# DSRIP Independent Assessor

# Mid-Point Assessment Report

Bronx Partners for Healthy Communities PPS

Appendix PPS Narratives

**New York State | Department of Health**

> # DSRIP Mid-Point Assessment - Organizational Narratives
> PPS must submit a narrative highlighting
> the overall organizational efforts to date.

**PPS Name:** SBH Health System

## Highlights and successes of the efforts:

### Governance

Bronx Partners for Healthy Communities (BPHC) has put in place a cross-institutional organizational governance structure designed to ensure consensus-based decision making on common goals, care models, clinical protocols, interconnectivity, interoperability, budgeting and the value-based payment (VBP) future. This structure consists of an **Executive Committee, Nominating Committee, four (4) Subcommittees** (Workforce, Finance & Sustainability, Information Technology, and Quality & Care Innovations), and a series of **Clinical Work Groups** (also known as "Rapid Deployment Collaboratives," or RDCs) that report to the Subcommittees. The members of the governance structure represent all provider sectors and a broad range of BPHC partners critical to transforming health care in the Bronx. Membership includes primary care, specialty, mental health and substance abuse providers; hospital and community-based independent physicians; home care, long-term care and rehabilitative services providers; community-based housing and social service organizations; and worker and union representatives. Clinical and non-clinical management, workers, and labor are actively involved to ensure buy-in and representation within the member organizations. BPHC's clearly defined reporting and communications framework promotes transparency and collective decision making to ensure broad-based input and support throughout the development, implementation and actualization of a clinically integrated system.

Charters were established to define the purpose of each committee and subcommittee (known collectively as the Project Advisory Committee, or PAC), as well as PPS policies related to adherence to clinical standards, monitoring partner performance, and addressing underperformance. Planning Calendars are made available to PAC members to focus committee attention on upcoming deliverables and benchmarks for which they are responsible. **Monthly meetings of the Subcommittee Co-Chairs** facilitate communication among governance sectors with the goal of reducing silos, encouraging cross-fertilization, and mitigating cross-cutting risks to high performance. The Clinical Work Groups act as clinical quality councils for designated DSRIP projects. Work group members representing a broad range of expertise from across BPHC partners meet bi-monthly to examine project implementation progress and performance data.

BPHC formed two **Community Engagement Workgroups** – **Community Engagement Plan Work Group** and **Community Health Literacy Work Group** – with more than 20 community-based organizations (CBOs) collaborating to finalize a Community Engagement Plan, based on the principals *inform, consult, involve, collaborate and empower*. The plan outlines engagement strategies to strengthen the role of CBOs in BPHC's DSRIP implementation and outlining tactics for communicating with the public and non-provider organizations (e.g., schools, churches, homeless services, housing providers, law enforcement). BPHC recognizes the important role that CBOs have in developing and guiding our principles for the transformation of in the healthcare delivery system in the Bronx. We have included CBOs in all aspects of planning, governance, and project implementation. Each of our governance committees has CBO representation. The membership of our Community Engagement Work Group is comprised entirely of CBOs representatives, and CBOs have representation on six of our seven Implementation Work Groups for our clinical projects.

BPHC is intent on integrating social service programs and agencies into its IDS network. While the Bronx is fortunate to have a deep base of community resources, more than one-third of CNA respondents do not find social services to be readily available, clearly demonstrating the needs exceeding the availability of resources. Our plan for distribution of DSRIP funds is structured in five waves, the **fifth of which is funding to support CBOs and social service agencies**, and is currently underway (please see next section for more details). Our approach was to use a Request for Proposals (RFP) process to select additional CBOs to contract with in four areas of focus supporting DSRIP goals, including 1) cultural competency, 2) community healthcare literacy, 3) community-based behavioral health, and 4) critical time interventions (CTI). We anticipate contracting with up to 20 additional CBOs through these four initiatives in the summer and fall of 2016.

Several public sector agencies were identified for engagement in the PPS and invited to participate in clinical project implementation work groups since DY1Q. We are collaborating with these agencies to create an **Agency Coordination Plan**. Two major public sector agencies (New York City Department of Health and Mental Hygiene and the New York State Office of Alcoholism and Substance Abuse Services) provided feedback on the plan.

Finally, BPHC recognizes the importance of a transparent, inclusive governance process to the success of our PPS. Through our effort in wave-based funds flow process (more in the Finance & Sustainability, Population Health Management, and Clinical Integration sections below), our Collaborative Contracting Model has been established to facilitate Partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships necessary to transition to risk-based contracting. The contractual relationships will: a) provide accountability for DSRIP program milestones; b) enforce Partner obligations; and c) provide a basis for evaluating/tracking BPHC and Partner performance against established metrics.

The **Master Services Agreements** (MSA) and Schedule As (contracts) for funds flow were executed with three CBOs: a.i.r. nyc, Institute for Family Health (IFH), and Health People. A collaboration and project management agreement was executed with the Jewish Board. **Work Groups reporting to the Workforce Subcommittee – Workforce Communications & Engagement Work Group**, **Workforce Advisory Group**, and **Workforce Planning Work Group** – met monthly to develop the workforce communication and engagement plan, which was approved by the Workforce Subcommittee.

Below is the list of PAC and work groups that BPHC has to date, in summary:

| Project Advisory Committee (PAC) | | Work Groups (WG) | Sub-Work Groups |
|---|---|---|---|
| Executive Committee | Finance and Sustainability Sub-Committee | VBP Planning WG | |
| | Information Technology Sub-Committee | CCMS Pilot Development WG | |
| | Quality & Care Innovations Sub-Committee | Health Home At-Risk WG | |
| | | Care Transitions / ED Triage WG | |
| | | PC/BH Integration WG | |
| | | CVD / Diabetes WG | |
| | | Asthma WG | |
| | | MHSA WG | |
| | | HIV WG | |
| | | Pharmacy WG | |
| | | Health Home WG | |
| | | Behavioral Health Leadership WG | |
| | | Cultural Responsiveness WG | |
| | Workforce Sub-Committee | Workforce Communications & Engagement WG | |
| | | Workforce Advisory WG | |
| | | Workforce Planning WG | |

## Finance and Sustainability

The BPHC Finance & Sustainability Subcommittee (F&SS) approved the PPS financial governance structure, and the Funds Flow format, policy and procedures early in DY1. A quarterly reporting process was established in which the Central Services Organization (CSO) presents monthly reports to the F&SS on its budget and funds flow schedule, and provides a distribution forecast based on actual waiver revenue received and funds expected. In DY1Q4 the complete funds flow budget and distribution plan were presented to the F&SS. The implementation funds were categorized into patient-centered medical home (PCMH) support and other project-related items (including startup funds to hire new staff in DY2), Information Technology (IT), Workforce Development, and CSO Operations.

- **PCMH Support:** BPHC is working with PCMH expert technical assistants (TAs) to work with BPHC providers to achieve NCQA PCMH 2014 Level 3 recognition by the end of DY3Q4. The CSO continues to monitor partners' transformation progress and will authorize payments as benchmarks are reached. As of DY2Q1, of the 780 eligible Primary Care Providers (PCPs), 35% have achieved of PCMH 2014 Level 3 recognition.
- **Funding BPHC partners:** BPHC conducted a Request for Information for Clinical Integration (RFI) process with the seven largest primary care partner organizations, who together employ over 75% of our PCPs and deliver 97% of primary care services to BPHC patients.  This process sought to determine staffing and baseline funding needs to achieve DSRIP clinical integration objectives. CSO reviewed the proposals internally and then with each of the partners to determine how they plan to achieve DSRIP goals when funded. Baseline funding decisions were based on identified needs and patient attribution. Schedule As were executed to facilitate the flow of funds to these partners in Spring 2016. An annual review and update process for the PPS baseline funding schedule and distribution plan has been defined. The next wave of partner funding will focus on CBOs.
- **IT:** BPHC has partnered with the Bronx RHIO to implement PPS-wide interconnectivity. The contract between BPHC and Bronx RHIO was signed at the end of DY1. BPHC has also developed a PPS-wide partner relations management platform in Salesforce. BPHC has contracted services from HIS PRO to improve IT system security and data protection compliance, in line with DSRIP requirements.
- **Workforce Development:** BPHC works with four vendors on direct workforce development: 1199 Training Education Fund (TEF), Montefiore's Care Management Organization (CMO), Health People, a.i.r. nyc , and IFH. These vendors will train and retrain individuals necessary for DSRIP staffing and redeployment throughout the PPS. BPHC has also contracted with the consulting group BDO to conduct a PPS-wide workforce survey and future state modeling, in collaboration with other NYC PPSs.
- **CSO Operations:** BPHC is sufficiently staffed with full-time employees at the CSO and has gradually lessened use of consultant services, reducing consultant costs by over 70% since the start of DY1 with an additional 10% reduction expected in DY2. In addition to central staff, BPHC has hired and trained DSRIP Program Directors (DPDs) who act as embedded liaisons and implementation facilitators at the seven largest primary care organization partners.

BPHC conducted its first **financial health survey** as part of the DSRIP planning process, which led to the formalization of the F&SS Charter. BPHC completed a second financial health survey in DY1Q4 as its Financial Stability Test, which included a proactive follow-up process to ensure the highest possible response rate. Out of 212 surveys sent, 104 responses were received (49%); however, the 104 organizations responding cover 95% of the PCPs in the BPHC network. The financial health survey contained a number of questions and data sets for completion, including inquiries into existing VBP arrangements. The F&SS decided to repeat this survey annually and to expand the data request for specific information on evolving cost structures and the impact of implementing value-based arrangements.

The organizations which responded in DY1 were divided into tiers based on their assessed financial health.
To determine the criticality of the role provided by any given failing organization, the F&SS will  consider the services provided and the population being served, including:

1. The number of patients served by the organization as a percentage of patients in the PPS
2. Service gap if this organization would not be able to continue providing services
3. Cost to provide the services
4. Other organizations in the PPS providing similar services and their current capacity
5. Opportunities to obtain services for PPS if these were not available from another member organization

While the PPS will not be responsible for financially assisting the failing entity, a vulnerable organization will have the opportunity to meet with Subcommittee members to present the financially distressed position, consider options and identify opportunities to help resolve the financial instability, in the context of maintaining patient care services within the PPS.

Existing VBP arrangements identified by the survey are under review by the PPS in order to understand the various financial arrangements currently in place (i.e., full-risk vs. shared savings models, subpopulations covered, levels of risk) and which Medicaid Managed Care Organizations (MCOs) administer which types of contracts.

BPHC established a VBP timeline that will initiate in DY3 and reach 90% penetration by DY5. The F&SS and the BPHC Executive Director worked with MCOs to form partnerships and a **VBP Planning Work Group** (a subset of the Finance & Sustainability Subcommittee) to help establish a successful VBP plan. Initial components of the plan include gauging partner interest in a BPHC-sponsored VBP contracting vehicle, conducting partner readiness assessments, establishing quality of care performance metrics, building common data warehouse infrastructure and analytic capabilities, and exploring available legal governance structures to determine which will be most appropriate for the PPS.

BPHC recognizes the diversity of providers within its network and seeks to define a VBP strategy tailored to meet the needs of the full range of licensed providers represented by the PPS. This will be undertaken in a transparent manner with consistent input from the members of the PPS.

**Compliance**: BPHC has a strong commitment to compliance and has developed a comprehensive and robust compliance program, approved by its EC, that satisfies the applicable requirements of New York Social Services Law Section 363-d ("SSL 363-d"), Title 18 of the New York Code Rules and Regulations at Part 521, and guidance from the New York State Office of the Medicaid Inspector General and the New York State Department of Health. BPHC's Compliance Officer oversees the planning, implementation and daily operations of the compliance program including: a) ensuring compliance with written policies/procedures in the form of a Code of Conduct and policies developed through the governance process; b) creating a training module and coordinating with member organizations to ensure that compliance training is provided to employees working on DSRIP; c) establishing a PPS-wide hotline and web portal for receiving compliance related complaints, including anonymously; d) ensuring open lines of communication with the compliance officer; e) conducting a risk assessment exercise to identify the areas of focus for compliance at this stage of DSRIP and planning for corrective action; and f) auditing and monitoring to ensure compliance. The Compliance Officer participates in the SBH compliance committee meetings and meets regularly with the SBH Compliance Officer. In addition, the Compliance Officer presents quarterly updates to the EC on compliance-related activities, gives presentations on compliance to other Subcommittees as requested, and participates in cross-PPS compliance work groups (see Exhibit B).

## Cultural Competency and Health Literacy

The Bronx is the only borough in New York City to have a Hispanic/Latino majority population, estimated to be 54.3%. It is home to nearly 800,000 Latino immigrants and their descendants hailing primarily from Puerto Rico, the Dominican Republic, and Mexico. Findings from a Community Needs Assessment (CNA) show that the Bronx's Latino population is overwhelmingly burdened by poverty, which is further exacerbated by limited language proficiency, high rates of as behavioral health disorders, and challenges in accessing resources to address social determinants of health, such as

housing, legal services, entitlements, and employment. The Bronx also has the highest rates of preventable inpatient Medicaid admissions, with significantly higher rates for substance use-related hospitalizations among Latinos. Community consultations conducted in communities with some of the highest concentration of Latino populations- Hunts Point, Mott Haven, Highbridge-Morrisania, and Crotona-Tremont reported higher rates of depression and anxiety, as well as concerns about how their emotional health impacted, and was impacted by, difficulties with housing, employment, and hunger. The CNA report also found that there is limited knowledge of how to access services to address behavioral health issues and that behavioral health diagnoses come with great stigma. In addition to improved pathways to obtaining services from within the community, health literacy needs to be improved so as to increase confidence in the clinical approaches for improving physical and behavioral health. Patients also need support with navigating and accessing the community resources where they can seek assistance with issues such as hunger, legal issues, and housing. Lastly, the clinical environment can be improved by increasing providers' awareness of key cultural beliefs and how to address stigma around behavioral health diagnoses and treatment.

Cultural competency and health literacy (CC/HL) are core components of BPHC strategy to address the health inequities and disparities that are common among disadvantaged communities in the Bronx. BPHC established a **Cultural Responsiveness Work Group** under its Quality and Care Innovation Subcommittee (QCIS), with representation from CBO and clinical institutions across the PPS, to develop a cultural competency and health literacy strategy for DSRIP implementation. Ultimately this strategy seeks to improve the responsiveness and quality of health service provision; to address cultural and communication barriers in access to care; and to build engagement and participation of patients and their communities in addressing their health needs.

In order to ensure a systematic and sustainable implementation of **CC/HL strategies**, the approach developed by the PPS involves deployment of a set of strategic interventions as part of its core programs, including workforce training, community outreach and clinical improvement projects. These interventions include: 1) Identifying priority groups experiencing health disparities, based on the community needs assessment results and participant input; 2) Identifying specific initiatives and standards based on best practices of member organizations, to improve access to high quality, equitable services and address health disparities; 3) Identifying tools and resources for Domain 3 projects that could build health literacy and support effective self-management of health conditions for priority groups experiencing health disparities;  4) Identifying best practices in cultural responsiveness and health literacy interventions to reduce health disparities and improve outcomes in primary care and care management models; and 5) Outlining the requirements and timing for integration of cultural competency in the training and re-training strategies linked to implementation of clinical projects and community initiatives.

The **Cultural Responsiveness Work Group** continues to hold regular meetings to further specify the plans, and implement and monitor the various programs and initiatives. CBOs worked with BPHC leadership to organize forums to obtain community input on barriers to care and the experiences of healthcare consumers. The Work Group determined that cultural responsiveness and methods to address the drivers of health disparities will be a component of every BPHC-sponsored training program. To establish the cultural competency training strategy, the Cultural Responsiveness Work Group held a series of meetings, attended two full-day trainings (including a Poverty Simulation with members of PPSs in the Hudson Valley) held numerous meetings with subject matter experts and sent out an letter of intent (LOI) to 183 CBOs requesting their interest in trainings for specific populations. BPHC also collaborated with other PPSs, particularly OneCity Health, in sharing best practices and resources. Major attention was paid to the target populations identified in the BPHC Cultural Competency Strategy. The identified courses include:

1. **Cultural Competency in the Bronx**, for front line staff (current RFP for vendor)
2. **Program to Identify and Address Healthcare Disparities for Immigrant Seniors**, available as part of the BPHC Speaker's Bureau, at no cost to member organizations (CBO-led)
3. **Cultural Competency Program for Home Health Aides**, developed and led by CBOs
4. **BPHC Cultural Competency Leadership**, led by the Jewish Board to examine and build mission, goals and strategies, values, policies and programs that promote effective, patient centered culturally competent care throughout BPHC.

5. **Poverty Simulation**, for representative teams from BPHC organizations with potential for cross PPS collaboration.
6. **Cultural Competency and the Social Determinants of Health for Practitioners**, focus on Primary Care and Behavioral Health Practitioners, to be delivered by the Center for Immigrant Health and Cancer Services
7. **Working with Behavior Health Patients**, for primary care team members and care coordinators throughout the PPS, led by The New York Psychiatric Institute, Columbia University, Center for Cultural Competency, and in collaboration with One City Health PPS
8. **Community Health Literacy Program,** because BPHC believes in the best practice models in which peer educators and community health workers educate community populations, the PPS will select CBOs to deliver the community health literacy curriculum, using a train the trainer format. These CBOs will be funded by BPHC to train staff from other CBOs to provide community health literacy training to their clients and the community on basic concepts and strategies for using the transformed care delivery system more effectively.  Topics include health insurance, primary care, using health care services effectively, care coordinators, care plans, consent to information sharing.

