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DSRIP Independent Assessor

Mid-Point Assessment Report

Bronx Health Access PPS

Appendix PPS Narratives

November 2016

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Prepared by the DSRIP Independent Assessor

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DSRIP Mid-Point Assessment - Organizational Narratives

PPS must submit a narrative highlighting the overall organizational efforts to date.

PPS Name: Bronx-Lebanon Hospital Center

Highlights and successes of the efforts:

The PPS has made significant progress in the implementation of 10 DSRIP projects led by Bronx-Lebanon Hospital Center (DSRIP lead entity), with active support from more than 200 partner organizations and providers. At the outset, the PPS established the primary goal to create a network of care that improves access, quality, and efficiency for the safety net population in the South Bronx. The PPS has experienced strong success towards the three main objectives identified in the PPS Organizational Application, specifically:

- ***Objective 1: Create a highly efficient Integrated Delivery System in collaboration with providers across the care continuum using IT interoperability and care coordination to improve the beneficiary's experience and outcomes.***
    - Success: Contracted with 240 partner organizations and agencies with representatives from a wide range of health and social service providers, including physicians, nursing homes, Federally Qualified Health Centers (FQHCs), IPAs, community-based organizations, hospitals, behavioral health providers, health homes, faith-based organizations, and others. Engaged the Bronx RHIO, as the primary support for all participating partner organizations, to implement PPS-wide health information exchange (HIE) and health information management (HIM) capabilities.

- ***Objective 2: Develop integrated value-based contracts and payment that brings all providers closer to the premium dollar.***
    - Success: Developing the financing systems to implement sustainable value-based payment reforms that incentivize providers to improve patient outcomes. The PPS is leveraging its strong health plan experience and increased "star" rating with Healthfirst—a large Medicaid managed care plan where Bronx-Lebanon (DSRIP lead entity) is part owner, managing 100,000 capitated lives—as well as, its two Health Homes—collectively managing the health of nearly 95,000 beneficiaries—to implement new value-based payment initiatives.

- ***Objective 3: Retrain and redeploy the health care workforce to provide services and supports that improve outcomes.***
    - Success: Implemented in-person and web-based training plans and courses, available to all PPS staff (direct and non-direct care) at no charge, to support the goals of the 10 DSRIP projects. Successfully created pathways to certification for paraprofessionals and accelerated training to increase hiring of proficient and bilingual clinical care staff.

- ***Objective 4: Create and implement multidisciplinary approaches to care that address issues identified in the CNA.***

  Success: Relevant evidence-based methods are being applied (e.g., the *InSHAPE* model in Project 2.b.i, the Coleman model in Project 2.b.iv, the Nurse Family Partnership model in Project 3.f.i, and others) to address the needs of a predominantly minority, foreign-born, and low-income population, where many patients experience significant barriers to care due to complex socioeconomic, mental health, and behavioral challenges. Each PPS patient is risk-stratified and assigned to a care coordinator to improve disease management. A multidisciplinary care team provides "wrap-around" services to address the patient's social needs. This system not only ensures care coordination for all medical, behavioral, and long-term care services, but also provides social and public health services as needed.

Through the implementation of the 10 DSRIP projects identified in the accompanying Project Plan narratives, the PPS is profoundly shifting traditionally used health care delivery approaches towards a new transformative structure that upholds the *Triple Aim: improving the experience of care, improving the health of populations, and reducing per capita costs of health care*. In DSRIP DY 1, the PPS resources, leadership, and staff expertise have collectively facilitated several strategic innovations in finance, clinical quality, IT, workforce, compliance, community collaboration, and stakeholder engagement as outlined in Section II. Committee and Workgroup highlights and successes.

I. Overview of cross-cutting measures and population health strategies

PPS leaders consider the most significant achievement to date to be the consensus among partners, and the implementation of best approaches, whereby the PPS will manage patients defined as super- and high-utilizers. Historically, there has been much effort centered on connecting these patients back to their community providers, however, there was not always a central focus on communicating with patients at their bedside to prevent subsequent and avoidable hospitalizations or ED visits. Based on lessons learned through the Bronx Health Home, the best way to prevent a future hospital admission or re-admission is to enact a person-to-person solution facilitated by IT infrastructure, in order to improve management during care transitions. The PPS is harnessing the power of the Clearinghouse (IT analytics from the Bronx RHIO) with skilled and culturally competent staff at the patient's bedside (person-to-person solution) in order to:

- Provide secure message alerts to providers, community health workers, care coordinators, and social workers in real-time when a patient is admitted to the hospital
- Deploy staff to engage patients at the point of care (i.e., inpatient unit, ED)
- Provide a LACE (Length of stay, Acuity of Admission, Comorbidities, and Emergency Department visits) score that risk stratifies patients into low-, high-, and super-utilizer groups
- Show insurance coverage status, Medicaid eligibility, Health Home assignment, acuity scores, and flags for high-risk social conditions (e.g., homelessness)
- Provide a demographic and clinical care patient snapshot showing missing services (e.g., recent HbA1c or eye exams for patients with diabetes) which are linked to PPS clinical quality metrics

Through the Clearinghouse, the PPS is able to answer questions in real-time that were previously unanswerable, such as: "Does this patient have a primary care provider?" "Is this patient eligible for Medicaid?" "What gaps in care does this patient have?" Patients eligibility for DSRIP projects is determined. Accountability reports are generated to ensure that necessary follow-up occurs with the patient's

documented preferred primary care provider within 30 days. The unparalleled capabilities afforded by the Clearinghouse will enable multidisciplinary care teams to develop actionable plans that will accomplish stated PPS ***objectives 5 and 6 (to reduce unnecessary beds in the PPS, and reduce unnecessary ER utilization through primary care and social services integration, respectively).***

Looking to the future, the PPS will be able to better manage gaps in services by merging the Clearinghouse capabilities with data received from managed care organizations (MCOs). In this way, prospective identification of patients (by individual client identification number, CIN) will help to determine gaps in services and if these services have actually occurred. Missing data will be resubmitted back to the MCO for reconciliation via a pseudo-claim. The PPS will also be in a better position to achieve improvements through value-based payment reforms as the Clearinghouse capabilities are scalable and will expand with PPS expansion. With PPS growth, the Clearinghouse will continue to provide significant and actionable information that will make other determinations quite evident, such as: staffing ratio projections, and the outreach mechanisms needed to maintain actively engaged patient targets.

II. Committee and Workgroup highlights and successes

The PPS currently operates under a Delegated Governance model. The Steering Committee oversees the execution of all PPS operations and PPS-wide strategic decision making. The Steering Committee consists of five voting members from Bronx-Lebanon and seven voting members from its partners (representing a majority of voting members): Comunilife, Urban Health Plan, VNS of NY, 1199SEIU, Hudson Heights IPA, Mount Sinai Hospital System, and Dominican Sisters Family Health Services. Through this Governance model, the PPS will have the requisite infrastructure to be able to shift towards pay-for-performance metrics in latter DSRIP years. The Steering Committee has delegated key management roles to five Committee Chairs who oversee their respective committees: 1) Finance, 2) Clinical Quality, 3) IT, 4) Workforce, and 5) Compliance. In addition, there are three cross-functional Workgroups that report to the Clinical Quality Committee: 1) PCMH, 2) Care Coordination, and 3) Stakeholder Engagement. A final cross-functional Workgroup, Cultural Competency and Health Literacy, reports to the Workforce Committee. A synopsis of Committee and Workgroup highlights follows.

1. **Finance Committee:** ***Victor Demarco, Bronx-Lebanon Hospital Center, Senior Vice President and Chief Financial Officer, Committee Chair.*** The Finance Committee has developed and approved policies and procedures for the flow of funds and the long-term financial sustainability of the PPS. To maintain accountability, monthly financial performance reports are provided to the Steering Committee, which provides detailed monitoring of DSRIP project finances. Currently, the Committee and primary CMO partner are discussing new pay-for-performance initiatives and structures to improve management of high-utilizer patients. The Committee participates in the CBO Panel workshops that engage the PPS partners on best approaches to strategically position their organization for financial sustainability.

2. **Clinical Quality Committee:** ***John Coffey, MD, Bronx-Lebanon Hospital Center, Emergency Department Director, Committee Chair.*** The Clinical Quality Committee convenes Project Workgroup meetings (with all committee leads, workgroups, project teams, and PPS leaders) to review project accomplishments, patient engagement strategies, and to align quality improvement strategies. With the synergistic collaboration of the PPS committees (e.g., Finance, IT, and Workforce), the Committee will address areas needing development to achieve DSRIP performance measures.

3. **IT Committee:** ***Ivan Durbak, Bronx-Lebanon Hospital Center, Chief Information Officer, Committee Chair; Chase McCaleb, Bronx-Lebanon Hospital Center, Bioinformatics Specialist; Steve Maggio, Bronx-Lebanon Hospital Center, Senior Project Manager.*** The IT Committee has created several dashboards, using data aggregated from the Bronx RHIO, showing a variety of measures at the PPS level, with drill-down specificity to the project and partner organization, including: the number of patients actively engaged; monitoring quality targets, metrics achieved, and gap-to-goal targets; and a review of baseline data and measurement timeframes provided by NYS. Salesforce, a multifunction customer relationship management platform, is being utilized to provide: organizational level milestones per project to support NYS DOH reporting; show updated and de-duplicated actively engaged patients reported from the RHIO per partner organization; a directory of project workgroup members; a directory of PPS partners by NPI number; and current status of DSRIP projects. Using Spectrum Analytics, the Committee has developed population health management tools with interactive data visualization capabilities displaying morbidity metrics and prioritized clinical performance metric dashboards for all PPS patients. The Committee will continue to work with the RHIO to support the PPS and DSRIP projects by defining requirements for quality metrics under development.

