Care IPA/Counseling Service of EDNY, Inc	HARP	2015	2019	Same as Above…
Mental Health Association of New York City	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Jewish Board of Family & Children's Services (JBFCS)/CBC IPA	HARP	2015	2019	Same as Above…
Center for Behavioral Health Services	HARP	2015	2019	Same as Above…
NAMI-NYC Metro	HARP	2015	2019	Same as Above…
St. Christopher's Inn	HARP	2015	2019	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC.	HARP	2015	2015	Same as Above…
FEGS Health and Human Services	HARP	2015	2015	Same as Above…
The Resource Training and Counseling Center, Inc.	HARP	2015	2019	Same as Above…
Pesach Tikvah Hope Development Inc.	HARP	2015	2019	Same as Above…
Saint Joseph's Medical Center	HARP	2015	2015	Same as Above…
Greenwich House, Inc.	HARP	2014	2014	Same as Above…
Medical Arts Sanitarium, Inc.	HARP	2015	2015	Same as Above…
SUS Mental Health Programs, Inc.	HARP	2015	2019	Same as Above…
CAMBA, Inc.	HARP	2015	2019	Same as Above…
Maimonides Medical Center	HARP	2015	2019	Same as Above…
Federation of Organizations	HARP	2015	2015	Same as Above…

Interborough Developmental & Consultation Center	HARP	2015	2019	Same as Above…
Housing Works, Inc	HARP	2015	2019	Same as Above…
Exponents	HARP	2015	2019	Same as Above…
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	HARP	2015	2019	Same as Above…
Community Counseling and Mediation (CCM)	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2015	2019	This SAMHSA grant, under the Federal Minority AIDS Initiative Continuum of Care Pilot, supports (co-located and integrated primary care in Bridging Access to Care's mental health clinic) (enhanced HIV treatment and prevention under CCM's program).
Bridging Access to Care; Sept.=	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2014	2018	Same as Above…
Visiting Nurse Service of New York	Comprehensive Care Management (CCM)	2001	2015	The Comprehensive Care Management program, funded by NY HRA, provides coordinated care to the SUD population receiving public assistance, including assessments and referal to treatment, and employment services.
Maimonides	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. The Brooklyn Health Home Health Care Innovation Award focuses on seriously mentally ill patients, and provides enhanced care coordination, multi-disciplinary care teams, and enhanced communication through an IT "Dashboard".
National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2013	2019	Same as Above…

CAMBA, Inc.	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works, Inc	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2016	2017	Same as Above…
APICHA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
JBFCS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
VNSNY	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Ohel	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
FEGS	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…

PRFI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
CAMBA	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
NADAP	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
HELP PSI	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…
Housing Works	Maimonides CMS Innovation Center Health Care Innovation Award (HCIA)	2012	2015	Same as Above…

4.c.ii Increase Early Access to, and Retention in, HIV Care (Focus Area 1; Goal #2)

Additional responses to question (b.) of Section 5. Project Resource Needs and Other Initiatives.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Saint Joseph's Medical Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	New York's Health Home program provides a suite of care management services to primarily adult Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or SMI), and in 2015, children. Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.

Greenwich House, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Diaspora Commuinty Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
SUS Mental Health Programs, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…

CAMBA, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2012	Same as Above…
Upper Room AIDS Ministry, Inc: Adult Day Health Care Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Visiting Nurse Service of New York; HH start	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
The Osborne Association/Osborne Treatment Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…
Arms Acres, Inc./Conifer Park, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2019	Same as Above…

National Association on Drug Abuse Problems, Inc. (NADAP, Inc.)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2012	2019	Same as Above…
Gay Men's Health Crisis (GMHC)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2014	2014	Same as Above…
CATHOLIC CHARITIES NEIGHBORHOOD SERVICES, INC./(Member Agency of Advance Care Alliance)	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2016	2017	Same as Above…
Episcopal Social Services	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2015	Same as Above…

Exponents	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2013	Same as Above…
Interborough Developmental & Consultation Center	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2013	2019	Same as Above…
Housing Works, Inc	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2011	2019	Same as Above…
Community Access	Health Homes for Medicaid Enrollees with Chronic Conditions and for Children	2015	2018	Same as Above…

Community Counseling and Mediation (CCM)	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2015	2019	This SAMHSA grant, under the Federal Minority AIDS Initiative Continuum of Care Pilot, supports (co-located and integrated primary care in Bridging Access to Care's mental health clinic) (enhanced HIV treatment and prevention under CCM's program).
Bridging Access to Care	SAMHSA Minority AIDS Initiative Continuum of Care Pilot	2014	2018	Same as Above…\
Village Center for Care	Village Center for Care CMS Innovation Center Health Care Innovation Award (HCIA)	2014	2017	Health Care Innovation Awards are federally funded Medicaid programs that support innovative ways of improving care for Medicaid populations. VillageCare's award focuses on treatment adherence through the advanced use of technology.