## IT Systems and Processes

In DY1 BPHC conducted an assessment of its partners to determine their current IT capabilities and needs in relation to the PPS vision for an integrated and interoperable system of care.  The CSO drew on various sources to inform the needs assessment, such as surveys, interviews, PCMH achievement, data from Salient Interactive Miner (SIM) and SDOH (e.g., Meaningful Use (MU) status and safety net status), and input from the Bronx RHIO, BPHC's Qualifying Entity (QE).

**Interoperability & Data Acquisition & EMR & MU & Care Management Operations**: To achieve an integrated system of care, BPHC is pursuing an interoperability strategy that includes: leveraging existing partner electronic medical record (EMR) systems for clinical documentation; utilizing the Bronx RHIO for health information exchange (HIE), central data management and analytics; implementing new or leveraging existing care coordination management systems (CCMS) for care planning, clinical and social service navigation, care transition management, patient assessment, population stratification, patient registries and patient engagement; technical assistance for practices integrating primary care and behavioral health services (3.a.i, PC/BH Integration, all 3 models); and technical assistance and monitoring for partners requiring EMRs or EMR upgrades, EHR MU attestation, PCMH 2014 recognition and RHIO/HIE adoption and integration. Additional systems are being considered if they can fill a niche and/or accelerate data capture and management.  The PPS will seek to collect critical documents and fields from various partner systems into the PPS centralized systems (Bronx RHIO, PPS CCMS, and others as needed) for centralized aggregation, population stratification, registries, reporting, and predictive analytics at the population level, leveraging the strengths of central systems.  Local partner systems and processes will conduct the majority of patient tracking activities and registries where local seems more appropriate.

**Support for PHM**:  QCIS identified registry-related field requirements for each of the ten (10) projects to inform population health management efforts. These continue to be reviewed to define the core data that needs to be collected and transferred between systems to support population health processes.

**Interoperability & Data Acquisition**:  The interoperability plan has been a complex and ongoing effort, which is being refined in effort to ensure widespread adoption of the interoperability strategy. We have identified the interoperability standards supported by the Bronx RHIO and performed a gap analysis of the largest partner data feeds to the Bronx RHIO related to key data elements needed to provide advanced proxy P4P metrics and registries. We continue to review the capabilities of proposed CCMSs, and participate in the ongoing GNYHA ongoing collaboration about the content and standards that we should align to in order to be able to interoperate with other downstate PPSs. A systems change management plan was developed and discussed. Funds to conduct interoperability standards training has been set aside and is included as part of the Bronx RHIO contract. We have identified some opportunities where the PPS may need to obtain additional technology for interoperability (for example, the Bronx RHIO cannot currently accept 837 messages or C-CDAs, and DIRECT messaging among our partners is uneven). Bronx RHIO already communicates emergency and inpatient ADT notifications to several PPS provider, CMA, and Health Home partners and plans for subscription alerts

and associated workflows are being formulated for the others.

**Consents & Data Sharing**:  Recognizing the need for patient consent, a plan for engaging attributed members in the QE was approved by the IT Subcommittee. This has been refined based on an evolving understanding of the regulatory environment and DSRIP partner challenges. The CSO investigated best practices applied by those organizations with the greatest success at collecting QE consent; knowledge is being shared and pilot improvement activities are being implemented. Business Associate Agreements (BAAs) were signed between the PPS and each partner organization, and Bronx RHIO has obtained data use agreements that allow it to share partner data with the PPS lead.

**MU & PCMH:** We are executing a comprehensive plan to support our safety net providers in obtaining **Meaningful Use (MU)** and Patient-Centered Medical Home (PCMH) which includes support for EHR development and customization and connectivity. Our agreement with Bronx RHIO will continue to serve as the foundation to achieve tasks to support this Work Stream. A **PCMH** program has been under way to bring in technical assistants (TAs) for practice transformation for eligible groups of PCPs and BPHC member organizations. After a vetting, matching, and interview process of the TAs and member organizations, comprehensive gap assessments were conducted of over 80 hospital based, FQHC, voluntary and independent practices. These resulted in 59 work plans upon which contracts between BPHC and TAs were formed and signed. Eight TA groups received funding through this effort which yielded, as of DY2Q1, 21 practices with PCMH 2014 Level 3 achievement which accounts for 269 primary care physicians – it is roughly 35% of our total eligible PCPs. Our **MU** plan will be part of a package of IT interventions for those providers which have yet to achieve EMR connectivity as well as the interconnectivity with RHIO. With the help of NYC DOHMH's Primary Care Information Project (PCIP), we performed a gap assessment of all BPHC providers, and using the information we've collected in the past, attributed all of our independent providers to organizations. The gap assessment looked at eligibility of physicians, and if eligible, where they are in the MU process. Based on this process a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as **EHR implementation** and RHIO connectivity and encounter notification systems deployment. We estimate a maximum MU opportunity of about $60 million which will help fund this work. Part of this plan will also be RHIO incentive funding and other revenue streams.

Finally, standalone systems to support communications and project management were implemented with limited IT Change Management implications. The BPHC Salesforce database acts as a partner network management and communications tool; member organizations can update their profiles as needed, submit rapid cycle evaluation metric data, and view CSO updates, such as PCMH participation and performance outcomes.  The Performance Logic DSRIP Tracker serves as the primary mechanism for managing the implementation timeline and monitoring progress towards achieving DSRIP milestones.

## Performance Reporting

A BPHC governance structure for oversight of performance reporting was developed and CSO-based performance reporting support personnel were hired. The PPS defined reporting categories and metrics for **Rapid Cycle Evaluation** (RCE), assessed reporting capabilities within the network, and formulated a strategy for beta-testing technical platforms used for reporting.  Sources for performance data were identified, including the Bronx RHIO, SIM, CCMSs, partner EMRs, and organization-specific  manual data collection (collecting and reporting data for RCE metrics).

The Executive Committee reviewed and approved the Performance Reporting and Monitoring Structure strategy, which defines the PPS vision for information sharing (what kind of data will be shared and with whom) and describes the committee structure that will monitor the performance data. The strategy includes written policies and procedures for data collection and reporting related to reporting of RCE and **Patient Engagement** metrics. It also describes BPHC's plans to create dashboards for clinical quality and performance metrics across our developing systems for partners to monitor their individual progress in the context of the rest of the PPS.

BPHC contracted with a vendor, Joselyn Levy & Associates, to work with BPHC on the development of a **performance reporting and continuous quality improvement (CQI) training program** for individuals deemed key to driving DSRIP implementation within partner organizations, as well as the CSO project managers. The program includes a focus on reporting expectations by role and the methods and tools by which reports are generated. The initial training curriculum uses examples from available systems (not all PPS planned reporting systems have been developed yet) and available data (PHI is still restricted in NY State systems). Initial performance reporting examples and training will leverage the availability of the MAPP dashboards, Salient, and Salesforce and later will include Spectrum, the RHIO's data analytics platform which is able to display near real-time data.  The training will ensure participants have a practical understanding of how to use these systems, what data they contain, and how to interpret the reports and analytics that they can produce. This will provide users an opportunity to both use the systems and real data, learn how to interpret that data and consider methods to make it actionable for their improvement needs.

## Practitioner Engagement

The **Practitioner Communications and Engagement Plan**, approved by the Executive Committee, states that the CSO and the BPHC PPS governing bodies will be responsible for creating and maintaining an environment across the network that encourages active practitioner participation collaboration, cooperation, transparent communication and professionalism. The Plan also includes mechanisms for standard performance reports to be created and distributed to appropriate practitioner groups and partners, to obtain feedback and aid in continuous quality improvement.

BPHC partner representatives, including senior clinical leadership and clinical practitioners, participate actively in the BPHC PPS governing bodies– the Executive Committee and its Subcommittees. Specifically, the QCIS is charged with establishing evidence-based practice and quality standards, and measurements, overseeing clinical care management processes, and, together with the Executive Committee, holding providers and the PPS accountable for achieving targeted metrics and clinical outcomes. The QCIS also overseas clinical work groups, made up of subject matter experts from across the PPS, which act as project-specific clinical quality councils. A Pharmacy Workgroup, comprised of representatives from independent pharmacies in our PPS, engages clinical pharmacists in our work and communicates best prescribing practices to our clinicians. In addition to the above-described opportunities for practitioners to participate in clinical guidelines/protocol development and to discuss, collaborate, and shape how DSRIP will affect their practices, BPHC has leveraged complementary avenues for practitioner engagement including learning collaboratives, teaching webinars/clinical forums, and Grand Rounds. A master calendar is developed each quarter identifying various engagement events that will be attended and/or conducted by the CSO. Where possible and appropriate, practitioners have and will continue to receive CME/CEU and/or MOC credits for participation in these activities.

BPHC's Chief Medical Officer also meets regularly with various practitioners to discuss and gain buy in for the various aspects of DSRIP implementation, including plans to achieve project and work stream milestones and conduct practice transformation to achieve broader DSRIP goals. It has been communicated to partner organization leadership that they expected to: provide protected time and issue directives/policies to its practitioners to enable them to participate fully in BPHC's projects and programs; use the mechanisms they already have in place to disseminate new policies to staff and hold them accountable for implementation; and *institutionalize* appropriate DSRIP performance measures.  Finally, agreements have been developed with project-specific vendors who are also our partners (such as IFH, Montefiore CMO, a.i.r. nyc, and Health People) to conduct trainings based on the Clinical Operations Plans (COPs) developed by BPHC's Clinical Work Groups.

## Population Health Management

BPHC's committees, subcommittees, and workgroups developed an overarching vision for the future state of population health management (PHM) for the PPS. These groups also worked to define interventions for priority populations of patients with a high degree of risk for poor health outcomes and high utilization.

PCMH consultants, contracted by BPHC in mid-DY1, conducted site-specific gap analyses with BPHC PCPs that including an examination of PHM IT infrastructure in order to formulate their strategies for achieving PCMH 2014 Level 3 certification. The consultants then signed contracts and began delving into the coaching practice with BPHC's primary care practices to support the practice redesign necessary to achieve PCMH 2014 recognition.

A PHM vision gap analysis was then conducted by the CSO to more deeply understand existing and future capabilities across key PPS systems, such as the Bronx RHIO and CCMS, for population health management functionalities. The PHM gap analysis reviewed functions such as patient stratification, registries or cohorts to track/trigger events to manage care, referral management, and ability to measure cost/outcomes/effectiveness, patient engagement, and care planning.

Next, the CSO assessed DSRIP startup needs for PHM capabilities, such as IT infrastructure and staffing, among the PPS's seven largest primary care organization partners via the wave 3a RFI process. The information received through this process was used to evaluate overall PPS staffing and IT readiness and develop the initial draft of the PHM roadmap. The CSO reviewed all of the RFI responses and the respective budgets, and determined the startup allocations, including ensuring each organization has designated funds available to support PHM activities. Also, in addition to working with the Bronx RHIO on increasing connectivity, BPHC is also working with the RHIO to further develop their Spectrum analytic product, which will be leveraged for numerous PHM capabilities as it has the ability to display near real-time data which is more actionable than lagging claims data.

BPHC PPS leadership has worked to determine the most effective manner in which to engage partners in the development of a **Bed Reduction Plan strategy**. SBH Health System, the fiduciary sponsor and one of the two hospital partners of BPHC, has since pre-2010 been paving a path as a leader in prioritizing value over volume, and has been transforming itself into an organization focused on driving down cost and utilization. The results are apparent in various areas including ED admissions reduction, ambulatory-sensitive discharges reduction, and the inpatient beds reduction among others. From 2009 through the start of DSRIP, SBH's ED admission has reduced from 22% (out of 100,700 total encounters) in 2009 to 13% (92,293 total encounters) in 2015. Also, its inpatient capacity reduced from 461 to 348 beds (18% reduction), and was repurposed into hospice unit, sleep lab, wound care center, and center for specialty care.

Analysis of the PPS's overall hospital utilization patterns was delayed in its start – due to limited systems and data access issues, the PPS was only able to begin analyzing inpatient utilization patterns at the end of the DY1. Subsequent analyses were started in Salient/SIM and will be continued throughout the rest of DY2 for presentation to several groups within the PPS. The PPS's first focus has been to look at residential and inpatient utilization for behavioral health diagnoses, and their medical and substance abuse comorbidities. BPHC leadership and SBH leads for ambulatory care met with the representatives from NYS OMH, OASAS and DOH to discuss BPHC's behavioral health vision and services, which included a conversation on psychiatric bed reduction. SBH has inpatient psychiatric beds, half of which are used for short-term substance abuse treatment. SBH is considering reducing beds for substance abuse (24 total), and OMH and BPHC agreed to start discussing transfer of overflow patients to state beds for longer-term stays/treatment.

Lastly, SBH Health System, BPHC's fiduciary sponsor and one of its two hospital partners, is participating in the DSRIP Medicaid Accelerated eXchange (MAX) Series. An evidence-based collaborative for maximizing efficiency in clinical processes and implementing sustainable change, the MAX Series is a twelve-month project focusing on super-utilizers (SU) that in July of 2015. The interdisciplinary team participating on this project includes representatives from SBH (Administration, ED, social work, psychiatry and substance abuse), two community-based organizations, BronxWorks and Riverdale Mental Health Parachute Program, and a staff member from BPHC. SBH SUs tend to be homeless and seek refuge in the ED, usually for non-medical reasons. During this period, SBH has focused on improving provider and staff education on the available community resources for them and their patients. SBH initiated Street Outreach Team Pick-ups to transport clients to the Living Room, a drop-in center at the supportive housing site, from the ED. SBH has produced standardized shared care plan for each of these individuals. A flag in the EMR was also established to notify providers that an individual is an SU. In the ED, SBH expanded the patient engagement team to include security guards

and detox counsellors who were assigned to identify patients and engage in transition planning.

## Clinical Integration

BPHC is in the process of creating an integrated delivery system offering high quality primary care and care coordination services, with increased attention to the social determinants of health. The PPS developed and the QCIS approved a Clinical Integration Strategy. The objective is to achieve alignment among providers within the network through collaboration, adherence to shared clinical standards, investment in IT infrastructure and data sharing systems, and expansion of payment reforms that reward value over volume.

Towards the standardization of clinical quality across the integrated delivery system, BPHC has developed the PPS-wide Clinical Operations Plan (COP) for adoption throughout all participating clinical provider organizations. This toolkit consists of narrative explanations, sample workflows, and policies and procedures that provide guidance to BPHC partners in their site-level implementation of BPHC DSRIP projects. The elements of the COP emerged from the work of the project-specific clinical work groups, reporting to the QCIS. The groups vetted evidence-based guidelines for recommendation to BPHC partners and all clinical elements received approval from the QCIS. MSAs signed by BPHC partners detail each partner's obligations regarding adherence to project requirements and clinical standards.

Prior to distribution of funding to partners for use through DY2, BPHC's RFI process served as a clinical integration needs assessment.  Funding allocations reflected the identified gaps in capacity required to meet BPHC's integration and performance goals. Expectations with regard to implementation and improved outcomes were communicated in written and verbal form to all partners receiving DSRIP funds.

BPHC and the Bronx RHIO are working together closely to ensure data can be shared in a secure manner among PPS partners through the health information exchange. All BPHC partners are strongly encouraged to establish connectivity to the Bronx RHIO, and the CSO works with partners to institute and expand their relationship with the QE. Enabling encounter notification services for admission, discharge, transfer and use of the Emergency Department notification sharing is an early priority. Providers and CBOs have been involved in the patient QE consent strategy and trainings will be conducted periodically to ensure accurate and consistent messaging.

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

## Workforce

The Workforce Subcommittee is leading BPHC's efforts to assess the current state of the workforce (including compensation and benefits), define a future state vision, develop a transition plan, and  create a training strategy. To aid in this work, the Subcommittee formed work groups to address planning, communications, and labor relations. BPHC also formed and leads a consortium with a total of seven New York City PPSs to select a workforce consultant to support the achievement of DSRIP goals.  During DY2Q1 the **Workforce Communication and Engagement Work Group** (WC&EWG) met to develop ideas for communication with the BPHC workforce using new media. This was a recommendation from the Workforce Subcommittee due to the size of the PPS Workforce, originally estimated to be 35,000, and recently realized to be more than 70,000, as a result of the current state survey conducted across the PPS. The WC&EWG also made plans for the distribution of *DSRIP 101*, an online learning module created by our training

vendor, 1199 TEF, with major input from the PPS.  Distribution will occur in DY2Q2 due to delays in installing Health WorkForce apps, or HWapps, a web-based workforce tools application for PPSs, which we plan to use as a Learning Management System, among other purposes, at BPHC.

BPHC worked with the chosen consultant, BDO, to define the workforce future state needs of the PPS and conduct microsimulation modeling. Project managers employed by the CSO have been actively engaged with the Workforce Subcommittee to determine the anticipated workforce impact of each of BPHC's DSRIP projects. BPHC has also worked with the other PPSs in the workforce consortium to forecast the future demand for healthcare services and providers, based on changing population counts and demographics, greater emphasis on healthcare delivery in primary care and community settings, and VBP reimbursement. Concurrently the PPS is working with partner organizations to define the workforce elements that will be required to achieve DSRIP goals. The information from these processes will be compared and reconciled to finalize the BPHC future state.

The Workforce transition roadmap will be created by the Workforce Subcommittee and workforce planning work group with support from BDO. BPHC plans to utilize information derived from the current state survey, the target state assessment and the gap analysis to identify and prioritize transition steps. BPHC will identify short and long term steps to address workforce gaps through training of existing staff and hiring additional staff, and develop sustainability strategies. A review of the training strategies under development will also be utilized to develop a transition roadmap template for Workforce Subcommittee review and feedback.

The PPS has completed the compensation and benefit survey and is currently aggregating survey results to identify the current compensation and benefit ranges for job titles. In addition, we are working with consulting partners to develop the future state compensation and benefit ranges for new hires, redeployed and retrained staff critical to DSRIP.