4. **Workforce Committee:** ***Selena Griffin-Mahon, Bronx-Lebanon Hospital Center, Assistant Vice President, Human Resources, Committee Chair.*** The Workforce Committee is comprised of members from various partner agencies and representatives from three unions. Many of the members also serve on other committees, which enables collaborative communication that benefits various DSRIP projects. Several project partners participate in the Bronx Health Care Learning Collaborative, an innovative multisector partnership between other PPSs, 1199 SEIU, the Training & Education Fund, CUNY, health care institutions, and other organizations, to improve the health care industry and standards of care. Furthermore, partners participate in the Greater NY Workforce Committee, created by the Greater NY Hospital Association, a forum for information sharing, and where issues needing advocacy with NYS can be discussed. The Committee has successfully implemented staff training plans and strategies, with support from lead vendor, the *Training Education Fund*, to focus on the health and well-being of patients using a patient-centered care model including: DSRIP awareness classes for all staff (direct and non-direct care); and the “Language of Caring Program” that fosters engaged communication between physicians, patients, families, and the health care team. This program also provides Spanish classes for physicians, nurses, patient care technicians, nurse leaders, and social workers. Refresher courses are offered to maximize skills for all licensed staff, and to upgrade skills, creating a path to certification for paraprofessionals and staff with their GED (e.g., Social Workers, Substance Abuse Counselors, Medical Assistants, Patient Care Technicians, Care Coordinators, Peer Educators, etc.). The Committee surveyed partner agencies to assess staffing and training competency needs to support DSRIP project goals. Currently, a project leader or project manager can send a training request to the Committee, and customized curriculums, developed by various vendors, are offered to project staff. The Committee will be running three multi-site recruitment sessions in order to increase training for bi-lingual nurses (English and Spanish, or English and French) through an accelerated program to improve service delivery to the PPS’ diverse patient population.

5. **Compliance Committee:** ***Jasmine Gourdain, Bronx-Lebanon Hospital Center, Chief Compliance Officer, Committee Chair.*** The Compliance Committee consists of key leaders from several partner agencies including Uptown Health Care Management, Inc. (a primary care provider organization); and the Visiting Nurse Service (providing in-home nursing care, therapy, hospice, and palliative services). In consultation with Garfunkel Wild, PC, the Committee has developed a work plan and QI strategy to govern all PPS project activitites. Subsequently, the necessary policies and procedures for financial accountability, guidance for health care quality, and staff training were developed to monitor compliance. All Committee policies are based on guidance from the Office of the Medicaid Inspector General (OMIG). The Committee developed a survey to assess the status of each partner's internal compliance structure, as defined by OMIG, and to ultimately determine resource needs. Survey questions included: "Do you have a functioning compliance program?" "Do you have a compliance officer?" "Is there an overall quality management framework?" All responses are expected by the end of Quarter 2 and will facilitate future and ongoing Compliance Committee activitites.

The following cross-functional Workgroups report to the Clinical Quality Committee.

1. **PCMH Cross-Functional Workgroup:** ***Blaze Gusic, MD, Bronx-Lebanon Hospital Center, Medical Director Outpatient Services, Attending Physician Department of Pediatrics, Workgroup Lead.*** Five of the PPS' DSRIP projects require the achievement of 2014 Level 3 PCMH recognition by the end of Demonstration Year 3 (2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management; 2.b.i Ambulatory ICUs; 3.a.i Integration of Primary Care and Behavioral Health Services; 3.c.i Evidence based strategies for disease management in high risk/affected populations; and 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies). The PCMH Workgroup has selected Insight Management as the chosen vendor to engage participating providers. Insight Management has organized more than 150 provider practices into four waves for strategic implementation, depending upon provider organization size and challenges anticipated. It is anticipated that the PCMH upgrade will be completed prior to the DSRIP deadline.

2. **Care Coordination Cross-Functional Workgroup:** ***John Coffey, MD, Bronx-Lebanon Hospital Center, Emergency Department Director, Workgroup Lead.*** To ensure a fully integrated delivery system within the PPS, the Care Coordination Cross Functional Workgroup is designed to improve the synergy between the project and PPS work streams to improve care coordination and service integration for Medicaid enrollees with high-cost and complex chronic conditions. Workgroup members are representatives of various PPS organizations including: R.A.I.N. (a multi-social service agency), MHA NYC (mental and behavioral health services provider), Dennelisse LHCSA (a social profit agency providing case management, health and home care services, and facilitating access to resources), Community Care Management Partners Health Home, and Premier Home Health Care. The Workgroup is responsible for developing care coordination standards and protocols to address individual patient needs. The Workgroup has successfully begun making progress on the following objectives: 1) Developing a PPS-wide understanding of care coordination provider roles and responsibilities; 2) Partnering with other DSRIP project workgroups to develop PPS-wide standardized care coordination tools; and 3) Partnering with the Workforce Committee to develop a PPS-wide staff training program to implement the care coordination/navigation plan.

3. **Stakeholder Engagement Cross-Functional Workgroup: *Roy Wallach, Senior Vice President, Arms Acres; and Joann Casado, Compliance Officer, Urban Health Plan, Workgroup Co-Leads.*** The Stakeholder Engagement Workgroup consists of three Stakeholder Managers. Each Manager is an extension of the Project Manager assigned to each PPS DSRIP project. The Workgroup has successfully eased provider communication with the assigned vendor spearheading the PCMH certification process. In these instances, relationship management was needed to liaise between Insight Management and partner agencies to alleviate concerns regarding privacy issues and to signify the importance of achieving DSRIP goals regarding practice transformation. The Workgroup acts as the initial point of contact for each partner organization from the onboarding process and conducts regular outreach with each partner. When issues are identified, these are communicated back to the Project Management office. Using this streamlined and efficient method, each partner has one point of contact for all questions, concerns, and action items relating to DSRIP. The Workgroup also maintains a roster of all potentially interested partners in the South Bronx. An introductory meeting is held to assess their interests in projects, and most importantly, to assess fit—compare gaps in the PPS to a potential partner's strengths or value added. The Workgroup has completed the redevelopment of the PPS web site, for launch at the end of the summer (2016). The newly developed web site will serve as an interactive, one-stop shop for existing and potential partners. It will feature useful PPS resources, a monthly newsletter, an events calendar, signup for email blasts for upcoming trainings, and announcements regarding quarterly town hall meetings. Due to the continuous and aggressive efforts of this Workgroup, additional Stakeholder Managers will be added to meet the needs of partners as the PPS expands.

One final cross-functional Workgroup, reports to the Workforce Committee.

1. **Cultural Competency and Health Literacy Workgroup: Diane Strom, *Administrator, Pediatrics Department, Bronx-Lebanon Hospital, Workgroup Lead.*** The Cultural Competency and Health Literacy Workgroup is comprised of members from 10 organizations, including hospitals, pharmacies, behavioral health organizations, and other community-based organizations. KPMG developed a survey to identify challenges among partners pertaining to language barriers, community needs, and other relevant conditions. A new hire will be responsible for spearheading the implementation of all Cultural Competency and Health literacy initiatives for the PPS. The incumbent will utilize a three-pronged strategy to institute free trainings: 1) face-to-face at partner sites, 2) on-line through Health Workforce Act (HWX), and 3) through mentorship. All training materials will be based on a handbook approved by the Joint Commission. As a result, a PPS-wide Health Literacy and Cultural Competency standard will govern the interaction and care of patients from different race/ethnicity, language, age, disability, immigration, and sexual orientation groups. The Workgroup's goal is to have a fully implemented Cultural Competency and Health Literacy strategy at the end of DSRIP year 1.

The PPS will continue to use the framework and strategic initiatives outlined here to further the success of DSRIP goals, achieving better care, better population health, and lower health care costs in the South Bronx.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 2.a.i

Challenges the PPS has encountered in project implementation:
The Bronx Health Access PPS chose to implement Project 2.a.i in order to provide the infrastructure, governance, evidence-based methods, IT framework, community-based collaborative networks, and payment reforms necessary to achieve health system transformation in the South Bronx. As a result, Project 2.a.i is considered to be the umbrella and scaffold for the remaining 9 DSRIP projects, and its effective implementation is vital to the overall success of the PPS. The PPS has experienced strong success in project implementation. The project team is co-led by John Coffey, MD, Chairman, Emergency Medicine, Bronx-Lebanon Hospital Center; and Debbie Lester, LMSW, Director Quality Improvement, Urban Health Plan; with support from Steve Maggio (Senior Project Manager) and Doris Saintil Phildor, MPH (Site Director). Two primary challenges have occurred in project implementation. First, given the immense significance of this project and its broad-sweeping project components, it was challenging to begin the initial project planning stages. Several key questions required consensus responses from the Steering Committee regarding how the project should be structured, which partners should be at the forefront, what planning steps should occur first, which vendors should be engaged, and to quantify available resources? Secondly, it was initially anticipated that the development of an IT solution providing inter-agency EMR connectivity and data sharing among PPS partners would be an organizational hurdle for the PPS. Additional complicating factors included the use of numerous IT interfaces and varying levels of EMR connectivity among partner agencies.
Efforts to mitigate challenges identified above:
Several solutions have been implemented to mitigate the primary implementation challenges identified. First, the project team developed the required structure necessary to organize the implementation of Project 2.a.i. with the approval of the Steering Committee. The Clinical Quality (CQ) committee was developed to strategically implement all DSRIP projects. The committee met weekly for two years (just recently moving to a bi-weekly meeting). Project 2.a.i was subdivided into tasks to be completed by separate committees including: Finance, IT, Workforce, and one cross-functional workgroup, Stakeholder Engagement. Bimonthly Project Workgroup meetings occur with all committee leads, workgroups, project teams, and PPS leaders to present project accomplishments, patient engagement strategies, and to align quality improvement strategies. Now in year 2, the focus of these meetings will shift to areas needing

development and will align to the performance measures used to accomplish DSRIP goals. The IT committee created a tracking system (quality dashboard) showing the status of quality metrics achieved and project progress in relation to patients actively engaged and the project objectives achieved.

Secondly, to begin to achieve PPS-wide health information exchange (HIE) and health information management (HIM) capabilities, the IT committee has engaged the BronxRHIO as the primary support for all participating partner organizations. The IT committee surveyed each partner to conduct an initial assessment of data sharing capabilities and existing gaps (e.g., the primary EMR and vendor, level of connectivity to the BronxRHIO, and staff IT training needs were identified). The necessary data exchange agreements were developed (between partnering agencies and the RHIO) and individual partner agencies using homegrown or paper-based systems are in the process of selecting the best EMR to suit their practice needs. The IT committee has focused the IT deployment on the most critical partners to meet DSRIP project goals first. The IT deployment will utilize a three-phased iterative approach to achieve HIE and HIM that will evolve as projects are implemented over time.