BPHC's Workforce Subcommittee is working with 1199 TEF, our workforce vendor, on the development of the BPHC training strategy.  It will be largely informed by the workforce transition roadmap, with additional input from the PPS partners and the focus groups being conducted with representatives from the PPS workforce.

A number of trainings have been developed and delivered or are currently in development. Already completed trainings include: *Operational Components of BPHC Projects* (for site-specific DSRIP implementation teams), *Clinical Integration* (for Clinical Leadership), *DSRIP 101* (for front-line staff). Workforce development trainings are already underway on the *Essentials of Care Coordination* and the *Medical Office Assistant Refresher and Certification Program*. These trainings were developed in coordination with TEF and additional pedagogical and subject matter experts. *Performance Improvement and Reporting* trainings, developed with JLA, are underway as well.

**Several courses related to primary care and behavioral health integration are ongoing**, including*: Introduction to Collaborative Care, Creating a Culture of Wellness: A 360-Degree View, Depression 101 for Non-Prescribers, Documentation, Motivational Interviewing, Primary Care Providers Working in Mental Health Settings, The Role of Clinical Leadership in Creating a Culture of Patient and Family Centered Care, Tracking Integrated Care – Clinical Processes, Transforming Clinical Practice Initiative Support and Alignment Network, Treatment Planning, Behavioral Activation, Billable Practices for Collaborative Care, Billing Effectively for Integrated Behavioral Health Services, PHQ screening, Problem Solving Treatment, Psychiatric Consultation, Psychopharmacology, safeTALK, SBIRT, and Self-Management Support for Patients with Chronic Conditions*.

**Additional courses** are currently under development, including: *Care Transitions Training; ED Navigator Training; Care Management Supervision; Cultural Competency for Practitioners;; Working with Seriously Mentally Ill and Substance Abusing Populations; Working with the Bronx RHIO; Coding, Billing, and Quality Assurance Reporting; Compliance; Cultural Competency in the Bronx; ED Navigation and Care Transitions Overview for Primary Care Practices; Leveraging Care Coordination (for Providers); Provider Continuity and Panel Management; Evidence-Based Guidelines; Registry Testing; and Value-Based Payments.*

BPHC training sessions are available to all members of the PPS, as appropriate to their workforce role, and required for all funded partner organizations.

## Building a PPS Vision and Strategy

To support its DSRIP work and the development of an integrated delivery system, BPHC is working to compile its various strategic documents to create an overall strategic plan document describing the PPS vision for DSRIP implementation and beyond (see Exhibit A).

## Cross-PPS Collaboration

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals (see Exhibit B).

**Exhibit A: BPHC Strategy Documents**

| Work Stream / Project | Strategy Document | Timeline for Completion |
|---|---|---|
| Governance | Community Engagement Plan | Complete |
| | Reporting and Monitoring | Complete |
| | Workforce Communication and Engagement | Complete |
| | Public Sector Agency Coordination | Complete |
| Finance / Budget / FF | Finance and Sustainability Strategy / Budget and Funds Flow Distribution Plan | Complete |
| | Compliance Plan | Complete |
| | Value-Based Payment Plan | December 31, 2016 |
| Workforce | Workforce Transition Roadmap | September 30, 2016 |
| | Training strategy | September 30, 2016 |
| Clinical Integration | Clinical Integration Strategy | Complete |
| Cultural Competency and Health Literacy | Cultural Competency / Health Literacy Strategy | Complete |
| | Cultural Competency / Health Literacy Training Strategy | Complete |
| Practitioner Engagement | Practitioner Engagement and Communications Plan | Complete |
| | Training and Education Plan | Complete |
| Performance Reporting | Performance Reporting Structure | Complete |
| | Clinical Quality and Performance Reporting Training Plan | Complete |
| IT Systems and Processes | IT Change Management Strategy | Complete |
| | Clinical Data Sharing and Interoperable Systems Roadmap | Complete |
| | Plan for Engaging Members in QEs | Complete |
| | Data Security and Confidentiality Plan (SSP Workbooks) | Complete |
| Population Health Management | PHM Roadmap | March 31, 2018 |
| | Bed Reduction Plan | December 31, 2018 |
| Integrated Delivery system | VBP growth plan and compensation model | March 31, 2017 |
| | Project-Specific Strategy Document | August 31, 2016 |
| Health Home At-Risk | Care Coordination Strategic Plan | March 31, 2017 |
| | Project-Specific Strategy | August 31, 2016 |
| ED Care Triage | Project-Specific Strategy | August 31, 2016 |
| Care Transitions | Payment Strategy for Transitions of Care | March 31, 2017 |
| | Project-Specific Strategy | August 31, 2016 |
| PC / BH | Project-Specific Strategy | August 31, 2016 |
| CVD | Project-Specific Strategy | August 31, 2016 |
| Diabetes | Project-Specific Strategy | August 31, 2016 |

| Asthma Home-Based | Project-Specific Strategy | August 31, 2016 | |
| MHSA | Project-Specific Strategy | August 31, 2016 | |
| HIV | Project-Specific Strategy | August 31, 2016 | |
| Other | BPHC DSRIP Funds Flow Process & Strategy | August 31, 2016 | |
| | Primary Care Plan | August 31, 2016 | |
| | Hot-spotting Strategy | December 31, 2016 | |

## Exhibit B: BPHC Cross-PPS Collaboration

| Group Name | Purpose | PPSs Involved | Primary CSO Staff |
| --- | --- | --- | --- |
| HANYS DSRIP Executive Leadership Group | Gather leadership of PPSs to exchange ideas on various topics | All are invited | Irene Kaufmann |
| GNYHA DSRIP Executive Leadership Forum | Gather leadership of PPSs to exchange ideas on various topics | All are invited | Irene Kaufmann |
| GNYHA Clinical Leadership Forum | Gather CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms. | All are invited. Regular attendees include: Montefiore Hudson Valley, Westchester Medical Center, Bronx Lebanon, HHC/One City, Maimonides, Refuah, Advocate CP, Albany, NY Presbyterian | Amanda Ascher |
| GNYHA Post-Acute Work Group | Gather representatives of PPSs to cover various topics related to Care Transitions | All are invited. Regular attendees include: Staten Island, Mount Sinai, Maimonides, Nassau-Queens, NY Presbyterian, Montefiore Hudson Valley, others | Meredith Stanford |
| GNYHA One Care Plan Work Group | Care Transitions, Care Coordination and development of a standard care plan using the CCDA architecture | All are invited. Regular attendees include: Staten Island, Mt Sinai, Maimonides, Nassau-Queens, NYP, Montefiore Hudson Valley | Meredith Stanford & Zoe Stopak-Behr |
| GNYHA Compliance Workgroup | Compliance professionals from PPSs across the state work collaboratively on common issues and share resources. | Montefiore Hudson Valley, NYU Lutheran, Maimonides, HHC/One City, ECMC, Advocate Community Partners, Northwell Health, SUNY Stony Brook, Mount Sinai | Suzette Gordon |
| Bronx-Based PPS Group | Gather leadership of PPSs to exchange ideas on various topics including QE, consent strategies, etc. | Bronx Lebanon, HHC/One City, Advocate Community Partners | Irene Kaufmann |
| EIP Contracting Workgroup | Developed a common approach to EIP contracting with MCOs | Mount Sinai; Montefiore Hudson Valley, Maimonides, Bronx Lebanon, Nassau-Queens, NYU Lutheran | Irene Kaufmann |
| PPS Compliance Professionals | Compliance professionals from PPSs across the state work collaboratively on common issues and share resources. | Adirondack Health Institute, Albany Medical Center Hospital, Alliance for Better Health Care LLC, Bassett Medical Center, Care Compass Network, Central New York Care Collaborative Inc., Millennium Collaborative Care, Mount Sinai, Refuah, Samaritan Medical Center, Sisters of Charity Hospital of Buffalo, SUNY Stony Brook | Suzette Gordon |
| Performance Reporting CIOs | Monthly calls with SDOH/PCG on data requirements, Salient, MAPP, | Representatives from all participating PPSs | Janine Dimitrakakis |

| | | | |
|---|---|---|---|
| | dashboards, etc. PPSs provide feedback to the State. | | |
| Workforce Collaborative | Meet with BDO for joint planning and contracting on workforce milestones (target state survey, future state survey, gap analyses, compensation /benefit survey). | HHC/One City, Maimonides, NYU Lutheran | Mary Morris |
| Cultural Competency Training Strategy | Training and contracting planning for MHSA populations. | HHC/One City | Mary Morris |
| IDS Best Practice Exchange | Discuss best practices around IDS, Salesforce, DSRIP Tracker. | Bronx Lebanon, Maimonides, FFLPS – 3 reoccurring conversations; planning to merge. | Vitaly Chibisov |
| Health Home At-Risk Collaborative | Best practice sharing and standard setting around Health Home At-Risk project implementation and engagement with Health Homes. | Staten Island, HHC/One City, Maimonides, Bronx Lebanon, Advocate Community Partners, Montefiore Hudson Valley | Zoe Stopak-Behr |
| CVD Collaborative | Monthly conference calls to share ideas and resources and discuss common challenges/answer questions about the CVD project. | Advocate Community Partners, Care Compass Network, Nassau Queens, HHC/One City, Montefiore Hudson Valley, SUNY Stony Brook, Catholic Medical Partners | Caitlin Verrilli |
| MHSA Group | Work with vendor (Jewish Board) and city agencies (DOH, DOE, Office of School Health) to roll out project components and contract with CBOs. | Bronx Lebanon, Maimonides, HHC/One City | Rebekah Epstein |
| PPS HIV Coalition | Convened by NYCDOH to set project priorities and standing committees for implementation | NYU Lutheran, Maimonides, HHC/One City, Bronx Lebanon, Mount Sinai, NY Hospital Queens | Monica Chierici |
| GNYHA Integration Work group | GNYHA convening members of PPS that are working on integration projects. They coordinate content expertise and timely topics related to implementation of these projects | All PPS in NYC are presently engaged | Monica Chierici |
| NYC Regional Planning Consortium Behavioral Health Steering Group | Similar to GNYHA group, but convened by NYCDOHMH. The RPC is a more formalized structure with additional workgroups on DSRIP related implementation topics (Irene is engaged at governance level) | All PPS involved in BH projects | Monica Chierici |
| NYC RPC Managed Care & PPS Subgroup | This group is meeting semi-monthly to look at creating a framework for VBP in integrated settings. Current discussions are around creating a demonstration project | All PPS involved in BH projects and the MCO's (Fidelis, Beacon, Emblem) | Monica Chierici |
| Cross PPS Meeting on Care Transitions and ED Care Triage Protocols | This group was formed by BPHC and includes the Bronx-based PPSs to see how best to share information post-discharge and post-ED visit and how to best route patients to their PCPs and HHs, regardless of PPS. | BPHC, OneCity Health, Bronx Lebanon and Advocate PPS | Meredith Stanford |
| DSRIP Care Plan Joint Content & IT Subgroups | It is a collaboration led by GNYHA to standardize the content of care plans and the technical standards so that | All RHIOs | Bronx RHIO |

| Meeting | someday they can all pass seamlessly between PPSs. | 15 | |
| --- | --- | --- | --- |

**DSRIP Mid-Point Assessment - Project Narratives**

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

**PPS Name:** SBH Health System

**Project:** 2.a.i

## Challenges the PPS has encountered in project implementation:

One of the first challenges to be addressed in establishing BPHC's IDS organizational infrastructure was to develop and implement  contracting terms that outlined the relationship between BPHC and partner organizations as well as the ensuing service and financial obligations between BPHC and  its various member organizations including community based organizations (CBOs), voluntary and independent practitioners, major provider groups, Health Homes (HHs), and others.  The  task involved acquiring  a full understanding of and expertise in DSRIP  projects and measures by the PPS Central Services Organization (CSO) and then conveying the required conditions  effectively to the members themselves. This process was an essential challenge to mitigate since it would determine provider engagement and performance. Failure to meet this challenge successfully  would create difficulties reaching provider participation goals, undermine provider engagement in care management and population health management activities and risking BPHC's ability to provide  patients  full access to the continuum of comprehensive and coordinated care.

BPHC faces several serious challenges as it works to  develop and deploy IT strategies which will ensure that  numerous participating member organizations and their providers  meet DSRIP PPS interconnectivity and interoperability requirements. First,  more than just risking the PPS's ability to meet IT goals,  providers who still have not implemented Meaningful Use and Patient Centered Medical Home (PCMH) 2014 compliant EHR systems, and/or those who are not on a path to achieve PCMH 2014 Level 3 recognition by DY3Q4,  risk limited participation in coordinated interventions, care management, and population health management  negatively affecting their ability to drive improvement in patient outcomes. Second,  central to BPHC strategy is reliance  on the Bronx RHIO (BxRHIO) as our HIE and integrated patient information hub. . It is a challenge to develop RHIO connections between individual EHRs, pool patient information, and increase the percentage of patients with consent, so that comprehensive patient data will be available to coordinate care.  .Third, care coordination and management systems (CCMS) used by HHs lack integration, resulting in information silos and ineffective population health management. BPHC aims to develop an electronic care coordination management and referral management tool that can be shared across all BPHC providers to enhance information sharing and interoperability. Multiple IT systems (EMR, Care Management, Population Health Management registries, and others) are employed by HHs and PCMHs, and some partners lack systems with any of these electronic capabilities. Challenges have arisen during implementation with regard to integrating such a wide array of systems into a single centralized care management platform and identifying the right vendor to meet the needs of the PPS, adding  to the development time for achieving  BPHC's desired IT solution.

Another challenge for developing an IDS is managing the complex network of practitioners and collecting information about their operations and performance; this is a time and labor intensive process which lends itself to mistakes, and delays.

Finally, BPHC has also worked to meet the challenge of  planning for  contingencies of interruptions of funds flows or and delays in funds distribution. BPHC had to ensure that it could survive short term cash flow issues and net funds decreases and continue its mission of implementing DSRIP projects and meeting program goals. We were also challenged to develop financial incentives based on performance and adherence to protocols in the early phases of

## Efforts to mitigate challenges identified above:

To mitigate contracting challenges in an uncertain environment, BPHC took steps to learn more about our member institutions and implement measures to stress transparency and clear expectations. Providers entered master services agreement (MSAs) with BPHC early, deferring agreement on detailed requirements until they were known and incorporated in the contracts   in the form of schedules attached to the MSA. BPHC made an early, meaningful commitment to the transformational work of achieving PCMH 2014 Level 3 recognition, which we view as foundational to the program: BPHC hired and paired technical assistants with our Primary Care partners to help member organizations with both the NCQA application and the real work of transforming their practices. BPHC also provided education to demonstrate to providers eligible for PCMH and Meaningful Use (MU) changes in SDOH incentives and support which reward care management and population health management.

IT challenges were addressed in a variety of ways: 1) To address the issues of CBOs and connectivity, BPHC profiled all of its CBO partners through various means. We used BPHC-customized surveys and public online sources to understand the services they offer and IT capabilities. The information collected is being curated to enable an eventual referral management solution.   A workgroup made up of BPHC CBOs, our Community Engagement Initiative, is working on planning BPHC CBO activity to ensure CBO buy-in and that we are meeting our CBOs' needs. Some CBOs were contracted for specific services through MSAs and made certain IT commitments. BPHC also signed MSAs with all three HHs in the PPS which detail policies, procedures and serve as agreements to adopt standards. These HHs are aligned with Care Management Agencies (CMAs) and other social service agencies that provide CBO services.

2) To address the challenge of providers who still have not implemented Meaningful Use and PCMH 2014 compliant EHR systems, BPHC developed a comprehensive PCMH/MU plan based on IT assessments and will prioritize implementation to reach DSRIP goals. BPHC supports practices, deploys external consulting resources, and provides customized technical assistance, coaching, and care team training modules.

To manage challenges around using BxRHIO for population health management and other purposes, BPHC has developed a timeline to prioritize practices for phased connectivity, and mechanisms to monitor this expansion of HIE/IDS. BPHC is exploring the expansion of local HIE DIRECT messaging outside of the RHIO, and the abilities of CCMS systems to message and alert. These would allow partners more flexibility, leverage existing partner infrastructure where it exists, and provide redundancy in case the RHIO cannot keep pace with partner demand.

BPHC has been working to overcome the challenges associated with developing a PPS-wide CCMS. All necessary system and business requirements have been defined with the IT subcommittee and a CCMS Pilot Development Work Group. The work group mapped existing and future-state workflows for care management in the HH, HH At-Risk, Care Transitions, and ED Care Triage project contexts, which will allow rapid development and roll out of the BPHC CCMS platform. BPHC will work with a vetted vendor capable of developing an electronic care coordination management tool that will be made available to BPHC partners and comprehensively integrate all care coordination and transitional care management plans created across the PPS. The pursuit of interfaces between the BPHC CCMS, the BxRHIO and the various partner EMRs will ensure the robust exchange of care management planning information and greatly enhance clinical integration across BPHC providers. We are waiting until the CCMS solution is deployed to work out a comprehensive strategy for telehealth, remote monitoring, and the use of digital health apps.

To manage our extensive PPS network, a client relationship management solution was designed in Salesforce and deployed to collect, store, and use data concerning PPS members. Using such a platform created flexibility, allowing us to collect information about our members to more easily implement programs and affect change; for example, we are using this platform to collect Rapid Cycle Evaluation Metrics from our partners, metrics that will be used to monitor

implementation progress and drive continuous quality improvement initiatives aimed at improving patient outcomes.