Implementation approaches that the PPS considers a best practice:

The chief implementation approach identified to date has been the development of the **Clearinghouse**. The Clearinghouse is a system of logic managed through an IT platform supported by the BronxRHIO, that serves as a centralized point of contact with multifunctional capabilities including:

- Alerts to providers, community health workers, care coordinators, and social workers in real-time when a patient is admitted to the hospital (e.g., ED, inpatient, and the Comprehensive Psychiatric Emergency Program)
- Identifies a patient's care coordinator, Health Home, and care management agency (if relevant)
- Shows insurance coverage status and Medicaid eligibility
- Deploys staff (e.g., physicians, social workers, etc.) to engage patients at the point of care and reconnects them to the PPS' care coordinators
- Refers Health Home eligible patients to a Health Home for enrollment (if they are not enrolled)
- Risk stratifies patients to target super utilizers using a LACE (Length of stay, Acuity of Admission, Comorbidities, and Emergency Department visits) score (i.e., score > 10 and > 14 ED visits in previous year), and additional elements (e.g., number of ED visits, DSRIP project eligibility) may be used as part of the risk stratification logic
- Generates accountability reports to ensure that patients are re-engaged in primary care within 30 days and that providers are routinely assessing missing services for their assigned patients
- Enables providers and care coordinators to view gaps in care (i.e., missing HEDIS measures)

Using data from the RHIO, the Clearinghouse capabilities will occur in real-time. The unparalleled capabilities of the Clearinghouse will allow the PPS to aggressively determine patient eligibility for the clinical DSRIP projects. Defined workflows specify precise protocols for super-, high-, and at-risk patient groups. The Clearinghouse is a new PPS paradigm that will support the achievement of DSRIP goals.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The project team has accomplished many of the core activities and initiatives that are critical to the success of Project 2.a.i and the development of the PPS overall including:

- Developing the system to ensure care coordination for all medical, behavioral, and long-term care, as well as, social and public health services (Core Project component #1). Using the relevant evidence-based method, each patient is risk-stratified and assigned to a care coordinator to improve disease management and a Behavior Specialist to address their social needs.
- Developing the collaboration necessary to provide a comprehensive strategy for effective population health management to meet the needs of PPS patients (Core Project component #2).
- Expanding access to high quality primary care through expansions in primary care capacity, PCMH recognition, and EMR interoperability (Core Project component #3). Two vendors have been engaged to begin ensuring all partners achieve 2014 Level 3 PCMH standards by the end of Year 2 of DSRIP. The Bronx RHIO is providing primary support for all participating partner organizations to achieve PPS-wide HIE and HIM capabilities.
- Created the governance structure for the integrated delivery system with a steering committee comprised of 12 voting members (Core Project component #4).
- Developing the financing systems (i.e., funds flow paradigms) to implement payment reform initiatives in the transition from Pay for Reporting to Pay for Performance (Core Project component #5). The PPS has a strong relationship with Healthfirst, through Bronx-Lebanon (PPS lead agency). Currently, discussions are occurring with the primary CMO partner to strategize and develop processes for the real-time management of high-utilizers.
- Beginning the deployment of a phased initiative to develop EHR linkages to promote data exchange among all eligible participating providers supported by the Bronx RHIO (Core Project component #6).
- Supporting collaboration with a broader group of providers (through the PPS' 200+ collaborating organizations and agencies) and its two Health Homes (which collectively manage the health of nearly 95,000 beneficiaries) (Core Project component #7).
- Instituting the project protocols, staff training, and guidelines to ensure competency to serve all PPS members (including patients of varying cultures, racial/ethnic and religious backgrounds, primary languages, special needs, and sexual orientations) with support from the Workforce Committee and KPMG (Core Project component #8).

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

As the overarching PPS Domain 2 project, the goal of Project 2.a.i is to focus the PPS' efforts on population health management. As such, the population targeted for Project 2.a.i encompasses all patients attributed to the PPS. As outlined in the individual project narratives, each project team is carefully reviewing the eligibility criteria established in each individual project protocol. Changes to the populations proposed will be made as needed as project implementation continues.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:
The following challenges have been encountered as the Project 2.a.iii team begins to implement the Health Home At-Risk Intervention Program: • A few PPS partners have been reticent to hire community health workers because they do not know if they will have a sufficient panel size to support a full-time staff person, under the new per member, per month reimbursement model. • CHW access to CareDirector® case management software is currently limited. CareDirector® is a fully integrated case management, time and attendance tracking and billing system, which allows providers to manage care plans, document work activities and bill for services. Some partners do not have the software and those that have acquired the software need to train their CHWs on how to use it. A related issue is the significant lag time, which can be as long as one week, between the CHW seeing the patient and data entry into CareDirector®. Currently, primary care providers do not have electronic access to CHW notes in CareDirector®. One of the future PPS challenges for Project 2.a.iii is program sustainability. Unlike Health Homes (HH), HH At-Risk interventions are not reimbursable services. During the DSRIP demonstration project, DSRIP funds will be used to pay for care coordination services on a per-member, per-month basis.
Efforts to mitigate challenges identified above:
Supporting the cost of community health workers to provide HH at-risk services is most appropriately addressed by providing payor reimbursement for these services. Bronx Health Access, in collaboration with other PPSs and professional associations, will advocate to have CHW services reimbursed by New York State Medicaid. In the interim, the PPS is working on developing bonus funds for CHWs who meet quality measures. The access issues with the CareDirector® care management software have been partially addressed and additional solutions are being developed going forward. Access to CareDirector® has been made available through BLHC's license to active partners that do not have the software and BLHC has provided two staff training sessions on use of the software. The PPS is in the process of hiring a HH At-Risk Coordinator who will be responsible for entering patient data into CareDirector®, in real time during business hours, so that patients can be enrolled into the program at the point of care. The PPS is pursuing an electronic solution with the BronxRHIO to connect CareDirector® with the Allscripts EHR, so that providers at Bronx-Lebanon and the Dr. Martin Luther King, Jr. Health Center can see CHW notes in CareDirector®. This will occur in the

very near future. The PPS is also working with the RHIO to enable information exchange on patient demographics and HEDIS measures, which can populate the Care Assessment/Care Plans of any given HH At-Risk patient). A longer term solution, which is currently being piloted with the Greater New York Hospital Association Care Plan Collaboration, is the upload of Care Assessment/Care Plans into the RHIO, where they will be available to any PPS provider with RHIO access.

Implementation approaches that the PPS considers a best practice:

Bronx Health Access PPS has created several unique approaches or practices that are proving successful to the implementation of the HH At-Risk Intervention Program in the Bronx:

- Development of a care coordination Clearinghouse or set of rules, agreed upon by the PPS leadership, that defines which patients are at highest risk of not achieving a pay-for-performance metric and establishes a specific organization accountable for managing the care of these high-risk individuals.
- Development of a hybrid community health worker model, whereby CHWs that work for the Health Home will also serve patients in the HH At-Risk program. This is a more efficient staffing model, particularly for smaller providers, who cannot support the salary of a full-time CHW. The hybrid model will also ensure that CHWs meet DSRIP productivity requirements—completing 300 annual care plans.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The 2.a.iii project team has accomplished many of the core activities and initiatives that are critical to the success of the project.

- The 2.a.iii committee has successfully built an equitable collaboration of PPS members to implement the HH At-Risk Intervention Program. Bronx-Lebanon, as the PPS lead, has developed good working relationships with its PPS partners and incorporated partners at all levels of participation into the planning and implementation of the project. Several partners have committed at a core level to hiring a care coordinator or CHWs to manage the care of higher risk patients who are not eligible for the Health Home. Five partners (Boom Health, Brightpoint, Hudson Heights IPA, Unique People Services and Uptown Health Care Management) have hired care coordinators or CHWs and have begun to enroll patients. Bronx-Lebanon is also in the process of hiring CHWs.
- The PPS has developed Standards of Care Guidelines for providing HH At-Risk Intervention services that incorporate the five core services for Care Coordination services and health care delivery (from the NYS Health Home Standards), which define the eligible target population and describe the responsibilities of the HH At-Risk Care Coordinator.
- The project team is in the process of engaging a training vendor through 1199 SEIU Training & Employment Funds to conduct two-day training workshops for CHWs. Future training for HH At-Risk program staff will include presentations on the IMPACT model, and training for physicians on how to integrate CHWs into their practice.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The 2.a.iii project team has invested considerable effort in defining patient eligibility for the HH At-Risk Program. Eligibility criteria were developed based on qualifying medical conditions and social and behavioral factors that put patients at risk for progression of disease, development of complicating conditions, and for poor health outcomes. Individuals at risk for homelessness and those who exhibit high utilization patterns will be designated as priority populations. The eligibility criteria will be reviewed annually and adjusted, as needed, to ensure that the program is capturing the target population—Medicaid enrollees who do not meet the criteria for Health Homes, but who are on a trajectory that will result in becoming Health Home eligible.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 2.b.i

Challenges the PPS has encountered in project implementation:
The PPS has experienced initial success in the implementation of Project 2.b.i under the leadership of Jeffrey Levine, MD, Chairman Psychiatry, Bronx-Lebanon Hospital Center; Isaac Dapkins, MD, Medical Director, Ambulatory Care, Bronx-Lebanon Hospital Center; and Debbie Lester, LMSW, Director Quality Improvement, Urban Health Plan; with support from Kathleen Craig, Senior Project Manager. The project team has encountered two primary challenges in project implementation. As initially anticipated in the DSRIP Project Plan application, developing resources—primarily for staffing and secondarily for the space needed to implement the project activities—has been a great challenge. First, hiring the needed providers (i.e., psychiatrists and nurse practitioners) and staff (i.e., care coordinators, care mangers, social workers, and nutritionist) for the project has been difficult. Particularly as the time and care commitment required for patient visits will be extensive at the outset, creative solutions are needed to attract and recruit talented personnel. Second, a dedicated location is needed to accommodate a fully integrated medical psychiatric center where patients can receive both primary care and psychiatric services on-site. In this model, the fully integrated multi-specialty provider team can accept Ambulatory ICU (AICU) referrals and align these services with the implementation of Project 3.a.i (Integration of Primary Care and Behavioral Health Services). At the outset, large resource investments are needed to create and stabilize the infrastructure required to properly implement AICUs in the PPS. While initially resource intensive, financial projections support that the move towards Value Based Payment in later DSRIP years will show financial improvements (as high-utilizer inpatient admissions, readmissions, and ED visits are reduced).
Efforts to mitigate challenges identified above:
Several solutions have been implemented to mitigate the primary implementation challenges identified. First, the PPS has contributed significant resources towards staff hiring: 1 FTE psychiatrist, 1 FTE nurse practitioner, and 1 FTE social work assistant. The psychiatrist will be working at the Bronx-Lebanon Center for Comprehensive Care (CCC) (three days per week) with a focus on patients with HIV/AIDS who have other comorbidities (nearly 500 patients). The nurse practitioner, currently at the CCC, will focus on patients who are chronically mentally ill with medical comorbidities. The social worker assistant will work at the OMH licensed BronxCare clinic, located at 401 East 167 Street in the Bronx. Currently, the team communicates with primary care providers through secure messaging. Aggressive recruitment efforts will continue to add care coordinators, and other needed staff to the team through collaborative efforts with project partners

(VIP Services, Inc., and Urban Health Plan) and the Workforce Committee. Once the provider team is fully staffed, the early experiences gained will position the providers well for system transformation in later DSRIP years and beyond.