To manage cash flow and funding challenges, BPHC is installing a number of critical control measures to monitor program implementation, progress towards PHM and outcomes measures. Performance Reporting and Continuous Quality Improvement (CQI) trainings have been designed and Change Management trainings are being designed for our network partners so that interventions can be instituted when appropriate. Budgeting and contracting are used and revised as needed to ensure continuous sustainable operations. Financial Incentives based on performance and adherence to protocols will be included in DY3 funding for primary care partners, specifically with our independent practices with Bronx United IPA, and have already been included in the Request for Proposals for our Critical Time Intervention program.

## Implementation approaches that the PPS considers a best practice:

**Governance.** BPHC has put in place a cross-institutional organizational governance structure designed to ensure consensus-based decision making on common goals, care models, clinical protocols, interconnectivity, interoperability, budgeting and the value-based payment (VBP) future. This structure consists of an Executive Committee, Nominating Committee, four (4) Subcommittees (Workforce, Finance & Sustainability, Information Technology, and Quality & Care Innovations), and a series of Clinical Work Groups (WG) that report to the Subcommittees. WGs are also known as Rapid Deployment Collaboratives (RDCs) in the SBH Project Plan Application, and focus in part on: appropriate utilization, chronic condition management and population health, primary care/behavioral health integration and patient engagement.

Below is the list of PAC and work groups that BPHC has to date, in summary:

| Project Advisory Committee (PAC) | | Work Groups (WG) | Sub-Work Groups |
|---|---|---|---|
| Executive Committee | Finance and Sustainability Sub-Committee | VBP Planning WG | |
| | Information Technology Sub-Committee | CCMS Pilot Development WG | |
| | Quality & Care Innovations Sub-Committee | HH At-Risk WG | |
| | | Care Transitions / ED Triage WG | |
| | | PC/BH Integration WG | |
| | | CVD / Diabetes WG | |
| | | Asthma WG | |
| | | MHSA WG | |
| | | HIV WG | |
| | | Pharmacy WG | |
| | | HH WG | |
| | | Behavioral Health Leadership WG | |
| | | Cultural Responsiveness WG | |
| | Workforce Sub-Committee | Workforce Communications & Engagement WG | |
| | | Workforce Advisory WG | |
| | | Workforce Planning WG | |
| | Nominating Committee | | |
| | | Community Engagement WG | Community Health Literacy Sub-WG |

**PCMH and Practice Transformation**. BPHC began the process to ensure all applicable providers meet PCMH recognition where possible, and is prepared to deploy Advance Primary Care (APC) support when guidance for that program is released. During the summer of 2015, BPHC requested Requests for Information (RFIs) of over 30 technical assistance (TA) groups to help BPHC members transform their practices. After a selection process, 10-12 TAs became approved BPHC vendors. At the same time, BPHC profiled its member organizations. Those with large numbers of primary care

providers (PCPs) were guided by BPHC in a match process with the TAs. Based on the organization's profile, they were matched with 2-3 TAs and then the primary care organization selected one TA group to work with. BPHC also retained one TA group to help manage the logistics of the administration of the program.

Standardized gap assessment tools were created by BPHC and then administered by the TAs on practice locations permitted/approved by CSO to assess their PCMH readiness. Over 115 practice locations have been thus far authorized with 80 gap assessments returned. Based on the gap assessments, TAs produced work plans and negotiated them with BPHC CSO. Then practice leadership was introduced to the plans and buy-in was secured as Memoranda of Understanding (MOUs) were signed between TAs and practice leadership. This was followed by contracting between TAs and BPHC for transformation work. Thus far we have seven TAs under contract for PCMH transformation work. This effort resulted in 23 practice sites achieving PCMH 2014 Level 3 recognition; accounting for some 35% of our SDOH identified PCPs as of July 2016. While our largest primary care sites have been prioritized for maximum patient impact, work is ongoing to support the remaining practices. Efforts are underway to evaluate the potential for non-traditional primary care program such as  School Based Health Centers, Mobile Vans, PACE programs, long term care centers, for achieving NCQA PCMH recognition.

The eight consulting groups were invited to be a part of a Community of Practice (CoP) BPHC has organized to build/establish best practices, share and collaborate with experts on PCMH transformation, and transfer the experience and knowledge to other population health initiatives. Within this group we shared our Clinical Operations Plan (COP), which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups. The COP includes narratives, policies and procedures of how members will provide various services to patients in a standardized, reliable way within the most efficient structure. As part of this PCMH integration strategy, and in order to leverage the efforts of the consultants and prevent duplication of labor, BPHC aligned, as closely as possible, the recommendations contained in the COP with the PCMH requirements. We also developed guidance for the PCMH consultants which outlines the links between the DSRIP projects and the PCMH requirements.

**MU, EHR, and RHIO Support**. We are executing a comprehensive plan to support our safety net providers in MU and PCMH which includes EHR support and connectivity of data captured therein. Funding has been distributed for expanding IT connectivity and processes for this funding's distribution have been developed and communicated to the member organizations. Schedule As (i.e., contracts) have been developed to distribute some of this funding as a result of the process.

Our MU plan will be part of a package of IT interventions for those providers which have yet to achieve connectivity. With the help of Primary Care Information Project (PCIP) we performed gap assessments of all BPHC providers and using an existing network map we attributed them to organizations. The gap assessment looked at eligibility of practitioners, and if eligible, where they are in the MU process. Based on this process, a work plan is being developed for each individual organization, prioritizing those physicians which have yet to start the program. As part of the work plan, we are including other IT infrastructure improvements, such as EHR implementation and RHIO connectivity and encounter notification systems deployment. In conjunction with PCIP, the PPS is tracking providers' IT infrastructure, developing training materials, and other supports needed for EHR use and deployment.

**Population Health Management**. Our agreement with BxRHIO will serve as the foundation to ensure that all participating safety net providers are actively sharing health information. A successful QE consent program is pivotal for this to succeed. A series of meetings between Bronx PPSs, including Bronx Lebanon, OneCity Health and Advocate PPS, were called to discuss best practices. Member organizations were identified by the BxRHIO with exemplary success in collecting consents and conveying the value of sharing data to patients to elicit a positive response. Best practices were collected and are now being implemented in select members. Three strategies are being deployed: 1) Frontline staff training and workflows are being implemented to improve consent rates. 2) Reintroduction of the BxRHIO to providers to improve adoption. 3) Modifications to the EMR are being made to facilitate QE collection. Continuous measures are

being taken by the BxRHIO and reported to BPHC to measure progress. This comprehensive BxRHIO patient consent strategy is increasing our attributed member participation in data-sharing and data agreements between member organizations are creating an environment where PHM will be easier to implement.

We are working to leverage the BxRHIO technology to implement the Encounter Notification System (ENS) more widely across our PPS and have begun participating in beta-testing of Spectrum, BxRHIO's data analytics tool, onto which we will develop our population health management (PHM) platform. We are exploring the MAPP/Salient resources to use as additional PHM source. Furthermore, specific metrics have been prioritized during BxRHIO contract negotiations to accelerate our work in improving outcomes measures. BPHC deployed a rapid cycle evaluation (RCE) program and selected measures to promote PHM and continuous quality improvement.

Furthermore, PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access. BPHC's Quality and Care Innovation Subcommittee (QCIS) and Executive Committee decided on a care coordination staffing model that involves embedding care coordination teams within large primary care practices. This model had been adapted to the context of each of BPHC's large primary care partners, who are currently working to staff and train their Care Coordination teams. These teams are overseen by Nurse Care Management Supervisors and made up of care coordinators, community health workers, and care coordination assistants; many also contain social workers or operate in concert with the practices' social work teams. The Care Coordination teams work closely with Primary Care teams to identify patients in need of care coordination, for whom they conduct outreach, assessment, individualized care planning, referrals to services, follow-up and reminders and general healthcare system navigation assistance. A CCMS as described above or EHR will help staff coordinate individualized patient care plans and manage appointment scheduling and reminders for the patient appointments. In order to provide care coordination services to patients of practices that do not have a panel large enough to warrant embedded care coordination teams, BPHC is working with its HH partners to define a process to match these practices with designated CMAs who will offer these services.

**Contracting / Network Development**. BPHC prioritized building relationships with members which provide diverse services to BPHC attributed patients. BPHC has put in place a cross-institutional organizational governance structure designed to ensure consensus-based decision making on common goals, care models, clinical protocols, interconnectivity, interoperability, budgeting and the value-based payment (VBP) future. The PPS finalized the MSA structure, implemented processes for collecting them, and collected MSAs covering approximately 75% PCPs in our network and 79 non-PCPs (who together account for 97% of primary care services to BPHC attributed members). CSO solicited the partners' startup funding needs through an RFI for Clinical Integration process to partners who have a signed MSA with the CSO. Responses were reviewed and analyzed to determine the greatest areas of need: clinical team and care management staffing, IT, and population health management. For all but 4% of these providers (those who are part of a complicated independent physician association), a budget was negotiated based on the RFI and subsequently turned into a Schedule A (contract). A similar process was used to develop Schedule As with all hospital systems in the PPS to implement specifically the ED Care Triage and Care Transitions projects.

Recently another CBO, Health People, entered a contract with BPHC for Diabetes Self-Management peer education program services (DSMP), in addition to other CBOs who've already signed contracts with BPHC (a.i.r. bronx and Institute for Family Health). The Community Engagement Work Group (CEWG) met to discuss how to provide training opportunities for CBOs. The CEWG provided advice on what topics to include in community health literacy trainings. From the CEWG, another subgroup, the Community Health Literacy Work Group (CHLWG), discussed topics to offer for training. From the work of the CEWG and CHLWG, a survey was developed and distributed for comment to the Project Managers of the Central Services Organization, Implementation Work Groups, Site Specific Implementation Teams, DSRIP Project Directors and the Cultural Responsiveness Work Group; the survey was then reviewed by the CHLWG to further define what to include in a subsequent Request for Letter of Intent (LOI) from the membership. BPHC, the CHLWG and the CEWG will continue to develop an RFP to address the training needs of the CBOs and the community.

Agreements have also been signed with two of the three HHs – Community Care Management Partners (CCMP) and Coordinated Behavioral Care (CBC) – and we will sign one with Bronx Accountable Healthcare Network (BAHN) next quarter.

Another approach that might be considered a "best practice" is the establishment of the Pharmacy Workgroup. The kickoff for this group was held on February 25th and included representatives from 7 of the 10 BPHC pharmacy partners. This workgroup is brainstorming strategies to support the challenges pharmacies face in helping our patients and identify solutions that align with DSRIP goals. The work group is exploring ways to spread the best practices of its workgroup members. They are also developing the resource for prescribers to share valuable insights as we begin to design and implement new projects and collaborations.

**Value-Based Payment**. BPHC is proactive in its communication and relationship with the six Medicaid MCOs that are the conduit for the Equity Infrastructure Program (EIP) and Equity Performance Program (EPP) funding. Quality measures and activities for EIP and EPP funding were chosen that work in concert with the BPHC's selected clinical projects, with our cross-cutting organizational work, and with the healthcare needs of the population being served. Through the EIP and EPP correspondence as well as the communication through the VBP Planning Workgroup, BPHC and MCOs will continue to work closely. In addition, HealthFirst has a seat on our Executive Committee, regular monthly meetings where we will review utilization trends, performance issues, and planning for payment reform. These relationships, and our ability to leverage Risk and Shared Savings contracts already in place through the Montefiore CMO, will serve as the foundation for when an integrated system and VBP arrangements are formally established.

**Community-Based Organizations**. BPHC identified community-based services necessary for our attributed population and recruited CBOs accordingly. BPHC continues to develop strategies for CBOs involvement in service delivery for the at-risk population engaged in care management. Leveraging a list of social services most commonly utilized by the at-risk population, developed by BPHC's clinical work groups, as well as surveys on existing services offered by organizations within the PPS, BPHC has developed a referral directory for use throughout the network, an essential development in creating a referral management system. The resource directory incorporates consolidated information from various sources: surveys, research, existing directories and platforms. In the next steps, the resource directory will be made available for comment by the community engagement work group and edits will be incorporated. This directory will be searchable by zip code and service category and will eventually be included in the CCMS and/or referral management platform.

BPHC contracted with two CBOs to work on clinical projects. a.i.r. bronx is delivering home-based self-management services to asthmatic clients and their families. This engagement with a.i.r. bronx is supporting the employment of 21 staff. Health People, a CBO that is a certified Stanford Model trainer, is currently working with our member organizations to identify patients with diabetes to receive training to become peer educators, and lead the DSMP courses. We plan to train 20 peer coaches, who are compensated for their training and teaching, and we have a planned capacity for up to 800 students in the DSMP courses. Fifteen new peer educators are being currently supported at Health People by BPHC.

BPHC is engaging with CBOs in other ways as well. BPHC engages HHs in the IDS, utilizing existing capabilities to deepen PPS-wide clinical integration, and work with the HH downstream care management agencies (CMAs) and social service agencies. BPHC has convened a cross-HH group for collaboration around provider and community education, bottom-up referral processes, minimum standards for PCP-HH communications, HH At-Risk service provision, and other topics. The first meeting of the group was held in June 2016 with participation from the three organizations serving the vast majority of BPHC attributed HH enrolled patients: BAHN, CCMP, and CBC. At the meeting it was determined that the BPHC CSO and the HHs will undergo a process to match small/solo practices with designated CMAs to build relationships and ensure consistency of care coordination service provision. HHs will also consider whether they would like their CMAs to identify Care Managers for participation in BPHC-organized care coordination trainings. BPHC-affiliated HH representatives will continue to meet regularly and collaborate in this fashion going forward.

**Patient Engagement.** BPHC has commenced the development of screening tools for social determinants of health, with a focus on factors that could be impacted by health system interventions or referrals to community-based services. These tools will assist partners in identifying HH and HH At-Risk eligible patients, and will aid in patient risk stratification efforts. Some partners have already begun to build relevant fields in their EMR platforms to track social determinants of health, and the CSO is compiling best practices to share with other partners who aim to build similar fields. This work includes consultation with subject matter experts to develop standard definitions of key social determinants in order to ensure risk stratification and other population analytics that use these EMR fields will be comparable points of reference among BPHC organizations. A non-EMR-based screening and referral form based on the same standards has also been developed for use by a wider range of partners.

BPHC established a Cultural Responsiveness Work Group under its QCIS, with representation from CBO and clinical institutions across the PPS, to develop a cultural competency and health literacy strategy for DSRIP implementation. Ultimately this strategy seeks to improve the responsiveness and quality of health service provision; to address cultural and communication barriers in access to care; and to build engagement and participation of patients and their communities in addressing their health needs. One outcome of the effort was BPHC, through a RFI process, seeking to contract with organizations to help improve health literacy in Bronx communities. The RFI had three components: 1) Train the Trainer where a selected CBO will be trained by BPHC to deliver the community health literacy curriculum developed by the Cultural Responsiveness Work Group; 2) Educate the Community where once trained on the curriculum, community-based organizations will provide basic community health literacy education to a defined population in the Bronx community; and 3) Maximize Available Resources where BPHC will provide additional funding support for organizations that will also successfully connect eligible individuals to the programs profiled in the education curriculum.

In order to ensure a systematic and sustainable implementation of cultural competency and health literacy (CC/HL) strategies, the approach developed by the PPS involved deployment of a set of strategic interventions as part of its core programs, including workforce training, community outreach and clinical improvement projects. These interventions include: 1) Identifying priority groups experiencing health disparities, based on the community needs assessment results and participant input; 2) Identifying specific initiatives and standards based on best practices of member organizations, to improve access to high quality, equitable services and address health disparities; 3) Identifying tools and resources for Domain 3 projects that could build health literacy and support effective self-management of health conditions for priority groups experiencing health disparities; 4) Identifying best practices in cultural responsiveness and health literacy interventions to reduce health disparities and improve outcomes in primary care and care management models; and 5) Outlining the requirements and timing for integration of cultural competency in the training and re-training strategies linked to implementation of clinical projects and community initiatives. Patient engagement is also being conducted by peer educators as part of our Diabetes Self-Management Program with the help of Healthy People.

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

Significant efforts are under way to collaborate with neighboring PPSs on project implementation and reporting. Over 80% of BPHC providers are in multiple PPSs and we have three other PPS in our geographic region working with similar populations. Even among the Medicaid primary care patients seen by SBH Health System, our lead applicant, about half are attributed to other PPSs. We are working closely with these other PPSs and the BxRHIO to implement policies, procedures, and solutions to negate the administrative and reporting problems which arise from this. Project implementation boundaries are being negotiated by BPHC with member organizations and other PPS to ensure success and best use of funds. The BxRHIO is instrumental in deduplication patient engagement metrics in a significant effort to ensure compliance with SDOH directions.

Efforts are ongoing to position the PPS to respond to the August opening of the MAPP tool for additions to the PPS and to provide supporting documentation to support primary care physician categorization. This milestone has been

completed and will be continually updated.

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

There are no changes to the populations that were proposed to be served through the project based on the original community needs assessment.

## DSRIP Mid-Point Assessment - Project Narratives
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health System

**Project:** 2.a.iii

| Challenges the PPS has encountered in project implementation: |
|---|

Bronx Partners for Healthy Communities (BPHC) aims to develop an electronic care coordination management and referral management tool that can be shared across all BPHC providers to enhance information sharing and interoperability. Multiple information technology (IT) systems (Electronic Medical Records [EMR], Care Management, Population Health Management, and others) are employed by Health Homes and Patient-Centered Medical Homes (PCMHs), and some partners lack systems with any of these electronic capabilities. Challenges have arisen during implementation with regard to integrating such a wide array of systems into a single centralized care management platform and identifying the right vendor to meet the needs of the PPS, resulting in delayed development of BPHC's desired IT solution.

BPHC-affiliated entities have expressed challenges around the pre-identification of the Health Home At-Risk population among their patient panels. Referrals to care coordination under the BPHC model should result from an in-person encounter with the patient and warm handoff to care coordination, rather than identification from a list; however, pre-identifying potentially-eligible patients is useful for resource allocation and pre-visit planning. Creating a registry of eligible patients has proven technically difficult—Health Home At-Risk patients have a single-uncontrolled chronic condition (in contrast to two or more conditions for Health Home eligibility) and therefore reports must isolate the presence of a single condition in the absence of any other Health Home-qualifying conditions. As a result of technical barriers, some partners lack a clear understanding of the quantity of their patients who may be eligible for this level of care coordination.

Some challenges have arisen surrounding the recruitment and training of sufficient numbers of qualified, bilingual care coordination staff to serve the needs of the Bronx population. The slow pace of hiring has affected the timing of trainings and delayed the full ramp up of patient referrals into Health Home At-Risk care coordination. Furthermore, at this point in DSRIP implementation, the PPS cannot fund as many care coordination staff as may be required to fully meet the needs of the population.

A barrier to referrals into Health Home and Health Home At-Risk interventions stems in part from a lack of care coordination-related knowledge among primary care teams, behavioral health providers, and community-based organizations. Some health and other service providers (e.g., primary care physicians [PCPs], hospital staff, CBOs, correctional facilities, etc.) may not have a clear understanding of the benefits of care coordination and some, particularly small practices, may not have prior linkages with Health Homes.

Maintaining a short-term care management intervention for Health Home At-Risk patients is necessary to preserve optimal caseloads for Care Coordinators and to extend services to as many patients as required under BPHC's speed and scale commitments. However, partners' experience with care coordination suggests it can be difficult to "graduate" patients out of these services once they have been engaged.

A number of factors—including those listed above—contribute to BPHC's risk of missing patient engagement targets for project 2.a.iii. Another related barrier involves limited access to data on patients with care management plans.

Issues around right to use of patient names and Medicaid Client Identifications Numbers (CINs) have arisen with partners conducting care management on behalf of managed care organizations. This represents a significant portion of the Comprehensive Care Management Plans currently being developed within BPHC's provider network.

## Efforts to mitigate challenges identified above:

BPHC has been working to overcome the challenges associated with developing a PPS-wide care coordination management system (CCMS). All necessary system and business requirements have been defined with the IT subcommittee and a CCMS Pilot Development Work Group. The work group mapped existing and future-state workflows for care management in the Health Home, Health Home At-Risk, Care Transitions, and ED Care Triage project contexts, which will allow rapid development and roll out of the BPHC CCMS platform. BPHC will work with a vetted vendor capable of developing an electronic care coordination management tool that will be made available to BPHC partners and comprehensively integrate all care coordination and transitional care management plans created across the PPS. The pursuit of interfaces between the BPHC CCMS, the Bronx Regional Health Information Organization (RHIO) and the various partner EMRs will ensure the robust exchange of care management planning information and greatly enhance clinical integration across BPHC providers.

To address the technical difficulties experienced by some partners in estimating the magnitude of their Health Home At-Risk eligible population, BPHC is preparing technical guidelines to aid IT and Population Health Management staff in pulling accurate reports. BPHC has also provided funding to its partner organizations to enhance their IT and Population Health Management capacities, in order to address these and related patient identification queries.

BPHC's workforce strategy looks to mitigate care coordination hiring challenges by working with community colleges and coordinating with the 1199 Training and Education Fund (TEF), Montefiore CMO, and the New York State Nursing Association (NYSNA) to identify capable workers and provide training in Spanish when needed. BPHC also is coordinating with other Bronx PPSs on workforce strategy to align priorities and reduce competition. The first PPS-wide Care Coordinator Training launched in July 2016, with staggered trainings planned for the coming months to accommodate new hires anticipated to onboard throughout the summer and fall. BPHC anticipates that hiring of care management staff will expand among the practices as the PPS shifts to a value-based payment structure.

As part of its Health Home and provider engagement strategies, BPHC is working with Health Home partners, primary care organizations, and behavioral health providers to improve education and ongoing recognition of the benefits of care coordination services. This is occurring presently through internal meetings between DSRIP Program Directors and care teams, Health Home trainings for primary care providers, trainings of ED Care Navigators (project 2.b.iii) and Care Transitions Clinical Coordinators (project 2.b.iv), and CBO engagement in health literacy initiatives. Additional initiatives are under development, including deeper engagement with behavioral health providers around referrals to care coordination, as well as a primary-care focused education campaign on the benefits of care coordination services for patient outcomes. On the basis of lessons learned from these early initiatives, BPHC will explore other avenues for expanding education and referral campaigns, including working with Health Homes to deploy outreach staff to hospitals and other settings. BPHC will also seek to leverage the experiences of PPS partners involved in New York State's Criminal Justice/Health Home Pilot Project to improve linkages to services for justice-involved patients.

In an effort to maintain a short-term care management intervention for Health Home At-Risk patients, BPHC is working with its training vendor, the Primary Care Development Corporation (PCDC), to ensure necessary modules are included in the Care Coordinator Training curriculum.  Through this training, Care Coordinators will be prepared to work with patients to set realistic, time-limited goals and achieve their objectives within the allotted three- to nine-month intervention period. The PPS is also exploring "step-down" models to ease the transition, such as enrollment in a peer group after "graduation" from Health Home At-Risk care coordination services.

To overcome data access challenges, BPHC is pursuing additional data sharing agreements with its partners and third party entities, such as managed care organizations (MCOs).

## Implementation approaches that the PPS considers a best practice:

During the initial months of DSRIP, the target population, staffing model, assessment tool and intervention strategy for the Health Home At-Risk program were developed by a Transitional Work Group (TWG) made up of subject matter experts from across the PPS. The group also defined training requirements for care coordination team members and rapid cycle evaluation (RCE) metrics to measure program progress and success.

Based on the work of the TWG, a Clinical Operations Plan (COP) was developed for the Health Home At-Risk Intervention Program, which includes policies and procedures for each element of care coordination. The COP chapters specific to Health Home At-Risk include: Target Conditions; Staffing; Patient Intake and Assessment; Patient Management; Transitioning Out of Care Management; Annual Update of the Care Plan; and Patient Reactivation in Care Management Services. The COP details the roles and responsibilities of primary care team and care coordination team members in each of the processes described, such as referring patients to care management services, assessing patient needs, setting goals with patients, and identifying appropriate interventions (including referrals).

The TWG, the Quality and Care Innovation Subcommittee (QCIS) and Executive Committee decided on a care coordination staffing model that involves embedding care coordination teams within large primary care practices. In order to foster the conditions necessary to fully implement the embedded care management model outlined in the COP, the Central Services Organization (CSO) worked with partners' Site-Specific Implementation Teams (SSITs) to determine their organizational care coordination staffing plan and submit requests for assistance in funding new positions. Based on these requests the CSO deployed funds to its large primary care organization partners to recruit, hire and/or redeploy personnel to serve in the care coordination team roles of Care Coordinator, Nurse Care Management Supervisor, Care Coordination Assistant, and Population Health Manager. As these staffing efforts got underway, the CSO met with each of the funded organizations to emphasize key implementation priorities and to identify any anticipated challenges to full development of the primary care-embedded care coordination and chronic disease management models.

As described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. This provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice).

During the implementation phase, the Health Home At-Risk project is overseen by an Implementation Work Group (IWG), which acts as a clinical quality council and reports to the QCIS. The IWG has defined the recommended evidence-based guidelines on care coordination for the PPS and continues to meet regularly to monitor data, trends, and implementation challenges across the partner organizations. After conducting an in-depth literature review, the group selected the Agency for Healthcare Research and Quality (AHRQ) guidelines entitled, *Designing and Implementing Medicaid Disease and Care Management Programs* and voted to recommend *Section 8: The Care Management Evidence Base* to the Quality and Care Innovation Subcommittee (QCIS) to serve as BPHC's evidence-based guidelines on care coordination. The group also chose to recommend the full eight-section document to serve as an implementation reference guide for practices engaged in the Health Home At-Risk Intervention Program. The group has also overseen the rollout of rapid cycle evaluation metrics and development of the Care Coordinator and Nurse Care Management Supervisor trainings.

BPHC chose curriculum development and training vendors to produce and deliver the Care Coordinator and Nurse Care Management Supervisor trainings. Each cohort of 15-20 participants will receive approximately 60 hours of Care Coordinator training over a three-month period, with the first session launching in early July 2016. This includes 44 hours of Comprehensive Care Coordinator training, designed and delivered by the Primary Care Development Corporation (PCDC); eight hours of Motivational Interviewing training, designed and delivered by the National Council for Behavioral Health; and eight hours of training on Care Management for SMI/Substance Users delivered by various subject matter experts. Nurse Care Management Supervisors will participate in the training with the Care

Coordinators and receive an additional two day training on supervision, delivered by the National Council for Behavioral Health.

BPHC has convened a cross-Health Home group for collaboration around provider and community education, bottom-up referral processes, minimum standards for PCP-Health Home communications, Health Home At-Risk service provision, and other topics. The first meeting of the group was held in June 2016 with participation from the three organizations serving the vast majority of BPHC attributed Health Home enrolled patients: Bronx Accountable Healthcare Network (BAHN), Community Care Management Partners (CCMP), and Coordinated Behavioral Care (CBC). BPHC-affiliated Health Home representatives will continue to meet regularly and collaborate in this fashion going forward with a focus on education and outreach, communication standards, data and analytics, and access to services.

In order to provide Health Home At-Risk care management services to patients of practices that do not have a panel large enough to warrant embedded care coordination teams, BPHC is working closely with its Health Home partners to define a process to match these practices with designated Care Management Agencies (CMAs). It was deemed a priority to ensure a single CMA would be associated with each practice, to encourage relationship building between partners and ensure consistency in care coordination service provision.

The Health Home At-Risk Intervention Program focuses heavily on bridging the gap between clinical and social services. BPHC's Community Engagement and Communications Group convened during DY2 Q1 to finalize the development of an electronic Community Resources Directory, accessible to providers across the network, in order facilitate connections between clinical and social services. The directory is searchable by service type and zip code and is connected to the PPS Salesforce platform, allowing partners to keep their information consistently up to date. The Central Services Organization (CSO) worked with partners to define their referral procedures, with particular attention to closed loop referral tracking on all referrals to social services.

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

To further engage community based organizations (CBOs) and de-silo clinical and social services, the CSO issued a request for proposals (RFP) to CBOs to provide  health literacy training to community groups and help identify and connect eligible individuals to needed primary care , Health Home At-Risk, and Health Home services. The CSO will receive and re-direct referrals from CBOs and behavioral health providers through a centralized hotline, in order to expand access to needed services among targeted populations not sufficiently connected to primary care or care coordination. This centralized hotline will complement the development and expansion of hospital-based call center units at St. Barnabas and Montefiore, which administratively coordinate patient referrals from the ED to HHs, PCPs and other non-hospital providers.

BPHC has commenced the development of screening tools for social determinants of health, with a focus on factors that could be impacted by health system interventions or referrals to community-based services. These tools will assist partners in identifying Health Home and Health Home At-Risk eligible patients, and will aid in patient risk stratification efforts. Some partners have already begun to build relevant fields in their EMR platforms to track social determinants of health, and the Central Services Organization (CSO) is compiling best practices to share with other partners who aim to build similar fields. This work includes consultation with subject matter experts to develop standard definitions of key social determinants in order to ensure risk stratification and other population analytics that use these EMR fields will be comparable points of reference among BPHC organizations. A non-EMR-based screening and referral form based on the same standards has also been developed for use by a wider range of partners.

The CSO has also identified a potential need to standardize communication and information sharing between Health

Home Care Managers and providers (Primary Care / Behavioral Health) for actively managed patients. Some BPHC PCPs have expressed frustration at not knowing what happens after they have referred a patient to a Health Home; some providers would like to be part of shaping the care plan and not just act as the referral source. BPHC is working with its Health Home partners to plan focus groups with providers and Care Managers to capture each group's wants regarding the content, frequency and format of communications between parties. The eventual output would be basic processes and basic templates for communications and data exchange. The CSO and Health Homes will work on enhancing training curricula for Health Home Care Managers to include skills around engagement with providers, as well as scripts and templates to guide Care Managers in these interactions.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support their projects. Specifically for this project, BPHC participates in a cross-PPS Health Home At-Risk collaborative focused on best practice sharing and standardization, which includes Staten Island, Health + Hospital, Maimonides, Bronx Lebanon, Advocate Community Providers, and Montefiore Hudson Valley PPSs. BPHC is also actively involved in the Greater New York Hospital Association (GNYHA) One Care Plan Work Group (working on the development of a standard care plan using CCDA architecture) and the GNYHA Clinical Leadership Forum, which gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, and understanding various vendor platforms.

Additionally, a critical component of the Health Home At-Risk Intervention Program is the ability to share data, not only within each individual PPS, but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

Based on the information gained via the Community Needs Assessment and through the work of the Health Home At-Risk Transitional Work Group, BPHC more specifically defined the target population for the intervention to align with the needs of the Bronx Medicaid population. Eligible patients have one uncontrolled chronic condition and are considered at-risk for developing another, based on social or other risk factors. Target clinical conditions identified by the PPS include: Highest priority: heart disease, diabetes, asthma, chronic obstructive pulmonary disease (COPD), mild/moderate depression, substance abuse, and arthritis; Moderate priority: cancer, Alzheimer's, sickle cell anemia, pediatric epilepsy and pediatric attention deficit/hyperactivity disorder (ADHD). Although originally identified as a priority, gastroenterology was not chosen by the TWG as a target condition. Social risk factors include: homelessness, overcrowded housing, history of incarceration, joblessness, food insecurity, domestic violence, and pregnancy. Other relevant factors include: history of frequent avoidable ED use, recent potentially preventable inpatient admissions, and a recently diagnosed condition.

**DSRIP Mid-Point Assessment** - **Project Narratives**
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health SystemSBH Health System

**Project:** 2.b.iii2.b.iii

## Challenges the PPS has encountered in project implementation:

BPHC aims to roll out the ED Care Triage program in all five PPS Emergency Departments (ED) by March of 2017. Although an ED Navigator program exists at Montefiore, the expansion of the program into other EDs may be delayed due to recruitment and training challenges. Identifying bilingual staff with the appropriate background, willingness to work non-traditional hours, (off-hour and weekend shifts) and experience has been challenging. The original model called for all ED Navigators to be Registered Nurses (RNs) which contributes to the recruitment challenges, given the shortage of experienced nurses available for hire. The slow pace of hiring has affected the timing of trainings and delayed ramp up of the program at all sites.

Defining staff roles and responsibilities has also been challenging. There are several unknowns at this early point in implementation with respect to the exact services patients will need and how to manage the intersections of the work of ED Navigators with work of social workers and that of Health Home Care Managers. The true coordination of care among providers within the hospital as well as outside may take longer than expected. Real-time communication may be challenging and the uncoordinated engagement of patients by both ED Navigators and Health Home Care Manager may create confusion, duplication of work efforts, and even possible disagreement in the plan of care and recommendations.

BPHC aims to develop an electronic care coordination management and referral management tool that can be shared across all BPHC providers to enhance information sharing and interoperability. Multiple IT systems (EMR, Care Management, Population Health Management registries, and others) are employed by hospitals, Health Homes and PCMHs, and some partners lack systems with any of these electronic capabilities. Challenges have arisen during implementation with regard to integrating such a wide array of systems into a single centralized care management platform and identifying the right vendor to meet the needs of the PPS, resulting in delayed development of BPHC's desired IT solution. This makes electronic communication and care plan sharing challenging across partners, and across services: tasks/recommendations cannot easily be transferred from the ED Navigator to the community based or centralized care coordinator.

BPHC partner hospitals have expressed challenges that patients with behavioral health conditions tend to overutilize the ED and may impact DSRIP's goal of reduction in avoidable ED use. Patients with behavioral health conditions, especially those experiencing crises, tend to overutilize and can be a difficult population to engage. These patients, especially those who are homeless or precariously housed, tend to see EDs as a safe/welcoming place to "escape" and as an alternative to a shelter. An alternative for behavioral health patients who use the ED to "escape" exists through the parachute NYC program's behavioral health crisis respite centers. However, utilization of these programs by our hospitals and EDs has been low because of lack of knowledge of and understanding of the benefits of these programs.

An additional challenge lies in the heavy social service needs of patients targeted for this project. The needs for those social services, such as transitional housing, further complicate patients' medical needs making chronic diseases more difficult to manage. Many of these patients arrive at the ED during off-hours, when it is difficult to connect patients

with needed social services. These needs are compounded in extreme weather conditions.

Likewise, identifying patients' PCPs and making real-time appointments, especially when patients arrive in ED at off-hours, is challenging. In the ED, it may be difficult to identify the patient's physician and/or care manager, especially if that patient is not already known to one of the hospital systems. This may present itself as an IT problem as accurate Health Home and PCP assignments are not easily available to ED Navigators in one place through EMRs or the RHIO. . Related to this difficulty in identifying and returning patients to their provider, IT challenges across providers (varied EHRs, no EHR, EHR not compliant with PCMH or MU, lack of RHIO connectivity) present additional challenges to 2.b.iii and care coordination efforts.

Lastly, BPHC has originally committed to opening at least two new urgent care centers and one additional respite facility to make additional sites available for at-home or in-community stabilization. This is a challenge because BPHC partners did not receive DSRIP Capital Restructuring Financing Program (CRFP) for these projects.

## Efforts to mitigate challenges identified above:

To mitigate the challenge of delayed program expansion, BPHC will stagger the DSRIP program expansion, beginning in the SBH ED and Montefiore's Moses EDs and then moving to other Montefiore EDs. BPHC has contracted with the Montefiore's Care Management Organization (CMO) to help lead program development and training, and other programmatic functions (developing staff competencies and job descriptions) to minimize delays, address the challenges of defining staff roles and responsibilities and ensure proper programmatic oversight.  BPHC is working closely with the CMO to design the curriculum as well as test aspects of that curriculum with current ED Navigators. SBH Health System is staffing their program with a mix of RNs, Social Workers, and non-clinical navigators, which broadens the pool of applicants and helps mitigate some of the recruitment challenges.