Second, a new location has been identified in the Concourse Division of Bronx-Lebanon (1775 Grand Concourse). Capital Restructuring Financing Program (CRFP) funds will be utilized to renovate the new location, provide the necessary equipment and connectivity, and align it to specifications regarding the pod layout for accessible and sequential team based care. It is anticipated that the new space, to see patients and accept referrals, will be fully operational by the Summer of 2017. At the same time, Urban Health Plan has also instituted a system of comprehensive team meetings for selective high-risk primary care patients in a highly successful manner. Plans to spread the AICU to other agencies are targeted for DY3 and DY4. In the meantime, the current AICU's will serve as consultative resources for other PPS partners.

The solutions presented demonstrate existing efforts and assets that have been mobilized to achieve full implementation of project 2.b.i.

Implementation approaches that the PPS considers a best practice:

The project team is pleased that the speed and scale of implementation targets for year 1 have been met, and is confident that the project will remain on track to meet the year 2 targets identified. To date 267 participants for DY2 have been enrolled in the project. The lead and partner agencies are well positioned to provide the culturally competent, multi-disciplinary, multi-specialty care required for project implementation given their capacity, experience, and extensive collaborative efforts through the PPS' two Health Homes (Bronx Health Home and Community Care Management Partners). Yet, the project leaders acknowledge the immense difficulty in addressing the full gamut of patients' physical, mental, and social needs.

In the course of conducting project activitites, a significant best practice developed by the Dartmouth Group has been identified. The Dartmouth Group has conducted several studies showing the effectiveness of a health-promotion program for obese adults with SMI, *InSHAPE*, that provides personalized fitness and nutrition coaching by a fitness trainer or *Health Mentor*. They have gained experience running a statewide implementation study including a learning community to facilitate implementation of *InSHAPE*. In 2014, the Co-investigators from Bronx-Lebanon (Dr. Jeffrey Levine, Chair Department of Psychiatry; and Dr. Kamala Greene) participated with researchers from Dartmouth University, and other Community Mental Health Centers in the first proposed study to empirically evaluate the effectiveness of a virtual national Learning Collaborative, and the *InSHAPE* program compared to conventional implementation (consisting mainly of instruction only). Bronx-Lebanon served as one site in the first cohort of 12 organizations to implement the *InSHAPE* program with adult patients diagnosed with SMI and a BMI > 25. Patients were assigned a *Health Mentor* and given a free gym membership. Over the course of the 12-month program, patients experienced not only improvements in physical capacity but a marked positive response in terms of self-confidence and, in a few patients with a history of multiple psychiatric hospitalizations, very impressive decreases in hospital admissions. Bronx-Lebanon participated in monthly virtual meetings with program staff and workgroups with other participating sites over an 18-month period.

The *InSHAPE* model is our best transformative evidence to date on how to effectively transform community mental health organizations by embracing patient wellness as central to our mission and services. Future plans are to use DSRIP funding to expand this program to support activities for project 2.b.i and invite more patients to participate.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Many other initiatives have supported successes to date in accomplishing the stated project objectives. First, as stated in the Project Plan Application, it was initially anticipated that the development of an IT network sharing platform would be an organizational hurdle for the PPS. While all project partners have not yet reached the same level of connectivity, the project team in collaboration with the IT Committee is developing a one-view spreadsheet for each patient using data from the BronxRHIO provided in real-time (i.e., patient demographic information, MCO PCP name, homelessness flags, primary care facility misalignment flag, behavioral health utilization history, etc.). The Bronx Health Access PPS Clearinghouse initiative will serve as a central point of contact for PPS providers and a vehicle to alert AICU staff when an at-risk patient is in the ED or admitted to the hospital. When notified, care coordinators will be deployed to the Inpatient, ED, and Psychiatric ED.

Secondly, the PPS projects are highly interconnected, for example, project 3.a.i (Integration of Primary Care and Behavioral Health Services) and project 2.b.iv (Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions), along with this project, will utilize the same referral systems, collaborative care model, criteria for high-utilizers, and the Clearinghouse. A main venue that provides a consistent opportunity for interaction between the project team, workgroups, and the PPS leadership is the bimonthly Project Workgroup Meeting. In addition, the PPS-wide Clinical Quality Meeting is used to present project accomplishments, patient engagement strategies, and to align quality improvement strategies. These meetings will incorporate patient engagement strategies as well as performance measures that will ultimately be used to accomplish DSRIP goals.

Future plans are to continue the in-depth care review and care planning provided through the project, and ultimately entrust four PPS agencies with the expertise to implement AICUs.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The population originally targeted for this project consisted of: individuals who have had (in the previous 12 months) one or more potentially avoidable hospital admission and/or two or more potentially avoidable ED visits. Further eligibility criteria include: persons ages 18 and over who have presented with one or more of the following in the last 12 months:

- One mental health condition; or
- One substance abuse condition/addiction; and
- One or more co-morbid chronic condition (characterized as ambulatory care sensitive conditions, or, chronic conditions such as diabetes, cardiovascular related diseases, behavioral health, chronic renal disease, and respiratory related conditions).

The project team does not anticipate any changes to the target population as project implementation continues.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:
The PPS has experienced strong success in the implementation of Project 2.b.iv. The project team, led by Natalie Cruz, MSN, RN, Care Transitions Manager, Bronx-Lebanon Hospital Center; and Isaac Dapkins, MD, Medical Director, Ambulatory Care, Bronx-Lebanon Hospital Center; with support from Kathleen Craig, Senior Project Manager; has encountered three primary challenges in project implementation. First, as initially anticipated in the DSRIP Project Plan application, patients living with chronic conditions in the service area experience significant social barriers to medical care arising out of their underlying unmet socioeconomic and psychosocial needs; namely, high poverty, homelessness, and regular access to food. The comprehensive Community Needs Assessment showed that more than 38% of households in the PPS live below the Federal Poverty Level (compared to 19% in NYC and 14% in NYS). Second, the project team has encountered some difficulties engaging a subset of care coordinators in specific instances, for example during evening and nighttime shifts (4pm-12am). Third, many patients served have low health literacy. Compounding low health literacy is the low educational attainment among South Bronx residents (61% of PPS residents graduated high school, compared to 79% in NYC and 85% in NYS).
Efforts to mitigate challenges identified above:
The three main project objectives are to provide—1) pre-discharge patient education, 2) care record transitioning to the receiving practitioner, and 3) community-based support for the patient over a 30-day transition period post-hospitalization. Several solutions have been implemented to mitigate the three implementation challenges identified in support of the aforementioned project objectives. First, of the more than 200 PPS partner agencies collaborating to implement all DSRIP projects, 33 provide housing services for homeless populations; 11 are food banks, community gardens, and farmer's markets; 10 are not-for profit welfare agencies; 20 provide employment support services; and 7 are HIV Prevention/Outreach and Social Service Programs. When patients are enrolled in the project, the Care Transitions Nurse conducts an initial inpatient interview to assess medical, behavioral, and social needs. When challenges are identified and documented on the Problems and Intervention Form, the Care Coordinator identifies partner agencies that provide relevant services to meet patient needs, and coordinates referrals as needed in support of the project objective (to provide community-based support

for the patient post-hospitalization).

Second, to engage care coordinators during an ED visit and during a short admissions timeframe, the BronxRHIO was engaged to expand capabilities of the Allscripts EHR system. Following these upgrades, internal alerts have been built into Allscripts which notifies the Care Transitions Team once a high-utilizer is registered in the ED. The Care Transitions Team has more lead time to contact the appropriate Care Coordinator and initiate project protocols (in support of project objectives to develop care record transition and post-hospitalization community-based support for patients). Furthermore, monthly Quality Assurance/Quality Improvement meetings are used as a venue to hold Care Coordinators accountable for attendance and accomplishing project tasks. Finally, a job posting has been published for a licensed Social Worker (LMSW in NYS) to staff the 4pm-12am shift. This novel addition to the Care Transitions Team will fill needed gaps in service during a shift that has been largely understaffed.

Third, patients with low health literacy may not understand the instructions given by providers, specifically regarding their medications. Polypharmacy (when providers independently prescribe multiple medications) was identified as a risk to patients upon discharge from the hospital. In the worst instance, problematic polypharmacy can lead to drug interactions and life-threatening medication side effects. This challenge has been resolved through the addition of a Clinical Pharmacist to the Care Transitions Team. The Clinical Pharmacist engages patients at the bedside providing pre-discharge patient education (a project objective) and provides medication reconciliation when more than eight medications have been prescribed as part of the patient's discharge plan. Other topics discussed include anti-coagulation and medication management. The Pharmacist also acts as the liaison for the Home IV Infusion program. In this program, the Pharmacist is informed when patients are discharged on long-term antibiotics to ensure that patients receive their medications at home as scheduled. The Pharmacist is also contacted to ensure that discharged patients have been in contact with the visiting nurse agency for related self-teaching. In addition, the Pharmacist is the point of contact with the IV Infusion company when a provider needs to be reached for consultation.

Implementation approaches that the PPS considers a best practice:

The project team is pleased that the speed and scale of implementation targets for year 1 have been met, and is confident that the project will remain on track to meet the year 2 targets identified. Three best practices have been identified which have largely added to the project's successful development and initial implementation.

First, the use of the Coleman Care Transitions Model as the evidence-based clinical intervention protocol to reduce risks of readmissions across care settings has largely guided the development of the Care Transitions project and subsequent QA/QI procedures. The Care Transitions Team uses the LACE (Length of stay, Acuity of Admission, Comorbidities, and Emergency Department visits) Index/Score to prospectively review the status of admitted patients and determine their risk for future hospitalizations. This model has dovetailed well with the existing continuity of care protocols in place at Bronx-Lebanon, partner agencies, and with community providers.