To further mitigate the challenge of clearly defining roles and responsibilities of ED Navigation staff, BPHC will begin testing various workflows designed to address communication and care coordination. These include: the use of RHIO to find as much information about the patient's medical travels and care providers, making outreach to the Health Home Care Coordinators, and identifying other care coordinators involved with the patient. Each of these small tests of change requires detailed workflows that will be added to the workflows required at milestone completion. Efforts are also in progress for SBH to have a cross-disciplinary team of nurses, social workers and non-clinical coordinators working as one ED navigation team. This team will work closely with the Health Home Care Managers at SBH and the navigators at outpatient clinics. Workflows will be piloted to see if having Health Home representatives in the ED (or come to the ED) is feasible. Through a PPS-wide population health strategy effort, large primary care partners, including SBH and Montefiore outpatient clinics, will utilize RHIO alerts/subscriptions and create an organized mechanism to receive and route those alerts to care coordinators and inform PCPs of interventions needed. Efforts to test communication and collaboration with Health Home Care Managers are underway. BPHC partners may be more motivated to test this communication and collaboration in light of the new IA guidance on patient engagement counting appointments with a Health Home Care Manager.

BPHC has been working to overcome the challenges associated with developing a PPS-wide care coordination management system (CCMS). All necessary system and business requirements have been defined with the IT subcommittee and a CCMS Pilot Development Work Group. The work group mapped existing and future-state workflows for care management in the Health Home, Health Home At-Risk, Care Transitions, and ED Care Triage project contexts, which will allow rapid development and roll out of the BPHC CCMS platform. BPHC will work with a vetted vendor capable of developing an electronic care coordination management tool that will be made available to BPHC partners and comprehensively integrate all care coordination and transitional care management plans created across the PPS. The pursuit of interfaces between the BPHC CCMS, the Bronx RHIO and the various partner EMRs will ensure the robust exchange of care management planning information and greatly enhance clinical integration across BPHC providers.

CBOs can help mitigate the challenge of BH patients overutilizing the ED: Parachute NYC is an effective program that provides an alternative to the ED and inpatient admissions through peer-run respite centers and mobile crisis intervention. Crisis respite centers provide a soft landing where behavioral patients with an established treatment provider who are not a danger to themselves or others can experience a peer living arrangement that allows for therapeutic support in a non-traditional setting. To mitigate the challenge of buy-in to these programs, BPHC CSO has arranged tours, presentations, and identified champions at our hospitals for these programs. SBH has already started referring patients to these services; and the Chief of Psychiatry at Montefiore Medical Center Department of Psychiatry and Behavioral Sciences, and the Chief Operating Officer of Montefiore's behavioral health care management organization, University Behavioral Associates (UBA), has convened a meeting with inpatient and ED Psychiatrists and staff to encourage referrals to these programs. The social work department at Montefiore also refers to Parachute on a limited basis as part of their Housing at Risk program.

To mitigate the challenge that patients are in need of social service referrals at off hours, ED Navigators will have access to a web-based directory of CBO providers that will provide comprehensive information on the scope of social services provided across the PPS. The Implementation Workgroup (IWG) will continue to engage in helping hospital partners make connections with CBOs. The ED Navigators will be trained to recognize flags of homelessness such as "staying with a friend" or using a shelter or hospital address. BPHC will spread best practices from the Montefiore Housing at Risk program, already in place in some Montefiore EDs, to the remaining Montefiore EDs and the SBH ED. This program has been able to work closely with Safe Haven bed providers for patients known to the department of homeless services but who refuse to go to shelters, and transitional housing providers during extreme weather conditions. BPHC will explore collaboration with hospital partners, other PPSs and CBOs on the use of medical respite. BPHC will train staff to provide warm hand-offs to CBOs the next business day and track referrals to completion.

To mitigate the challenge of PCPs identification and making real-time appointments, the PPS is investigating other means of identifying patients' PCPs: through the RHIO, MCO databases, sharing PCP information with other PPSs, creating data management clearinghouses. We are also investigating the use of open access and portal scheduling to make appointments without having to call PCP offices.

Lastly, despite the lack of DSRIP capital funding for two new urgent care centers and one additional respite facility, BPHC lead, SBH Health System, is moving forward with plans to build a large urgent care center. BPHC is committed to the expansion of respite beds (both mental health and medical respite) in the Bronx, as we have seen the clinical and financial advantages of leveraging non-clinical settings for patients in behavioral crisis and for homeless patients who are too ill for the shelter system. Montefiore's Housing at Risk Program has seen a 300% return on investment (ROI) for the medical respite beds they use and Riverdale Mental Health Association (RMHA) has shown a reduction in preventable ED use and a reduction in readmissions for patients utilizing their behavioral health respite beds. Because BPHC believes that respite is an important component in a VBP system, we will leverage our relationships with Medicaid MCOs to see how hospital systems and MCOs can share the costs of respite beds as we plan for payment reform.

**Implementation approaches that the PPS considers a best practice:**

Key stakeholders from PPS clinical and community partners (including Health Homes) were identified and engaged in our ED Care Triage Implementation Work Group (IWG); meetings commenced in October 2015. BPHC, with Montefiore's Care Management Organization (CMO) and a joint SBH-Montefiore design team, completed the design of the ED Care Triage project.

BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups and design teams. Decisions made by the ED Care Triage design team regarding project design are reflected in the ED Care Triage section of the Clinical Operations Plan (COP). The COP includes detailed work flows and descriptions of the program, roles and responsibilities of the ED Navigators, role-specific competencies, various chapters on target population, evidence-based protocols, guidance for program enrollment and criteria, referral protocols, patient flows, patient/caregiver education and engagement, and practitioner engagement tools.

ED Navigators will be responsible for redirecting patients to a community primary care provider and determining referrals to appropriate community based organization (CBOs) that will address the social determinants of health. Members of the SBH and Montefiore Site Specific Implementation Teams (SSIT) have reviewed templates of documentation ED Navigators will use and will share those templates with their respective IT departments in order to build the documentation within their EMR. As SBH and Montefiore hire staff, Montefiore's CMO will conduct a training based on core competencies which were approved by the IWG. BPHC will also provide training to the ED navigators to provide assistance to homeless patients as well as those experiencing a behavioral health crisis.  Further, if a patient is eligible and not yet enrolled in Health Home, ED Navigator will attempt to make a bottoms-up referral.

BPHC is leveraging best practices developed by the SBH team who participated in the Medicaid Accelerated eXchange (MAX) series to establish more formal referral partnerships with providers of behavioral health, respite and transitional housing and involve those partners in developing training materials.

As part of BPHC's integrated, non-siloed approach, training will be scheduled and provided to ED Navigators for the referral of patients who meet criteria into the home based asthma intervention.

Another component of this non-siloed approach is the integration of the Patient-Centered Medical Home (PCMH) work happening as part of DSRIP with the project work of DSRIP. Because we believe that PCMH implementation truly is the foundation for much of DSRIP, BPHC provided PCMH transformation support to its partners (by funding expert PCMH consultants).  As part of this PCMH integration strategy, and in order to leverage the efforts of the consultants and prevent duplication of labor, BPHC aligned, as closely as possible, the recommendations contained in the COP with the PCMH requirements. We also developed guidance for the PCMH consultants which outlines the links between the DSRIP projects and the PCMH requirements.  For example, our COP recommendations for RHIO alerts (encounter notification system or ENS) were aligned with the NCQA PCMH 2014 element 5C: Coordinate Care Transitions. Finally, we believe that through PCMH transformation, access to primary care will increase, especially important as ED Navigators refer more and more patients to PCPs.  Through PCMH transformation, BPHC's community health centers will expand their scope of services and hours and be able to leverage open access scheduling to help get same day/next day appointments.

BPHC continues to actively work with its primary care partners by leveraging best practices and workflows from the Institute for Family Health, a BPHC primary care partner that already utilizes RHIO alerts to ensure real-time notification to PCPs and/or Health Home Care Managers. Alerts signal the providers that ED visit documentation is available in the RHIO. We are holding ongoing meetings with the Bronx RHIO and our seven largest primary care organization partners to further define workflow for utilizing alerts and communicating ED Navigator recommendations to PCPs and CBOs.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Specifically, for ED Care Triage, BPHC has begun collaboration with Fingerlakes PPS (FLIPPS) on ED Care Triage as well as geographically closer PPSs: Advocate, Bronx Lebanon and One City Health (HHC). Areas for collaboration include a population health management strategy for use of RHIO alerts (ENS) in order to prevent "alert fatigue" amongst practitioners and ways to ensure that patients seen in one PPS' ED, but attributed to another PPS return to/have care transitions to their own PCPs and Health Homes Care Managers. BPHC is working with the Bronx RHIO and large primary care site partners to leverage best practices for RHIO alerts already in use by Bronx Lebanon. BPHC's CMO attends the GNYHA Clinical Leadership Forum, where CMOs of PPSs cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Another critical component of the ED Care Triage project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access emergency departments or primary care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

There is a significant effort to de-silo and link the ED Care Triage Program/Project activities to all the other DSRIP projects through the establishment of a population health management strategy to prevent unnecessary ED use and meet the DSRIP goal of reducing avoidable hospitalization by 25%. We are running reports to identify our highest utilizers to support their needs outside of the ED.

SBH Health System, BPHC's fiduciary sponsor and one of its two hospital partners, is participating in the DSRIP Medicaid Accelerated eXchange (MAX) Series. An evidence-based collaborative for maximizing efficiency in clinical processes and implementing sustainable change, the MAX Series is a twelve-month project focusing on super-utilizers (SU) that in July of 2015. The interdisciplinary team participating on this project includes representatives from SBH (Administration, ED, social work, psychiatry and substance abuse), two community-based organizations, BronxWorks and Riverdale Mental Health Parachute Program, and a staff member from BPHC. SBH SUs tend to be homeless and seek refuge in the ED, usually for non-medical reasons. During this period, SBH has focused on improving provider and staff education on the available community resources for them and their patients. SBH initiated Street Outreach Team Pick-ups to transport clients to the Living Room, a drop-in center at the supportive housing site, from the ED. SBH has produced standardized shared care plan for each of these individuals. A flag in the EMR was also established to notify providers that an individual is an SU. In the ED, SBH expanded the patient engagement team to include security guards and detox counsellors who were assigned to identify patients and engage in transition planning.

BPHC is leveraging Montefiore's risk stratification tool and customizing it to ensure it aligns with DSRIP goals and helps prioritize our targeted populations. SBH's IT department is currently building the parameters of the risk stratification tool into the EMR.

We are also leveraging Montefiore's experience with their Care Management Resource Unit (CMRU) to expand the current role of SBH's call center. This will help coordinate patient medical and social service referrals, transportation, and home care needs.

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

The proposed population to be served by this project has not changed.

**DSRIP Mid-Point Assessment - Project Narratives**

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

**PPS Name:** SBH Health System

**Project:** 2.b.iv

## Challenges the PPS has encountered in project implementation:

BPHC has encountered challenges around coordinating the varied and fragmented care management efforts in place throughout the PPS: Health Home (HH), managed care, PCMH efforts including Health Home At-Risk. Primary Care Practitioners (PCPs), especially in our Independent Practice Associations, have voiced concern and frustration that it is difficult to get information and documentation from hospitals regarding why a patient was hospitalized or in the ED. It is apparent that inadequate coordination and communication between hospital-based teams, outpatient care managers (CM), PCPs, SNFs, and home-health care agencies exist. Coordination amongst these groups are key to effective hand-offs among providers and improvement of patient health outcomes and patient satisfaction with the health system.

BPHC aims to develop an electronic care coordination management and referral management tool that can be shared across all BPHC providers to enhance information sharing and interoperability. Multiple IT systems (EMR, Care Management, Population Health Management registries, and others) are employed by hospitals, HHs and PCMHs, and some partners lack systems with any of these electronic capabilities. Challenges have arisen during implementation with regard to integrating such a wide array of systems into a single centralized care management platform and identifying the right vendor to meet the needs of the PPS, resulting in delayed development of BPHC's desired IT solution.  This makes electronic communication and care plan sharing challenging across partners, and across services: tasks/recommendations cannot easily be transferred from the Care Transitions Care Coordinator to the community based or centralized care coordinator.

Review of the readmission data from BPHC hospital partners reveals that patients with unstable housing and behavioral health (BH) diagnoses including substance use disorder (SUD) greatly impact readmissions.  In some cases, hospitals report that a small group of patients are responsible for a large number of readmissions.  Members of the BH population are challenging to engage as once they leave the hospital they often do not have community supports to enable navigation of the healthcare system, medication management, and social services that could impact social determinants of health.

Although a Care Transitions program exists at both hospital systems, the expansion of the program to align with DSRIP goals and to engage more at-risk patients may be delayed due to recruitment and training challenges. Identifying bilingual staff with the appropriate background, willingness to work non-traditional hours, (off-hour and weekend shifts) and experience has been challenging. The original model called for all Care Transitions Care Coordinators to be Registered Nurses (RNs) which contributes to the recruitment challenges, given the shortage of experienced nurses available for hire. The slow pace of hiring has affected the timing of trainings and delayed ramp up of the program at all sites. In addition, the inpatient component of the program is new and hospital partners are struggling with workflows around warm hand-offs, sharing information among providers and coordinating care among hospital-based and community providers.  The two hospital systems have also chosen different staffing models which makes standardizing the program and training curriculum difficult.

Lack of standardization of existing policies and procedures for early notification of planned discharges among hospitals is challenging. Notification of HH CMs when patients are being discharged varies, particularly if patients are discharged earlier than expected. BPHC Hospitals will employ teams of Care Coordinators who will be assigned to inpatient units as well as a Post-Discharge call center. Together these hospital-based care coordinators will act as the transitional care managers and it is unknown how they will be able to identify and interact with outpatient care managers in Health Homes, primary care practices as part of BPHC's Health Home at Risk program, in managed care organizations and elsewhere. Efforts to identify, contact and collaborate and case conference while the patient is in the hospital are ideal but BPHC hospitals are struggling to build workflows around these processes. Even once a care management coordination system (CCMS) is deployed across the PPS, it will be challenging to know whether the "process" of enrollment of a patient into Health Home has started. Hospitals report the MAPP program for Health Homes has been difficult to use and is often restricted in use. Creating workflows to share TCPs with PCPs and CMs outside of our PPS is also proving challenging.

In our application, BPHC committed to expanding use of BPHC partners' skilled and non-skilled home care services, including PPS partner Methodist Home for Nursing and Rehabilitation, which was planning to convert 40 skilled nursing beds to an acute care step-down unit capable of receiving medically complex patients discharged from the hospital who need residential care, short-term rehabilitation and connection to community-based/care transitions services. This transition has not yet occurred, creating a challenge lowering readmission rates for high risk patients.

## Efforts to mitigate challenges identified above:

To mitigate the challenge of inadequate coordination/communication, BPHC is developing processes and workflows for Clinical Coordinators (CTCCs), post-discharge care coordinators (PDCCs) and outpatient CMs to share transitional care plans (TCP) through Bronx RHIO. This will be instrumental to Care Transitions hand offs, as will telephonic follow up to fill care gaps and perform closed-loop referral tracking. Eventually, care coordinators and CMs across the PPS will have access to an electronic care and referral management tool that can be shared across all BPHC providers. BPHC will assure that partners across multiple settings can use this tool to find and refer to various services needed during transitions of care. Community-based organizations have been part of the discussion through the ED/CT Implementation Workgroup (IWG) to determine how to create effective warm and e-handoffs. Prior to the CCMS PPS-wide rollout, an interim solution using respective hospital EMRs and secure email will be used to send transitional care plan summary to PCPs, HHs and/or relevant CBOs.

BPHC has been working to overcome the challenges associated with developing a PPS-wide care coordination management system (CCMS). All necessary system and business requirements have been defined with the IT subcommittee and a CCMS Pilot Development Work Group. The work group mapped existing and future-state workflows for care management in the Health Home, Health Home At-Risk, Care Transitions, and ED Care Triage project contexts, which will allow rapid development and roll out of the BPHC CCMS platform. BPHC will work with a vetted vendor capable of developing an electronic care coordination management tool that will be made available to BPHC partners and comprehensively integrate all care coordination and transitional care management plans created across the PPS. The pursuit of interfaces between the BPHC CCMS, the Bronx RHIO and the various partner EMRs will ensure the robust exchange of care management planning information and greatly enhance clinical integration across BPHC providers.

CBO partners will be engaged to assist with unstable housing and mitigate the challenge of higher readmission rates in patients with BH conditions SBH Health System (SBH) has partnered with two CBOs through the Medicaid Accelerated eXchange (MAX) Series. BronxWorks and Bronx Crisis Respite Center, CBOs who provide homeless services and crisis respite services respectively, have started to engage SBH BH patients. ED visit rates among BH patients have dropped ~35% over the six months since the CBO partnerships began. Efforts will be made to expand these CBO partnerships to all BPHC facilities and to develop the Critical Time Intervention (CTI) program described above, to complement these services. To prevent readmissions among SMI patients who are at risk for homelessness, BPHC has released a

Request for Proposals to fund BPHC Health Homes (HH) and/or other BPHC BH providers to provide Critical Time Interventions. CTI is a time-limited intensive care transitions program for seriously mentally ill individuals who are precariously housed Once selected and funded those organizations providing CTI services will engage hospital discharge planners on psychiatric units as well as through other means of referral.