Second, the project team has benefited from participation in the Medicaid Accelerated eXchange (MAX) Series. This learning collaborative has provided actionable support for the project with cross-PPS collaboration opportunities, and ready access to clinical and subject matter experts. In particular, the second workshop (topic 3) entitled "Managing Care for Super Utilizers" conducted on May 12, 2016 led to: the prioritization of performance measures to be targeted for improvement, the creation of an "Action

Team" staffed with key clinical leaders at Bronx-Lebanon who are engaged in meeting the complex care needs of high-cost patients, and activities to prevent high-risk patients from becoming super-utilizers. The Action Team attends weekly status calls with KPMG to address action plans that resulted from the MAX workshops (1 and 2). PDSA cycles are routinely used to implement rapid-cycle evaluation to address poor, satisfactory, and above satisfactory performance. As needed, changes to protocols are made and monitored as part of the overall QA/QI process.

Third, the project team has benefited strongly from the existing infrastructure of the Bronx Health Home, (Bronx-Lebanon Hospital is the lead agency). Using this framework, the project team has utilized many existing care management agency partners (who are PPS members) as referral sources for patients in this project. This has enabled continuity of care and seamless transitions across the care spectrum for patients. Through these activities, partner interest has increased in the Health Home and other DSRIP projects.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Many other innovations and initiatives have supported successes to date in accomplishing the stated project objectives. Chiefly, the Clearinghouse, a system of logic managed through an IT platform supported by the BronxRHIO, aligns PPS patients with Care Coordination services. The Clearinghouse is a centralized point of contact with multifunctional capabilities including:

- Alerts to care coordinators in real-time when a patient is admitted to the hospital (e.g., ED, inpatient, and the Comprehensive Psychiatric Emergency Program)
- The identification of a patient's assigned care coordinator and Health Home (if relevant)
- Alerts to the primary care provider that the patient is admitted
- Deploys staff (e.g., physicians, social workers, etc.) to engage patients at the point of care and reconnect them to the PPS' care coordinators
- Refers Health Home eligible patients to a Health Home for enrollment (if they are not enrolled)
- Risk stratifies patients targeting super-utilizers using the Coleman Model (LACE score/index)
- Generates accountability reports to ensure that patients are re-engaged in primary care within 30 days and that providers are routinely assessing missing services for their assigned patients
- Enables Providers and Care Coordinators to view gaps in care (i.e., missing HEDIS measures)

Using the existing infrastructure established through the Health Home, matched with the unparalleled capabilities of the Clearinghouse, the PPS can more aggressively connect patients to Care Transitions Support, the Health Home, and other DSRIP projects. Defined workflows stratify and specify precise protocols for super-, high-, and at-risk patient groups. Successful collaborations with the Healthfirst health plan have and will continue to enable the PPS to intervene and decrease admissions with high-utilizers first through transitions of care protocols. With this scaffold, the PPS is now ready to address the ultimate DSRIP goals to reduce preventable admissions and re-admissions.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The project team has defined high-utilizers as patients with four or more inpatient admissions over a one-year period, or at least 16 ER visits per year. The population targeted for this project consists of patients who are at risk of becoming high-utilizers. Revisions to the target population's age (originally documented in the Project Plan Application) have been made. Per the project protocol and Operations Manual, the target population for the project now consists of:

- All individuals with a hospitalization
- A LACE Index score greater than 11; and
- With special attention to children (18 months - 18 years) with asthma and diabetes, and adults (ages 19 years and older) with asthma, diabetes, congestive heart failure, reactive airway disease, chronic obstructive lung disease, psychotic or mood disorder, and cocaine, alcohol dependency, and/or heroin dependency.

The project team anticipates expanding this population in August 2016 to include patients with behavioral health disorders treated in the inpatient and outpatient Psychiatric units.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Bronx Health Access PPS has encountered relatively few challenges in implementing Project 3.a.i. The challenges encountered thus far are described below.

1. PPS partners have expressed the intricacies of being able to appropriately bill for SBIRT. Training for billing staff may be needed in order to insure that the appropriate codes are being used. The care team staff may also require training in succinct documentation that will support the relative coding structure.

2. Universal screening for depression has been adopted at all Bronx-Lebanon primary care sites, using the PHQ-2 and PHQ-9 screening tools. A template for capturing the data from the PHQ-9 screenings has been developed and is incorporated into the EHR system, allowing outcome data to be easily extracted. A similar capability for non-Bronx-Lebanon partners does not currently exist for capturing results from the PHQ-2 screens, making it difficult to get accurate counts of the patients that have been screened using this tool. Partners of the PPS have also standardized the use of PHQ-2 and 9 at their primary care sites.

3. Patients that received a score of 15 or higher on the PHQ-9 screen will be referred to the Depression Care Manager, for brief therapeutic interventions. Although the Depression Care Manager has been hired, patients are not yet being seen, due to delays in the Depression Care Manager obtaining the required certification (Model 3, Milestone 11), which includes specialized training in behavioral activation and problem-solving therapy. The initiation of treatment by the Depression Care Manager is off by one month as a result.

4. The implementation of an electronic patient registry to track patient engagement (Model 1, Milestone 4) has not been achieved to date. The PPS was initially going to use a system developed by the University of Washington, a partner on a related collaborative care project, but encountered potential liability over the ownership of patient data. Currently, the data is being collected manually, using Excel, while an alternative solution is being developed.

Efforts to mitigate challenges identified above:

1. For the first challenge, the project workgroup has begun discussions on current practices of SUD and delved a bit deeper into the coding issue.

2. For the second challenge, the inability to electronically capture the PHQ-2 screening data, the PPS Information Technology committee will develop a template, similar to the one created for the PHQ-9, which will allow Project Managers to extract data from the EHR, using a simple query.

3. For the third challenge, the delay in obtaining certification for the Depression Care Manager, the PPS has scheduled the required training classes, which will be conducted at the University of Washington. Trainings completion is yet to be determined.

4. For the fourth challenge, implementation of an electronic patient registry to track patient engagement, the PPS is temporarily using Excel for data collection. The PPS Information Technology committee has received a work request to develop the electronic patient registry and is pursuing a straightforward electronic solution, whereby data will be extracted from billing software. It is expected that the electronic patient registry will be fully operational by the end of DSRIP year two.

Implementation approaches that the PPS considers a best practice:

Bronx Health Access PPS, led by Bronx-Lebanon Hospital Center, considers co-location of behavioral health providers and the implementation of the Collaborative Care model to be a best practice. To effectively meet the milestones for Project 3.a.i, integration of primary care services and behavioral health, the PPS is collaborating with the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center, to implement the evidence-based Collaborative Care model. Developed by the University of Washington, the Collaborative Care model (IMPACT) is a specialized care model that treats common mental health conditions, such as depression and anxiety, which require systematic follow-up due to their persistent nature. Based on the principles of effective chronic illness care management, it focuses on tracking defined patient populations in a registry, and providing evidence-based psychosocial or medication treatments, supported by psychiatric case consultation, and treatment adjustment for patients who are showing the expected level of improvement. Collaborative Care has been tested in more than 80 randomized clinical trials and is shown to consistently lead to better patient outcomes, improved functioning, and lower health care costs, while achieving higher levels of provider and patient satisfaction.

The AIM Center, whose mission is to improve the health of populations by advancing effective integrated behavioral health care, tests and helps implement Collaborative Care. The Center has worked with over 6,000 clinicians in 1,000 clinics to implement the model. The 3.a.i. project committee has engaged training faculty from the AIMS Center to provide coaching and support for implementing the Collaborative Care model at PPS primary care sites. AIMS Center staff have provided formal training to clinic staff in Collaborative Care and conduct weekly conference calls to support the PPS implementation of the model. The PPS's approach to implementation employs the use of project work groups to identify shared challenges, the PPS Information Technology committee supports tracking and reporting activities.

For various reasons, certain Bronx Health Access community partners are not able to implement IMPACT. In these instances, they will develop a plan to enhance their current process of co-locating behavioral health

services in their primary care sites. Co-location is a strategy where multiple services are housed under the same roof, which will ultimately strengthen the outcome of the services to the target population. Evidence has shown that co-location improves diagnosis and treatment and produces greater engagement of patients in mental health care, resulting in better outcomes and lower medical costs. The PPS looks forward to standardizing the behavioral health co-location process, based on the partners' experiences, and will share a workflow that other community-based organization can implement.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

For Project 3.a.i, integration of primary care services and behavioral health, Bronx Health Access PPS is implementing model 1 (PCMH Site) and model 3 (IMPACT). The PPS plans to add and standardize SBIRT screening during DSRIP year three. The interaction of the behavioral health provider and the patients will include screening for other mental health illnesses, including substance use disorders. The PPS will also incorporate other screening tools, such as the GAD 7 for anxiety, which will be administered by the behavioral health provider/Depression Care Manager. Initially, nine primary care clinic sites operated by Bronx-Lebanon Hospital Center and the Dr. Martin Luther King, Jr. Health Center will participate in Project 3.a.i; one site, Fulton Family Medicine, has been selected as the pilot site to integrate behavioral health services into primary and to implement IMPACT. The pilot site went live on July 15, 2016. Two staff have been hired for the project, a psychiatrist and Depression Care Manager. They are working with training faculty at the University of Washington AIMS Center to implement the Collaborative Care model. Universal screening for depression, using the PHQ-2 and PHQ-9, has been established at all Bronx-Lebanon primary care sites. Two information technology projects, to track engaged patients and PHQ-2 results in the EHR, are getting started. For Project 3.a.i, it is expected that all PPS primary care clinics will employ the integrated care model and go significantly beyond its target for actively engaged patients by the end of DSRIP year two.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

The at-risk population for the Collaborative Care intervention is currently being defined as patients who score 15 or higher on the PHQ-9 screening tool and also screen positive using SBIRT. This defined population will receive the services of the Depression Care Manager. As clinical staff gain experience in this model, the PHQ-9 cut-off score of 15 will be evaluated, based on patient outcomes and available resources. The cut-off score may be changed in the future, which may result in a larger or smaller patient population.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 3.c.i

Challenges the PPS has encountered in project implementation:

There are several challenges that the PPS has encountered.

1. One of the challenges encountered by Bronx Health Access in implementing Project 3.c.i., evidence-based strategies for disease management in high-risk/affected populations (adults only), is engaging the primary care providers to participate in training. Providers need training in each component of the model selected for treating patients with diabetes, as well as those at high risk for developing diabetes—American Diabetes Association's Standards of Medical Care for Diabetes—2016, Stanford University disease self-management program, and the Chronic Care model. The PPS goal is to engage and train 80% of primary care providers by the end of DSRIP year two. Some of the provider practices are concerned that they will have to recruit and hire additional staff, such as Certified Diabetes Educators or Community Health Workers (CHWs). Others, especially those providers who have been in practice for many years, are reluctant to invest the time and effort to make the necessary changes in their practice.

2. Another challenge is ensuring that all diabetic patients in each practice receive the recommended exams and lab tests, such as annual dilated eye and foot exams. Within PPS practices, patient compliance with annual eye exams is problematic. Patients are scheduled for eye exams when they see their primary care provider, but may not show up for the subsequent appointment.

3. In addition, recruiting and retaining peers to train patients in the diabetes self-management program is a challenge to implementing the Stanford disease self-management program. To qualify as a self-management educator, peers must be patients or staff diagnosed with diabetes. The training for staff is 4.5 days and four days a week for five weeks for peer coaches.

4. Finally, partners need to track and engage diabetic and pre-diabetic patients to meet process and outcome measures. This requires a diabetes registry, hot spotting strategies, and the practice to be in tune with the tenets of a patient-centered medical home.

Efforts to mitigate challenges identified above:

Bronx Health Access has formulated effective strategies for mitigating the challenges identified above.

1. To improve provider engagement, the Project 3.c.i committee is enlisting the support of other DSRIP committees that have developed good relationships with physician practices and have been effective at engaging their participation for other DSRIP project activities. Once such committee is the Stakeholder Engagement Committee, a cross-functional committee that supports all the DSRIP projects, and the Patient-Centered Medical Home (PCMH) committee. The PCMH committee has been successful in engaging physician practices, partly due to payment incentives provided to physicians that achieve NCQA PCMH recognition. The project will also engage leadership of partners and work with physician leads to facilitate buy-in. The Project 3.c.i committee has adopted the "train the trainer model" to disseminate training throughout the PPS and monitor adoption of the guidelines.

2. To improve diabetic patient compliance with obtaining an annual dilated eye exam, the Project 3.c.i team is instituting a practice, whereby patients will be able to receive an undilated retinal photograph during their primary care visit, eliminating the need to attend a separate medical appointment with an ophthalmologist. Retinal eye cameras will be supplied for primary care practices and staff will be trained to take the retinal photographs. The retinal pictures will be forwarded to an ophthalmologist for review. Patients with abnormal photographs will be scheduled for an appointment with an ophthalmologist, while patients with normal eye exams may not need an eye visit. The PPS will embrace use of HbA1c point-of-care testing instruments to monitor patients with diabetes and those at high risk of developing diabetes. This obviates the need for patients to have blood drawn for laboratory analysis.

3. The PPS has developed a strategy for recruiting and retaining peers to educate patients in diabetes self-management. The primary care practices in the PPS represent a large pool of diabetic patients. The support of primary care providers will be enlisted to recruit peer educators from within the PPS practices. To encourage patients to volunteer to become peers, the PPS will create an incentive program, providing MetroCards for transportation during the training, and offering small stipends, to show appreciation for their volunteer work as peers. The Project 3.c.i committee will also encourage staff to be trained, including those with diabetes, to increase the pool of trainers.

4. The Bronx RHIO has created a diabetes registry that is used to track and manage the population of diabetes patients. Partners will be encouraged to join the RHIO to ensure care coordination and management of diabetic and pre-diabetic patients.

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Implementation approaches that the PPS considers a best practice:

The Project 3.c.i committee has found the following implementation approaches to be successful for the Bronx Health Access PPS.

- Bronx-based physicians were surveyed on the use of evidence-based guidelines in their practice. The committee selected evidence-based strategies for treating patients with diabetes, and those at risk for diabetes, that were most familiar and widely accepted by the primary care physicians surveyed. The evidence-based practices for diabetes management chosen by the committee include the American Diabetes Association's Standards of Medical Care in Diabetes—2016, the Stanford chronic disease self-management program, and Wagner's Chronic Care model. Moving forward with this strategy will reduce the amount of time spent training each physician and will minimize disruption to the provider's time while seeing patients.
- The Project 3.c.i committee is committed to offering various training formats to make trainings easily accessible to providers. Training will be offered in lecture and webinar formats. The PPS has also adopted the "train the trainer model" to educate all partners and sustain training efforts. Participating in the Bronx RHIO provides access to a diabetes registry that all partners can use, whether or not they have an EHR.
- The committee has also developed and employed an algorithm to risk-stratify the patient population for participation in Project 3.c.i.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Project 3.c.i committee has established a solid foundation for implementing evidence-based strategies for disease management for adult patients with diabetes or at high risk for diabetes. Accomplishments to date include:

- Meeting speed and scale targets
- A high rate of provider performance in meeting ADA-recommended HbA1c testing schedules, using point-of-care glucometers at primary care physician offices
- Evaluation and selection of evidence-based guidelines and strategies—the American Diabetes Association's Standards of Medical Care in Diabetes—2016, the Stanford chronic disease management model, and Wagner's Chronic Care model
- Initiation of provider training in the three components of the disease management model
- Development and implementation of a risk-stratification algorithm to define the patient population
- Beginning the selection of care coordination providers to serve high-risk patients
- Initiation of group education visits by Diabetes Health Educators
- Initiation of shared medical visits at Bronx-Lebanon practice sites, with high-risk patients seeing their primary care provider, diabetes health educator, social worker, and pharmacist all in one visit
- Collaboration with the PPS Information Technology Committee and the Bronx RHIO to develop a registry for "hotspotting" patients in high-risk neighborhoods and a performance measure dashboard
- Initiation of meetings with Managed Care Organizations to identify patients in the target population

Initiatives in the planning stages that will be implemented by the end of the demonstration year include training and implementation of retinal eye exams; training of peers and patients in diabetes self-

management; expansion of shared medical visits to additional PPS practice sites; development of care coordination policies and procedures; and contracting with partner organizations to provide care coordination services to the defined patient population.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

Bronx Health Access does not anticipate any changes in the population being served by Project 3.c.i. It will continue to serve all patients with diabetes and pre-diabetes.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 3.d.ii

Challenges the PPS has encountered in project implementation:

Bronx Health Access has encountered several minor challenges as it begins to develop and implement a home-based self-management program for adults and children with asthma. The PPS has identified strategies to mitigate these challenges, as described in the next section.

1. The most common problem encountered thus far has been getting access to patients' homes in order to conduct the initial home environmental assessment. Patients and families are often wary of allowing strangers into their homes and are reluctant for staff to invade their privacy and judge their home environment. This is particularly true when pediatric asthma patients live in homes where smoking is permitted indoors. Parents do not want to be identified as being the source of second-hand smoke for their children. More challenging is getting access to homes where marijuana is smoked, or where families fear identification by Immigration and Customs Enforcement officers.

2. Another challenge for program staff has been the administration of the questionnaire used to screen patients about potential asthma triggers in their home environment. The initial questionnaire contained sensitive questions, for example, regarding the presence and extent of dirt and mold in their home. This question can be interpreted as stigmatizing in some instances. The challenge has been to find a way to obtain the needed information, without offending the patient, and ensure that the patient is cooperative about participating in a home visit.

3. Although the PPS has recently instituted the home environmental assessments as part of the comprehensive home-based self-management program for patients with asthma, the PPS has already encountered some homes where the environmental conditions are not only unhealthy, but unsafe. In some cases, the appropriate resolution is to relocate the family on a temporary or permanent basis. Many of the solutions to remediating environmental triggers for asthma are expensive to implement. These include replacing carpeting with suitable floor coverings, providing pest management services, and upgrading HVAC systems. Families and landlords cannot always afford to make these recommended environmental changes and the DSRIP project has limited funds to assist in remediation efforts.

Efforts to mitigate challenges identified above:

Bronx Health Access has developed several effective strategies for mitigating the challenges identified above and continues to explore creative solutions to improve program implementation.

1. The Project 3.d.ii committee is pursuing a strategy to provide families with low-cost incentives to participate in the home environmental assessment. There are several items that could be given to the family during the home visit to help remediate the impact of allergens. These may include mattress and pillow covers, air filters, air purifiers, dehumidifiers, and odorless or non-irritating cleaning supplies. The choice of incentives will be dependent on budgetary limitations. The Program Manager has also applied to several foundations to seek grants to cover the cost of these items.

2. The project team has reviewed the environmental screening questionnaire, has identified potentially troublesome/sensitive questions, and is in the process of revising these questions. The Cultural Competency and Health Literacy committee is being consulted to ensure that the questions will also be rewritten to reflect the diverse cultures, as well as, differences in educational and health literacy levels among PPS patients. The PPS's policy is to hire Community Health Workers (CHWs) from the community where patients live, to reflect the cultural norms of the patient and enable patient engagement. CHWs will receive training on administering the questionnaire.

3. In cases where the home environment requires extensive remediation or when the environmental conditions are so detrimental that relocation must be considered, the program staff will refer the family to one of its PPS partners, BronxWorks, Bronx Legal Aid, or the New York City Department of Health, for further action. Both BronxWorks and the Department of Health have procedures in place to work with landlords to achieve necessary repairs and remediation solutions, such as pest management, as well as relocating families to temporary or permanent housing. BronxWorks is under contract with the New York State Office of Temporary and Disability Assistance to provide housing services to New York City residents under the Emergency Needs for the Homeless Program (ENHP). The organization has many years of experience conducting home visits and a legal staff to aggressively pursue remediation, when required. The New York City Department of Health enforces the City's health laws and has some legal funds for these efforts.

Implementation approaches that the PPS considers a best practice:

The Project 3.d.ii committee has developed several implementation approaches that are proving successful to the expansion of an asthma home-based self-management program in the Bronx.

- The backbone of the project is utilization of a screening tool for patients who are high risk for admission to the hospital for an acute asthma episode; providing monitoring, education, home visits, cigarette cessation; and addressing the social determinants of health that can impact illness.
- The committee's approach relies on hiring asthma competency and culturally competent staff; having culturally and literacy competent quality educational materials, home environmental assessments, and remediation; providing regular access to primary and specialty care; and providing early and effective care coordination. The certified asthma educator hired for the asthma program is experienced in working with the target population; speaks fluent Spanish, which is the predominant

foreign language in the Bronx, and has developed trust with individual patients and with the community. Having such an individual is critical to engaging patients and ensuring access to patients' homes to conduct environmental assessments.