In order to address recruiting and hiring difficulties and/or delays, BPHC is working with local community colleges, CBOs, 1199 Training and Education Fund and NYSNA to help recruit and train care management staff, offer competitive salaries, flexible hours, and job sharing, as feasible, to improve recruitment and retention. Montefiore's CMO has also been contracted to train new staff and provide post-implementation support to both teams. SBH Health System is staffing their program with a mix of RNs, Social Workers, and nonclinical navigators, which broadens the pool of applicants and helps mitigate some of the recruitment challenges. Efforts will be made between Montefiore's training team and SBH Nursing education department to tailor the training to SBH's staffing model and further define roles and responsibilities for different staff members functioning together as a team.

In order to address differences in notification methods to Health Home Care Managers, BPHC will require hospitals, Health Homes and PCPs to have RHIO connectivity, to use alerts, and to establish protocols requiring timely notification of discharges to HH CMs. RHIO alerts will alert providers to their patient's admits and discharges from EDs and hospitals in our PPS and in close proximity (Bronx Lebanon).

In an effort to share best practices and streamline methodology and workflows where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Specifically, for Care Transitions, BPHC has begun collaboration with neighboring PPSs (One City Health, New York Presbyterian, Advocate, and Bronx Lebanon) who are likely to see our attributed patients, and vice versa, to determine how to ensure that patients seen in one hospital, but attributed to another PPS return to/have care transitions to their own PCPs and Health Home Care Managers. We are also working to track hospital admissions/readmissions and transmit TCPs through the RHIO and SHIN-NY. BPHC is also working with the Bronx RHIO and large primary care site partners to leverage best practices for RHIO alerts already in use by Bronx Lebanon. TCPs will be shared with PCPs and HH CMs through RHIO alerts and telephone calls. HHs will be provided with one point of contact in the hospital so that CMs can easily receive relevant updates from the hospital-based CT team. RHIO training will be required by all hospital-based staff and pilots will test the use of the RHIO to identify the HH CM, (when consent is available and the patient is in a HH on the Bronx RHIO.) Hospitals will continue to investigate mechanisms to use the MAPP to identify HH CM and/or the patient's status of enrollment in a HH. Hospitals will establish open lines of communication with Health Home leadership and CMAs. Health Homes and primary care practices will be provided with one point of contact, who can determine which hospital-based care coordinator engaged the patient.

Despite the lack of an acute care step-down unit, BPHC is committed to leveraging all post-acute settings. We are especially committed to the expansion of respite beds (both mental health and medical respite) in the Bronx, as we have seen the clinical and financial advantages of leveraging nonclinical settings for patients in behavioral crisis and for homeless patients who are too ill for the shelter system. Montefiore's Housing at Risk Program has seen a 300% return on investment (ROI) for the medical respite beds they use and Riverdale Mental Health Association (RMHA) has shown a reduction in preventable ED use and a reduction in readmissions for patients utilizing their behavioral health respite beds. Because BPHC believes that respite and other post-acute settings are an important component in a VBP system, we will leverage our relationships with Medicaid MCOs to see how hospital systems and MCOs can share the costs of respite beds as we plan for payment reform.

**Implementation approaches that the PPS considers a best practice:**

BPHC is actively working with its vendor organization—Montefiore Care Management Organization (CMO)—to design the 30-day care transitions intervention and develop documentation that will result in a care transitions plan. Key stakeholders at Montefiore and SBH Health System as well as key community partners such as BronxWorks and Riverdale Mental Health Association were identified and convened for the joint ED Care Triage/30-day Care Transitions Implementation Workgroup (IWG); meetings commenced in October 2015.

BPHC, with Montefiore's Care Management Organization (CMO) and a joint SBH-Montefiore design team, completed the design of the 30-day Care Transitions project.  Care Transitions Project Design meetings have focused on defining the target population and the criteria for a work list of "high risk for readmission" patients to be targeted for the intervention by the inpatient care coordinators.  BPHC hospitals will use an evidenced-based risk stratification tool that takes into account Length of Stay, Acute admissions, Comorbidity and Emergency room visits (LACE).  BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups and design teams. Decisions made by the Care Transitions design team are reflected in the Care Transitions section of the Clinical Operations Plan (COP). The COP includes detailed work flows and descriptions of the program, roles and responsibilities of the inpatient, post discharge and outpatient care coordinators, role-specific competencies, various chapters on target population, evidence-based protocols, guidance for program enrollment and criteria, referral protocols, patient flows, patient/caregiver education and engagement, and practitioner engagement tools. A high-level workflow model has been developed as part of the Clinical Operations Plan (COP).  . Completion of the COP has been instrumental in CMO's development of a formal training for all incumbent and incoming staff that will be involved in the intervention.

The Care Transitions design team has developed and the IWG approved a final version of the transitional care plan to be included in the EMR, the care coordination management system (CCMS) and/or Bronx RHIO.  Providers from different settings have been part of the SBH-Montefiore design team and reviewed the Transitional Care Plan (TCP) in the context of resources designed by National Transition of Care Coalition, and the IWG, which nursing home and home care providers, gave input as to information that would be useful to them such as medication reconciliation and problems, goals and interventions (PGI) to be addressed during the 30-day period following discharge.  The TCP is created from multiple assessments performed in the hospital, and the post-discharge care plan is a further refined version of the TCP, after additional assessments have been completed by the post-discharge care coordinator.  Both sets of assessment tool detect social barriers to care and build problems, goals, and interventions directed at addressing said barriers.

Another best practice is how BPHC has engaged subject matter experts (SMEs) in CTI from the CTI Institute, Maimonides PPS, Center for Urban Community Services (CUCS) and BronxWorks as part of our work to establish a Critical Time Intervention program to address the transitions of care for behavioral health patients. SMEs have advised BPHC to define the target population, complete the program design and develop a staffing model through BPHC member Health Homes. BPHC has sent out a request for proposal (RFP) to our Health Home partners and behavioral health service providers – mental health services (Article 31) and substance abuse programs (Article 32) who may be interested in operating a CTI program. BPHC has already engaged inpatient behavioral health provider champions to support the identification and referral of eligible patients to the CTI team while the patient is still in the hospital.

BPHC's Community Engagement and Communications Group convened during DY2 Q1 to finalize the development of an electronic Community Resources Directory, accessible to providers across the network, in order facilitate connections between clinical and social services. The directory is searchable by service type and zip code and is connected to the PPS Salesforce platform, allowing partners to keep their information consistently up to date. The Central Services Organization (CSO) worked with partners to define their referral procedures, with particular attention to closed loop referral tracking on all referrals to social services.

CBOs that provide supportive housing, respite services as well as behavioral health treatment services have been engaged to provide specific transition assistance. In particular, an effort is being made to provide assistance to homeless patients and those experiencing a behavioral health crisis. BPHC will continue to leverage best practices developed by the SBH team participating in the Medicaid Accelerated eXchange (MAX) series to establish more formal referral partnerships with providers of behavioral health respite providers and transitional housing.

As mentioned above, (in *Efforts to mitigate challenges* section) BPHC has engaged with other PPSs across New York State. In addition to those previously described, BPHC has also collaborated with FLIPPS on training materials and scripts for Care Coordinators. Our Care Transitions project manager has been involved with the Greater New York Hospital Association (GNYHA) DSRIP Post-Acute care group. This workgroup has been sharing best practices on identifying patients at high-risk for readmission and creating care transitions interventions. We also participate in the GNYHA Care Plan Workgroup, aimed at standardized Care Plan fields that can be shared across settings through the RHIOs and SHIN-NY, and the GNYHA Clinical Leadership Forum gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Additionally, a critical component of the Care Transitions project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

There is a significant effort to de-silo and link the Care Transitions Intervention Model/Project activities to all the other DSRIP projects through the establishment of a population health management strategy to prevent avoidable readmissions and meet the DSRIP goal of reducing avoidable hospitalization by 25%. We are running reports to identify our highest utilizers to support their needs outside of the hospital.

BPHC is leveraging Montefiore's risk stratification tool and customizing it to ensure it aligns with DSRIP goals and helps prioritize our targeted populations. SBH's IT department is currently building the parameters of the risk stratification tool into the EMR.

We are also leveraging Montefiore's experience with their Care Management Resource Unit (CMRU) to expand the current role of SBH's call center. This will help coordinate patient medical and social service referrals, transportation, and home care needs.

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

The proposed population to be served by this project has not changed.

**DSRIP Mid-Point Assessment - Project Narratives**

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

**PPS Name:** SBH Health System

**Project:** 3.a.i

### Challenges the PPS has encountered in project implementation:

BPHC aims to expand primary care (PC) access within behavioral health (BH) settings and to expand behavioral health access within primary care settings. Lack of provider buy-in at some sites, due to concerns about costs related to the staffing requirements and infrastructure needs has posed challenges for spreading behavioral health/primary care integration models beyond our largest 7 partner organizations. BPHC attempted to launch PCBH with a network of independent practices, met with key stakeholders and planned in-person meetings with individual practices that met patient and practitioner requirements.  The team learned from initial meetings that these practices were resistant to this model and expressed concerns around the sustainability of integrating the recommended new staff and workflows. It was observed that these practices have a different patient panel and payor mix from practices aligned with care delivery organizations. For these practices committing to   such care delivery transformation poses a greater risk to their viability. It was decided that the CSO would focus on developing a modified approach to implementing this project, allowing practices to join at a later time when they have reached a self-defined state of readiness. The largest 7 partner organizations are eager to join this project and implement changes. However, the time needed for participating organizations to engage in needed trainings is concerning for organizational leadership and presents legitimate challenges to implementation progress.   With limited trainers available and a long menu of training needs, scheduling training and coaching opportunities will continue to pose challenges.

State Department of Health and Office of Mental Health regulations pose barriers to effective integration of PC and BH through co-location due to cost, complex applications, and length of the approval process for waivers. For example, Article 28 and Article 32 facilities may decide that it is best to treat a patient in the home, but there is no system yet for reimbursement for such visits. Most notably, the barriers to full reimbursement of same day visits, e.g., if a patient saw both their PCP and BH provider on the same day in a co-located setting, are in direct contradiction to the goals of this project. Billing for same day visits of co-located practices is a significant barrier to adoption of the co-location model and streamlining treatment between physical and behavioral health.

Additionally, SDOH, OMH, and OASAS have yet to grant any waivers that would allow two different providers licensed by different agencies to share space, e.g., a common waiting room used by an Article 28 and Article 31 facility.

Finally, the shortage of psychiatrists in our PPS, and Bronx-wide, as noted by the Community Needs Assessment, as well as licensed clinical social workers, is a major challenge to implementing this project for many of our partners.

### Efforts to mitigate challenges identified above:

To mitigate the challenges around buy-in and the concerns around training, BPHC has targeted a number of activities and strategies. BPHC will: (a) provide project-specific training and technical assistance (TA) on the IMPACT model processes and protocols to primary care providers (PCPs) and their care teams through an experienced training consultant over a 6-month training period. BPHC hired Institute for Family Health (IFH) as the vendor to deliver these trainings and each organizations' needs and capacities are factored into planning training and TA; (b) provide technical assistance for those organizations seeking to introduce primary care (PC ) into behavioral health (BH) sites or BH into PC sites. BPHC will connect organizations implementing co-location with peers that have successfully co-located PC and BH. BPHC will also seek ways to incentivize practitioner participation, e.g., offering access to tools for population health management, including registries and care coordination.

To mitigate challenges around billing, BPHC requested and received the following waivers from the State: Article 28 facilities may provide mental health or substance abuse services provided those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations; Articles 31 and 32 facilities may provide physical health services provided those services comprise no more than 49% of a facility's annual visits and the facility complies with various provisions of the new integrated services regulations.

BPHC will continue to advocate to the State for these and additional waivers to ensure project goals and milestones are met and support our practices in identifying solutions to the barriers they are experiencing by submitting waivers as well.

Additionally, BPHC is exploring the use of tele-psychiatry to increase BPHC's psychiatric capacity as implementation begins. Staff recruitment efforts will focus on identifying additional psychiatrists, and we work closely with IFH to identify LCSW's or LMSW's who are on the path to licensure. BPHC will also reach out to other PPSs in the region to collaborate on workforce issues that may impact recruitment strategies, including compensation. BPHC is currently in discussion with the NYC Department of Mental Health and Hygiene (NYCDOHMH) to engage our smaller and independent practices in primary care and behavioral health integration projects. NYCDOHMH, as a part of the City's larger mental health initiative, ThriveNYC, is launching a Mental Health Corps which will place behavioral health staff in practices for a period of one to three years. Practices would receive these staff without incurring costs, which assist with the transformation and sustainability of integration.

**Implementation approaches that the PPS considers a best practice:**

To support robust implementation across a diverse array of hospital, community, and ambulatory-based settings, BPHC has launched, in coordination with our vendor, IFH, a training and TA strategy that is flexible and responsive to the varying needs of our partners.

BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups. The COP section on PCBH provides guidance on policies and procedures that must be adopted in order to achieve integrated care through co-location or the IMPACT collaborative care model. The COP is easily adapted to organizational and site-specific formats for documenting the policies and procedures of their respective agencies.

A contract was finalized with our vendor, the Institute for Family Health, to provide training and technical assistance (TA) to practices implementing co-location models. Training and Technical Assistance Needs Assessments were conducted, which addressed the providers' current rates of patient assessment, with the focus of PHQ-2 and PHQ-9 (PHQ 2/9) screens. The assessments provided details on patients and workflows, as well as technical assistance and training needs. The assessments addressed the sites' need for hiring and training staff to fulfill the Depression Care Manager role. The role requirements were defined in collaboration with the Workforce Subcommittee and a job description was developed. Resources were identified to develop trainings for DCM's and the role has been defined in the COP.

The role of the Psychiatrist was also defined in the COP and a job description was developed, both of which were approved by the Primary Care/Behavioral health IWG and the Quality and Care Innovations Subcommittee. During the Training and Technical Assistance Needs Assessments, resources were provided to aid in the hiring of the psychiatrist, a key component of the IMPACT Model. The Institute for Family Health, in addition to conducting the trainings, provided assistance in identifying consulting Psychiatrists through a database that the organization maintains with behavioral health providers and consultants.

Training and Technical Assistance Plans were developed for each organization and their respective sites to provide an overview of the topics and, when available, dates for trainings. Many sites are receiving PHQ 2/9 screening trainings, in addition to the guidance provided in the COP. To date there are 53 unique sites participating in primary care and behavioral health integration. The DSRIP Program Directors are overseeing implementation and reporting to the CSO when challenges are observed. Trainings and the COP provide guidance on non-medical referrals to community-based providers.

Contracts were also finalized with PCMH consultants, who will provide services for PCMH readiness to ensure that co-location and PCMH 2014 Level 3 recognition requirements are met. CSO staff and the Institute for Family Health delivered an informational webinar in an effort to recruit more behavioral health providers for PCBH Model 2. The majority of the 14 sites that have committed to Model 2 have an existing primary care practice physically co-located, but will need assistance through training to adopt the new workflows and the overall transformations.

Evidence-based guidelines on "stepped care" were adopted for the COP for sites implementing the IMPACT Model as required. The guidelines were obtained through the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington.  The PCBH COP also outlines policies and procedures for effective implementation of Primary Care/Behavioral Health for all three models.

As described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice).

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

BPHC is presently in discussion with the vendor, Institute for Family Health, to review existing resources that can be adapted to assess progress of implementing co-location and IMPACT projects. The assessment process, if adopted, is planned for DY2Q3.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Specifically, for PCBH, the NYC Regional Planning Consortium Behavioral Health Steering Group brings together all PPSs involved in this project to focus on DSRIP related implementation topics. The GNYHA Integration Work group coordinates content expertise and timely topics related to implementation of PCBH and the GNYHA Clinical Leadership Forum gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Additionally, a critical component of the Primary Care Behavioral Health Integration project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

At this time there have been no changes to the populations that were proposed to be served through PCBH.

**DSRIP Mid-Point Assessment - Project Narratives**

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

**PPS Name:** SBH Health System

**Project:** 3.b.i

## Challenges the PPS has encountered in project implementation:

BPHC has made—and continues to make—a strong effort to structure its projects as a non-siloed, integrative strategy. While we firmly believe that this approach is cost-saving and more effective and sustainable, the downside is that delays in one area can have a ripple effect throughout our DSRIP implementation.

The delay in implementing a shared electronic care coordination system (CCMS) and the delays in hiring for team-based care have created challenges for the CVD project. We planned to use these resources—implemented as part of the Health Home At-Risk project—to implement selected CVD requirements. For example, we planned to use the CCMS to make referrals to CBOs as well as for reporting purposes, and care managers/coordinators to make referrals to outside organizations, and have had to come up with alternative approaches. (Milestones 13 and 17)

Similarly, we are working with the Bronx RHIO to build cross-project population health resources, reports and tools which will be used to fulfill Milestones 10 and 15. However, delays in this work mean that participating sites must develop interim resources and processes to identify and outreach to patients. Specific challenges for this project are population health management processes for patients with elevated blood pressure and no diagnosis of hypertension, and for those patients with hypertension and no recent visit. These efforts represent an interim solution while the cross-project resources referenced above is being implemented.

Additionally, while our partners have been receptive to incorporating patient self-management goal-setting as part of regular primary care visits, not all physicians and other PCMH care team members currently document self-management goals (SMG) in the medical record in a way that is conducive to demonstrating the activity was completed for reporting purposes—particularly important since this doubles as a measure of patient engagement.  IT departments at our partner organizations have had to devote more significant effort to this requirement than originally anticipated.

Another challenge has been achieving buy-in for the NYS Smokers Quitline (Milestone 16). Most providers are familiar with the resource but do not view it as particularly helpful for their patients.