- Through the American Lung Associations' certified asthma educator program, staff gain not only technical skills on asthma triggers and remediation techniques, but receive training in motivational interviewing to engage patients.
- Educational materials developed for the program address what is recommended in the NHLBI guidelines, but also incorporate the issues that PPS patients need to address, for example, smoking cessation and environmental control. During the intake assessment that takes place in multiple relevant settings, the Emergency Department, inpatient units, and outpatient clinics, staff administer questionnaires to patients to learn their asthma triggers and to invite feedback, which helps guide the development of the asthma education curriculum and materials.
- The committee also collaborated with the PPS's Cultural Competency and Health Literacy committee to ensure that all educational materials reflect the cultural diversity and varying levels of literacy and health literacy in the service area. All educational materials are made available in Spanish, and efforts are being made to translate materials into French, to meet the language needs of the growing West African immigrant population in the Bronx.
- Care coordination begins when patients are still in the hospital, starting with a screening to determine if they will require a home visit. An asthma action plan is developed for each patient and follow-up appointments with the primary care physician, as well as pulmonologists and allergy/immunology specialists, are made before the patient is discharged. Staff provides care coordination to ensure that patients get to their appointments.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

The Project 3.d.ii committee has initiated or completed several key initiatives required for expanding an asthma home-based self-management program for adults and children in the PPS service area.

Accomplishments to date include:

- Reaching patient engagement targets
- Beginning education of hospital staff about Project 3.d.ii
- Developing home-based self-management programs for adults and children, based on National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines, and home assessments, respectively
- Completing management guidelines, patient flow charts, and asthma education materials for the self-management program
- Contracting with PPS partner, BronxWorks, to conduct home environmental assessments
- Through the BronxWorks partnership, relocating two families whose homes were considered dangerous
- Providing home visits with environmental assessments
- Hiring 2 CHWs and 1 full-time RN, and piloting the self-management program at Bronx-Lebanon and Urban Health Plan sites
- Initiating the process to get staff trained as Asthma Educators by the American Lung Association

Initiatives in the planning stages that will be implemented by the end of the demonstration year include: Expanding home environmental assessments; conducting training with emergency department, inpatient,

and outpatient physicians to screen patients for the program; and conducting tabling events at PPS primary care sites to educate patients about the program.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:

Bronx Health Access is committed to serving all patients with asthma, but will direct its focus to the sickest patients—those at high risk for uncontrolled asthma.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 3.f.i

Challenges the PPS has encountered in project implementation:

The PPS has experienced strong success in the implementation of Project 3.f.i. The project team is led by Magdy Mikhail, MD, FACOG, FACS, FRCOG, FRCS, Chairman Obstetrics & Gynecology, Bronx-Lebanon Hospital Center; Glenys Thomas-Perales, MA, CHES, Project Director; with support from Kathy Alexis, Project Manager. Three primary challenges have occurred in project implementation.

First, as initially anticipated in the DSRIP Project Plan application, patients who are considered medically high-risk are often socially high-risk as well. Moreover, these patients experience significant social barriers to medical care arising out of their underlying unmet socioeconomic and psychosocial needs; namely, high poverty, homelessness, and regular access to food. The comprehensive Community Needs Assessment identified housing security, personal safety, food security, and transportation as primary issues that impact health in the South Bronx community.

Second, the original staff of four CHW was cut in half over the course of project implementation. The project team identified that the patient caseload was too high for the remaining two NYSDOH-trained CHWs directly implementing the project interventions (1. Nurse-Family Partnership program model for pregnant high-risk first time mothers, and 2. Community Health Worker program modeled on the Maternal and Infant Community Health Collaboratives program).

Third, in order to accomplish the primary project objective—to reduce avoidable poor pregnancy outcomes, subsequent hospitalizations, and improve maternal and child health through the first two years of the child's life—more primary care sites need to be engaged. Obstetrical and pediatric care is provided at both Urban Health Plan and the Bronx-Lebanon Hospital Center. The successful addition of a third primary care site will increase the provision of preventive care for pregnant women, women of childbearing age, and their babies (ages 0-2 years).

Efforts to mitigate challenges identified above:

Several solutions have been implemented to mitigate the three implementation challenges identified.

First, of the more than 200 PPS partner agencies collaborating to implement all DSRIP projects, 33 provide housing services for homeless populations; and 7 are HIV Prevention/Outreach and Social Service Programs. When patients are enrolled in the project, the CHW conducts an initial patient interview and documents any social (i.e., housing or unemployment), mental or behavioral health needs (i.e., depression) discussed on the Health Assessment Form. When challenges are acknowledged, the CHW identifies partner agencies (e.g., Catholic Charities, Bridge to Life, and South Bronx Healthy Families) that provide relevant services to meet patient needs, and coordinates referrals as needed. A key partner agency, Acacia Network is one of the largest providers of individual and family transitional housing for the NYC Department of Homeless Services. Acacia provides supportive housing for individuals and families living with chronic medical and/or behavioral health conditions. Through this collaborative relationship, some of the challenges related to unstable client housing, a primary issue impacting health in the South Bronx, have been mitigated.

Second, to better manage the CHW caseload, a tier system was created to breakdown project activities by the baby's age. In this way, the CHW does not provide services and education at the same intensity, nor frequency of home visits and follow-up calls, for all patients. The tiered structure allows for stratification of services provided as follows: high intensity services and education with three home visits (Tier 1, pregnancy to 3 months old), medium intensity services and education with two home visits (Tier 2, 4-12 months old), and low intensity services and education with two home visits (Tier 3, 13-24 months old). Patients receive a monthly follow up either in the office, clinic, or by phone call, and are reassessed when their baby reaches the maximum age identified for each Tier. This system has been approved by the Project Director, the project workgroup, and the PPS Clinical Quality Committee, and is now ready for implementation.

Third, to engage an additional primary care site for needed obstetrical and pediatric services, the project team has partnered with the Stakeholder Engagement Workgroup. The Stakeholder Managers are utilizing the project description to make partners aware of the need for additional primary care sites. On August 2nd, the project team will host a meeting to bring potential and past partners to Bronx-Lebanon and will directly engage their participation. The project team fully anticipates that these methods will lead to the successful addition of a third and subsequent primary care sites in the near future.

Implementation approaches that the PPS considers a best practice:

The project team is pleased that the speed and scale of implementation targets for year 1 have been met, and is confident that the project will remain on track to meet the year 2 targets identified. To date 317 project participants have been enrolled, and 33 new clients were enrolled in the last quarter.

Three implementation approaches have been identified which have largely added to the project's successful development.

First, the use of the two project intervention options (1. Nurse-Family Partnership program model, and 2. Maternal and Infant Community Health Collaboratives program model) as the evidence-based protocols have largely enabled the engagement of high-risk patients belonging to hard-to-reach populations. The project team works in conjunction with the Bronx-Lebanon High-Risk clinic where many patients have histories of trauma, substance abuse, childhood physical and sexual abuse, and incarceration. A weekly multidisciplinary case conference brings together medical providers, research nurses, and social workers to

review the cases most at-risk for subsequent hospitalizations and cases for HIV-positive women. And supporting these models, two NYSDOH-trained CHWs (one is bilingual and one is multilingual, working specifically with African clients) implement project activities. Using this bi- and multilingual CHW model, the PPS is actively working to eliminate racial/ethnic disparities by responding to the needs of the diverse racial/ethnic/language/cultural groups served.

Second, an additional partner, Coordinating Prenatal Care (CPCC), was contracted specifically to navigate women who have been lost to follow-up back into the project. In the event a client does not attend their scheduled clinical appointments, or if the client cannot be reached, the CPCC contacts their emergency contact and conducts outreach to locate the client. Additionally, providers have found that patients remain engaged when they can contact their provider directly, and therefore, providers encourage patients to text them on their personal cell phones. This strategy has worked well, as many patients have prepaid cell phone minutes which limits their access to voice calls, but their receipt of texts is unlimited.

Third, a referral system was developed to coordinate referrals for all PPS members. In the absence of this system, many patients were referred to partner organizations that did not provide the specific services they needed. Using this framework, each partner organization has specified the criteria for the services and patient types served. Now, there is a seamless referral system that has enabled continuity of care and seamless transitions across the care spectrum for patients requiring significant support due to various medical, social, and behavioral health conditions. This unified referral system is part of the resource machinery that has been developed and mobilized to directly achieve DSRIP goals.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Many other initiatives have supported successes to date in alignment with the project objectives.

First, as stated in the Project Plan Application, it was initially anticipated that the development of an IT network sharing system would be an organizational hurdle for the PPS. While, all project partners have not yet reached the same level of connectivity, the project team in collaboration with the IT Committee is developing a registry to track all project participants. Using data from the Bronx RHIO provided in real-time to the EMR, providers, social workers, and CHWs will be able to track preventive and emergency medical services administered to high-risk clients and their babies (up to age 2 years), and monitor their medical outcomes. It is anticipated that the registry will be fully operational before the end of DSRIP year 2.

Second, the PPS has implemented the DSRIP projects in such a way that facilitates bidirectional communication between key organizational leadership and project teams. This has cut down on many of the intervening steps that have created past administrative barriers to care and service delivery hurdles for providers and ancillary staff. A main venue that provides a consistent opportunity for interaction between the project team, workgroups, and the PPS leadership is the bimonthly Project Workgroup Meeting. In addition, the PPS-wide Clinical Quality Meeting is used to present project accomplishments, patient engagement strategies, and to align quality improvement strategies. Now in year 2, the focus of these meetings will shift to incorporate strategic emphasis on the performance measures that will ultimately be used to accomplished DSRIP goals.

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Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The population originally targeted for this project consisted of: high-risk (i.e., medically and socially) pregnant women and their infants; NICU patients and their families; and high-risk women of childbearing age residing in zip codes 10451-60, 10468, and 10472-74 (i.e., the poorest districts in the nation with approximately 40% of residents living below the Federal Poverty Level). The project team does not anticipate any changes to the target population as project implementation continues.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:

The only challenge that the Bronx Health Access has encountered thus far in this project is the time and effort required to implement a project with three other PPSs and other project partners, including the Jewish Board, the New York City Department of Education, the New York City Department of Health and Mental Hygiene, and the New York Academy of Medicine. It can be time-consuming to obtain feedback from all participating partners and come to collective agreement. The planning process has taken somewhat longer than if the PPS proceeded alone, but the expectation is that the program will be stronger and the final results better, as a consequence of this elaborated process.

Going forward, the primary challenge is achieving the ambitious goals of the Behavioral Health in Schools project. The project's goals are to: improve academic performance (higher graduation rates and test scores); reduce dropout rates; reduce truancy rates; reduce teacher turnover rates; reduce the number of 911 calls from the schools; and to improve the quality of behavioral health referrals within the community. Numerous other environmental factors impact achievement of these goals, in addition to the project, of which the PPS does not exercise control.

Efforts to mitigate challenges identified above:

Bronx Health Access has completed many of the most time-consuming planning steps and will be ready to start implementing the Behavioral Health in Schools project. An equitable and workable infrastructure has been developed to represent all project partners, which includes a Governing Body and Work Group. Developing the project, using a methodical and organized approach, has helped the project team to accomplish the planning steps in the projected timeframe and reach agreement among the partners on the project goals, model, potential school participants, and a contractor to manage, develop, and implement the model. The PPS has achieved an efficient governance and operating infrastructure which will allow it to successfully move forward in tandem with its project partners and three other New York City PPSs.

Although the PPS has established ambitious goals for the 100 Schools Project, the work group will establish achievable performance measures for each year of the project, after conducting a baseline evaluation of graduation rates, test scores, school dropout rates, truancy rates, teacher turnover rates, 911 calls, and behavioral health referrals. Behavioral health and education literature will be searched to identify environmental factors that impact the performance measures and set realistic goals for the target population.

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Implementation approaches that the PPS considers a best practice:

Bronx Health Access is collaborating with three other organizations to implement the Behavioral Health in Schools project—Bronx Partners for Healthy Communities, Community Care of Brooklyn, and OneCity Health. Each organization is represented in the project's Governing Body and Work Group, encouraging a more creative and collaborative process that will lead to change in the culture of behavioral health in New York City's school communities.

Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:

Bronx Health Access PPS has subcontracted with the Jewish Board to implement the Behavioral Health in Schools project to build the capacity of middle and high schools in the Bronx to address student behavioral health issues with existing staff, using the "train-the-trainer" model. The program model has three components: 1) helping schools to establish prevention and wellness programs for students and staff to increase mental health literacy, teach skills to reduce high-risk choices, and reduce behavioral health stigma; 2) selective interventions to decrease the acuity of mild to moderate behavioral health issues by assessing successes, identifying treatment gaps, identifying subgroups at higher risk for developing behavioral health problems, and addressing current inefficiencies in services; and 3) targeted intervention by establishing linkages to PPS behavioral health provider resources. The Jewish Board is implementing this four-year project on behalf of four PPSs in New York City and has targeted 100 schools for participation in the program.

Since the contract went into effect, the Project 4.a.iii committee, in conjunction with the Jewish Board has accomplished the following:

- Conducted planning meetings with the project partners, which includes the New York Academy of Medicine, the New York City Department of Education, and the New York City Department of Health and Mental Hygiene
- Developed criteria for participation and identified potential secondary schools in the Bronx to participate in the project
- Developed an evidence-based, three-pronged, train-the-trainer health education model
- Established project goals, which are to improve academic performance; reduce dropout, truancy, and teacher turnover rates; reduce the number of 911 calls from the schools; and improve the quality of behavioral health referrals within the community
- Discussed potential performance metrics
- Executed a subcontract with the New York Academy of Medicine to assist with model development and provide support and evaluation
- Drafted a Request for Information (RFI) to contract with providers that can provide staff training and support services to the schools.

The RFI was released in June 2016 and awards were made in July. Community-based agencies will begin providing training, coaching, and linkages to five schools in the Bronx as part of the pilot phase in September 2016.

Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
Future phases of the Behavioral Health in the Schools project will include more schools in the Bronx Health Access service area. The Project 4.a.iii team will review the exclusion and inclusion criteria for school participation at the completion of the pilot phase and may recommend changes, going forward into project years 2 through 4. Currently, the target population is middle and high school students; the inclusion of elementary school students will be considered in the future.

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DSRIP Mid-Point Assessment - Project Narratives

PPS must submit a narrative in each section for every project the PPS is implementing

PPS Name: Bronx-Lebanon Hospital Center

Project: 4.c.ii

Challenges the PPS has encountered in project implementation:

The PPS has experienced strong success in the implementation of Project 4.c.ii, under the leadership of Richard Cindrich, MD, Chief of Infectious Disease, Bronx-Lebanon Hospital Center; Deborah Witham, Executive Vice President/Counsel, VIP Community Services; and Leonardo Vicente, Executive Director, Bronx-Lebanon Highbridge Woodycrest Center; with support from Duane Granston, Project Manager. The PPS has begun implementing their chosen two sub-projects, of the seven possible projects, to improve outcomes for the high-risk population targeted. The two sub-projects are: 1) a peer-led health navigator program, and 2) an educational social media campaign.

The project team has encountered two main challenges in project implementation.

First, to develop peer specialists to deliver health navigation services, peers need extensive training. Initial hurdles regarding the identification of one standard peer training program were overcome and an agency partner (ASCNYC with a NYS DOH AIDS Institute recognized, state-of-the-art peer education training program) was selected. The program requires 90 hours of training (68 hours of core training and 22 hours of specialized training) for peer specialist certification and in preparation for the NYS AIDS Institute Peer Worker knowledge test. The project budget allocated a stipend for peers as part of their program participation, and to cover their time while training. However, the projected stipend amounts were over the allowable payment thresholds set by the Social Security, Department of Labor, and NYC HIV/AIDS Services. Uniform policies between federal, state, and local agencies to standardize one threshold peer stipend amount for persons living with HIV/AIDS (PLWHA) do not exist. It has been an ongoing challenge to ensure that peers participating in this project do not lose their benefits.

Second, to implement the educational social media campaign, there were many challenges regarding internet use among service area residents. Additionally, given the immense racial/ethnic/language diversity in the South Bronx, the nuances surrounding HIV/AIDS in different cultures, and the varied preferences within LGBTQ subgroups, initial plans for a universal educational social media campaign needed modification.

Efforts to mitigate challenges identified above:

To meet the main project objectives—to increase the percentage of HIV-infected persons with a known diagnosis who are in care, and to increase the percentage of HIV-infected persons with known diagnoses who are virally suppressed—several solutions have been implemented to mitigate the two challenges identified.

First, as an initial response to peer compensation challenges, stipend amounts were reduced and peers received guidance regarding limited hours for project participation. Next, a speaker from NYC HIV/AIDS Services was invited to talk to the project team (including peers). This brief talk outlined the NYC HIV/AIDS Services' specific policies regarding peer compensation and benefit thresholds. In addition, organizations (i.e., AmidaCare, Argus, and AIDS Service Center of NYC) that currently run successful peer programs for PLWHA have been engaged. It should be noted that two project partners, BOOM!Health and BronxWorks also run successful peer programs, and these partners have taken the lead in structuring the peer training program for this project; the PPS is developing a contract with ASCNYC to offer on-line and on-site training for peers. Based on current project timelines, it is anticipated that all peers will be trained and credentialed by Spring 2017.

Second, a focus group will be conducted during the Summer of 2016 to determine what elements should be included in the educational social media campaign to ensure that it is relevant and responsive to the varied racial/ethnic/cultural and LGBTQ subgroups targeted. Alternative plans will include the development of multiple foci to meet the needs of the diverse population targeted. Partner agencies working on this project include BronxWorks (with expertise in outreach to West Africans and LGBTQ groups), VIP Community Services, Inc. (to transsexual persons), Argus (to IV drug users), and BOOM!Health (to many groups). Additionally, BronxWorks has hired a dedicated media staff person to visit online sites frequented by MSM and engage persons in Q&A regarding HIV testing, prevention, care, and related issues. In a similar fashion, BOOM!Health social media staff conduct outreach to LGBTQ persons using online venues. To increase dissemination, the social media campaign will also encompass messages, images, and formats from the NYS End the Epidemic campaign (including how and where to receive PrEP and PEP). Given the continuous evolution of social media, ongoing assessment of the social media campaign will occur to ensure that it remains up-to-date and relevant.

Implementation approaches that the PPS considers a best practice:

The primary best practice identified has been the development of the 4.c.ii City-wide Workgroup to unite the 5-6 PPS' implementing project 4.c.ii. Through this workgroup, originally started by Amida Care, and now convened by NYC DOHMH, the project teams engage in joint planning, via a non-binding charter, with collective agreement from each PPS. The workgroup is co-chaired by two PPS leaders—one from New York City Health and Hospitals Corporation (HHC)/One City and another from Mount Sinai. The workgroup has provided a venue for cross-fertilization and brainstorming of actionable ideas, based on lessons learned from agencies/organizations who have implemented programs. Standing committees will begin in September 2016 and will allow for increased opportunities for partner involvement. In many instances, the project team has found that they have not had to start from scratch with project activitites (e.g., peer navigation program). The project team launched a pilot program in September 2015 and has begun measuring data. The project team fully intends to continue their commitment to the City-wide Workgroup in order to address major gaps in access to, and retention in HIV care.

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Additional details on the project implementation efforts beyond what is detailed in PPS Quarterly Reports:
Other innovations and initiatives that have supported the project's success to date in accomplishing the primary project objectives—to increase the percentage of HIV-infected persons with a known diagnosis who are in care and viral suppression—have included a multi-faceted and collaborative approach to project activitites across PPS' (through the City-wide Workgroup) and within the PPS (through partnering agencies and organizations). One such partner agency, BOOM!Health, has hired a Peer Coordinator and is spearheading the peer navigation activitites at BOOM!Health, BronxWorks, Argus Community, Inc.; and at Bronx-Lebanon. The aforementioned initiative serves as an exemplar for the PPS' ability to further the impact of Project 4.c.ii by maximizing resources within the PPS.
Address any changes to populations that were proposed to be served through the project based on changes identified through the community needs assessments:
The population targeted for this project originally consisted of persons who are/have: • A co-morbidity • Gay, lesbian, transgender, heterosexual, and MSM • Considered high-risk negative • Behavior health issues including addiction, mental health needs and serious mental illness. In total the populations listed above comprised persons aged 13-64 years who are/have: • HIV-infected (undiagnosed and diagnosed) • A recent potential HIV exposure (i.e., individuals eligible for PEP) • HIV-positive and out of care, or are in care but have unsuppressed viral load • Black and/or Latino undocumented immigrants. The comprehensive Community Needs Assessment findings supported the immense and growing racial/ethnic diversity in the service area; particularly, among the West African population (which includes predominantly Muslim and French-speaking groups). A local community gathering in the Bronx was attended by nearly 3,000 West African persons this summer. The project team anticipates expanding project activities in the near term with a specific focus on the cultural norms and values common to West African service area residents.