We have also had challenges related to implementation of the protocols for home blood pressure monitoring (Milestone 14) related to Medicaid coverage of blood pressure cuffs. Although our research has shown that cuffs are covered by all but one MCO plan, and covered by FFS Medicaid, many providers and pharmacists still believe they are not covered. Additionally, variations in the type of cuff covered by different plans, and shifts in the models individual plans cover have led to confusion and lack of buy-in for the program.

## Efforts to mitigate challenges identified above:

Related to the delay in implementing a care coordination management system (CCMS), BPHC is working to develop an alternative strategy which will make use of existing care management systems partners have put into place, while waiting for an integrated solution. Additionally, some of the functionalities which we initially anticipated making through the shared CCMS can likely be made through the PPS-wide customer relations management system BPHC has implemented. In this way we will mitigate delays and funding spending spent on interim solutions.

In order to mitigate delays in hiring for team-based care, BPHC recently committed to funding a recruiter to support its partners with workforce recruiting goals, including for care management staff.

Related to the delays in the RHIO solution for population-based health registries, BPHC and the RHIO have conducted a series of meetings to prioritize the work. Additionally, we are working with our organizational partners to ensure that the interim population health strategies and tools developed remain lean but effective. We conduct weekly meetings with project management staff at our partner organizations, and population health management topics are a focus area for the agenda of these meetings.

Related to patient self-management goals, BPHC aligned its guidance for this work with the related PCMH requirement Standard 4/Element B (Care Planning and Self-Care Support). In this way, we have been able to leverage the efforts of the PCMH consultants funded by BPHC to support the implementation of these requirements. We have also been able to make use of knowledge-sharing between BPHC's partner organizations to develop IT solutions. This was also a topic of the cross-PPS CVD learning consortium, which is a monthly call with members of seven PPSs participating in the CVD project. Following the meetings, resources are exchanged and the PPSs continue to provide updates on this work during the subsequent calls.

To address lack of buy-in for the NYS Smokers Quitline (Milestone 16), we are working with our DPDs (DSRIP project management staff at our partner organizations) to identify and develop champions for the program.

Medicaid coverage of blood pressure cuffs (Milestone 14) has been an area of focus for the BPHC pharmacy workgroup, which launched in February. The group is working to develop a resource for prescribers to support prescribing of home blood-pressure cuffs. This was also a topic of the cross-PPS CVD learning consortium.

## Implementation approaches that the PPS considers a best practice:

BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups. The COP section for CVD was developed in conjunction with the CVD-Diabetes Transitional Work Group (TWG). It includes various chapters on target population, evidence-based guidelines, guidance for at-home blood pressure monitoring, aspirin use, flu shots, patient-driven self-management goals, preferred drugs, referral protocols, patient flows, care team roles, patient/caregiver education and engagement, and practitioner engagement tools. We have recognized the diversity of our partner organizations by including a variety of approaches to certain requirements and including recommended but optional suggestions as well. In order to keep the document up to date we have a policy in place for regular review of its contents by our CVD-Diabetes Implementation Workgroup (also known as Rapid Deployment Collaborative, or RDC). The first edition was distributed at the CVD launch in February and the second edition was released this June. Our Chief Medical Officer held a Clinical Leadership Forum on Evidence Based Guidelines (EBGs) with clinical leadership from our largest 7 primary care and hospital-based partners to discuss best practices for adoption and spread of EBGs, including but not limited to the EBGs adopted by BPHC for CVD from Million Hearts as well as the JNC guidelines on blood pressure control. Another related best practice is how our Implementation Workgroups (or "RDCs") serve as project-specific quality councils and report up to QCIS on the following four transformational areas: (1) Appropriate Utilization (2) Chronic Condition Management and Population Health (3) Primary Care/Behavioral Health Integration (4) Patient

Engagement.

As part of the integrated, non-siloed approach described above, (see *Challenges the PPS has encountered in project implementation*), BPHC rolled out its projects in a staggered series. Since the implementation of team-based care is foundational to BPHC's primary care projects, the Health Home at Risk Project launched last January in advance of the CVD project, which was launched a month and a half later. This timing was meant to allow sites time to begin building their teams and making selected hires who would support the implementation of requirements for our disease-management projects (Diabetes, CVD, Asthma, PC/BH).

Another component of this non-siloed approach is the integration of the Patient-Centered Medical Home (PCMH) work happening as part of DSRIP with the project work of DSRIP. Because we believe that PCMH implementation truly is the foundation for much of DSRIP, particularly the disease-management, BPHC provided PCMH transformation support to its partners (by funding expert PCMH consultants). Additionally, in order to support Milestone 20 (80% participation), practices must commit to participating in the CVD project in order to qualify for the PCMH transformation support funding (in receiving the expert PCMH consultants)

As part of this PCMH integration strategy, and in order to leverage the efforts of the consultants and prevent duplication of labor, BPHC aligned, as closely as possible, the recommendations contained in the COP with the PCMH requirements. We also developed guidance for the PCMH consultants which outlines the links between the DSRIP projects and the PCMH requirements. For example, our COP recommendations for patient driven self-management goals (Milestone 12) were aligned with the NCQA PCMH 2013 guidance on patient self-management goals.

Another tactic we found successful was to use our TWG to identify optional existing resources that may be helpful for our partners. For example, to support fulfillment of Milestone 18, BPHC's CVD-Diabetes TWG reviewed the Million Hearts provider and patient resources and tools we thought our partners would find particularly relevant. These recommendations were included in the COP.

Another useful approach that might be considered a "best practice" is the establishment of the Pharmacy Workgroup referenced above. The kickoff for this group was held on February 25th and included representatives from 7 of the 10 BPHC pharmacy partners. This workgroup is brainstorming strategies to support medication adherence of BPHC patients (Milestone 11), and is exploring best practices of its workgroup members – including opt-in care management services provided by pharmacies, whereby patients will be alerted by the pharmacy in the event of a missed prescription refill and may elect to have the pharmacy contact the prescribing physician to resolve medication prescription issues. They are also developing the resource for prescribers to support prescribing of home blood-pressure cuffs described above.

While the populations we proposed to serve through this project have not changed, BPHC has contracted with Health People to provide training and implementation of the peer-group educator training for chronic diseases and we are exploring the possibility of 'hot-spotting' to identify and host classes in high-need areas, as well as hosting them at or near our provider sites. Given the prevalence and importance of faith-based organizations, these will likely be important partners for the implementation of the classes. We are also working with one of our partner organizations to offer these classes in African languages. Additionally, we are exploring offering these classes at supportive housing for individuals and families coping with chronic homelessness, HIV/AIDS, mental health and substance abuse, given the prevalence of these conditions in the Bronx.

Finally, as described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice).

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

In addition to the link the PCMH and the Health Home At-Risk project described above, we are also working to link the projects to each other in as a non-siloed, integrative strategy. For example, we are encouraging our partner organizations pilot their use of the RHIO Encounter Notification System to address some of the measures associated with the CVD project: Prevention Quality Indicator # 13 (Angina without procedure) and Prevention Quality Indicator # 7 (HTN). Our non-siloed approach will also help our CVD patients with co-morbid depression be routed to the resources being provided by our Integration of Primary Care and Behavioral Health project.

Additionally, we have tried to emphasize the links of the individual CVD requirements to one another. For example, our COP links the work done as part of the Self Blood Pressure Monitoring (Milestone 14) to the No-Copay, Drop-in Blood Pressure checks (Milestone 8) by recommending use of the Simplified Treatment Intervention to Control Hypertension (STITCH) algorithm and standing orders, so that RNs and Clinical Pharmacists are empowered to adjust medication for hypertension.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. Specifically, for CVD Disease Management, cross-PPS CVD Collaborative group conducts monthly conference calls to share ideas and resources, discuss common challenges, and answer questions about the CVD project. BPHC also participates actively in the GNYHA Clinical Leadership Forum, which gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Additionally, a critical component of the Cardiovascular Disease Management project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

The populations that were proposed to be served through this project have not changed.

**DSRIP Mid-Point Assessment - Project Narratives**
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health System

**Project:** 3.c.i

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**Challenges the PPS has encountered in project implementation:**

BPHC has made—and continues to make—a strong effort to structure its projects as a non-siloed, integrative strategy. While we firmly believe that this approach is cost-saving and more effective and sustainable, the downside is that delays in one area can have a ripple effect throughout our DSRIP implementation.

The delay in implementing a shared electronic care coordination system (CCMS) and the delays in hiring for team-based care have created challenges for the Diabetes project. We planned to use these resources—implemented as part of the Health Home at Risk project—to implement selected Diabetes requirements. For example, we planned to use the CCMS to make referrals to CBOs and Stanford model classes as well as for reporting purposes, and care managers/coordinators to make referrals to outside organizations and have had to come up with alternative approaches. (Milestone 4)

Similarly, we are working with the Bronx RHIO to build cross-project population health resources, reports and tools which will be used to improve performance on one of the DSRIP measures for this project (Comprehensive Diabetes screening - HbA1c, dilated eye exam, nephropathy monitor). However, delays in this work mean that participating sites must develop alternative resources and processes to identify and outreach to patients. These efforts represent an interim solution while the cross-project resources referenced above is being implemented.

Another challenge is engaging diabetic patients who are not seeking primary care services in the behavioral health practices and CBOs where they may seek services.

BPHC has contracted with Health People, a CBO that is a certified Stanford Model trainer in order to implement the Stanford model Diabetes Self-Management Program. While our partners have been receptive to providing such classes, some organizations already provide similar classes to their patients and others have expressed concerns that their patients have needs (for example, languages) that are not served by the Health People classes.

Health People is currently working with our member organizations to identify patients with diabetes to receive training to become peer educators, and lead the Diabetes Self-Management Program (DSMP) courses. Training began in July 2016, with classes beginning in late August/early September. We plan to train 20 peer coaches, who will be compensated for their training and teaching, and we have a planned capacity for up to 800 students in the DSMP courses. Unfortunately, identifying and recruiting individuals to become peer coaches has been more challenging than anticipated, and as a result these efforts are delayed by about one month.

**Efforts to mitigate challenges identified above:**

Related to the delay in implementing a care coordination system (CCMS), BPHC is working to develop an alternative strategy which will make use of existing care management systems partners have put into place, while waiting for an integrated solution. Additionally, some of the functionalities which we initially anticipated making through the shared CCMS can likely be made through the PPS-wide customer relations management system BPHC has implemented. In this way we will mitigate delays and funding spending spent on interim solutions.

In order to mitigate delays in hiring for team-based care, BPHC plans to encourage alternative employment tactics, such as flexible hours and job sharing, where feasible, to attract a broader pool of workers. Additionally, BPHC recently committed to funding a recruiter to support its partners with workforce recruiting goals, including for care management staff.

Related to the delays in the RHIO solution for population-based health registries, BPHC and the RHIO have conducted a series of meetings to prioritize the work. Additionally, we are working with our organizational partners to ensure that the interim population health strategies and tools developed remain lean but effective. We conduct weekly meetings with project management staff at our partner organizations, and population health management topics are a focus area for the agenda of these meetings.

To mitigate the challenge of engaging diabetic patients who are not seeking primary care services in the behavioral health practices and CBOs where they may seek service, we are creating an RFP for CBOs to engage in patient-level health literacy training and primary care referrals. Additionally, at SBH, the Chair of Psychiatry has engaged IT to create electronic flags for schizophrenic patients with diabetes and schizophrenic and bipolar patients on antipsychotic medications, to assure at any point of entry into the system (ED, inpatient, primary care, outpatient behavioral health settings), team members know to order an A1C test.

Related the Stanford Model classes, BPHC has worked to build support for the classes by working with our DPDs (DSRIP project management staff at our partner organizations) to identify and develop champions for the program. Additionally, we have communicated that other organizations are welcome to develop and implement their own Stanford Model classes if they feel such courses will better serve their patients.

## Implementation approaches that the PPS considers a best practice:

BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups. The COP section for Diabetes was developed in conjunction with the CVD-Diabetes Transitional Work Group (TWG). It includes various chapters on target population, evidence-based guidelines, guidance for at-home blood pressure monitoring, aspirin use, flu shots, patient-driven self-management goals, preferred drugs, referral protocols, patient flows, care team roles, patient/caregiver education and engagement, and practitioner engagement tools. We have recognized the diversity of our partner organizations by including a variety of approaches to certain requirements and including recommended but optional suggestions as well. In order to keep the document up to date we have a policy in place for regular review of its contents by our CVD-Diabetes Implementation Workgroup. The first edition was distributed at the Diabetes launch in February and the second edition was released this June. Our Chief Medical Officer held a Clinical Leadership Forum on Evidence Based Guidelines with clinical leadership from our largest 7 primary care and hospital-based partners to discuss best practices for adoption and spread of EBGs, including but not limited to the ADA 2016 Diabetes Guidelines.

As part of the integrated, non-siloed approach described above, (see *Challenges the PPS has encountered in project implementation*), BPHC rolled out its projects in a staggered series Since the implementation of team-based care is foundational to BPHC's primary care projects, the Health Home at Risk Project launched last January in advance of the Diabetes project, which was launched a month and a half later. This timing was meant to allow sites time to begin building their teams and making selected hires who would support the implementation of requirements for our

disease-management projects (Diabetes, CVD, Asthma, PC/BH). The frontline staff who are engaged in project roll-out are the Site Specific Implementation Teams at each large partner organization. BPHC asked partner clinical leadership to select an interdisciplinary team (made up of clinical leadership, PCPs, Medical Assistants, Care Coordinators, RNs and others) to act as DSRIP Champions, overseeing implementation and engaging clinicians. Clinicians and subject matter experts from our various partner sites are also engaged in this project through the CVD-Diabetes Implementation Work Group, a project-specific clinical quality council under our Quality and Clinical Innovations Subcommittee.

Another component of this non-siloed approach is the integration of the Patient-Centered Medical Home (PCMH) work happening as part of DSRIP with the project work of DSRIP. Because we believe that PCMH implementation truly is the foundation for much of DSRIP, particularly the disease management, BPHC provided PCMH transformation support to its partners (by funding expert PCMH consultants). Additionally, in order to support Milestone 2 (80% participation), practices must commit to participating in the Diabetes project in order to qualify for the PCMH transformation support funding (in receiving the expert PCMH consultants)

As part of this PCMH integration strategy, and in order to leverage the efforts of the consultants and prevent duplication of labor, BPHC aligned, as closely as possible, the recommendations contained in the COP with the PCMH requirements. We also developed guidance for the PCMH consultants which outlines the links between the DSRIP projects and the PCMH requirements. For example, the guidance points out the population health management work that targets diabetes screening for all patients or diabetes screening for schizophrenic patients aligns the work we need to do for our DSRIP Pay for Performance and EPP measures, and aligns with for *Element 6A: Measure Clinical Quality Performance, at least annually the practice measures or receives data on (2) at least two other preventative care measures and, (3) at least three chronic or acute care clinical measures.*

Another useful approach that might be considered a "best practice" is the establishment of the Pharmacy Workgroup referenced above. The kickoff for this group was held on February 25th and included representatives from 7 of the 10 BPHC pharmacy partners. This workgroup is brainstorming strategies to support care for individuals with diabetes and comorbidities. For example, the group discussed the possibility of having pharmacy-based satellite clinics offering A1C, glucose tests and blood pressure checks. Pharmacists said they were willing to participate in a flyering campaign encouraging patients taking antipsychotics to ask their PCPs for an A1C test once per year.

While the populations we proposed to serve through this project have not changed, BPHC has contracted with Health People to provide training and implementation of the Stanford Model for chronic diseases and we are exploring the possibility of 'hot-spotting' to identify and host classes in high-need areas, as well as hosting them at or near our provider sites. Given the prevalence and importance of faith-based organizations, these will likely be important partners for the implementation of the classes. We are also working with one of our partner organizations to offer these classes in African languages. Additionally, we are exploring offering these classes at supportive housing for individuals and families coping with chronic homelessness, HIV/AIDS, mental health and substance abuse, given the prevalence of these conditions in the Bronx.

BPHC is proactive in its communication and relationship with the six Medicaid MCOs that are the conduit for the Equity Infrastructure Program (EIP) and Equity Performance Program (EPP) funding. Quality measures and activities for EIP and EPP funding were chosen that work in concert with the BPHC's selected clinical projects, with our cross-cutting organizational work, and with the disease management needs of the population being served. Through the EIP and EPP correspondence as well as the communication through the VBP Planning Workgroup, BPHC and MCOs will continue to work closely. In addition, HealthFirst has a seat on our Executive Committee, a regular monthly meeting where we will review utilization trends, performance issues, and planning for payment reform. These relationships will serve as the foundation for our work with MCOs to engage patients assigned to a participating PCMH who have not received disease management services.

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

In addition to the link the PCMH and the Health Home At-Risk project described above, we are also working to link the projects to each other in as a non-siloed, integrative strategy. For example, we are encouraging our partner organizations to pilot their use of the RHIO Encounter Notification System to address some of the measures associated with the Diabetes project: Prevention Quality Indicator # 1 [Number of admissions with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma)]. Our non-siloed approach will also help our diabetic patients with co-morbid depression be routed to the resources being provided by our Integration of Primary Care and Behavioral Health project.

As described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice).

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. BPHC participates actively in the GNYHA Clinical Leadership Forum, which gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Additionally, a critical component of the Diabetes Disease Management project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

The populations that were proposed to be served through this project have not changed.

**DSRIP Mid-Point Assessment - Project Narratives**
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health System

**Project:** 3.d.ii

## Challenges the PPS has encountered in project implementation:

BPHC contracted with a.i.r. bronx, a community-based organization (CBO) with 10 years' experience providing home-based services to asthmatic clients and their families to provide the home-based self-management program that is central to this project. a.i.r. bronx has been a true partner in this project—BPHC's Central Services Organization (CSO) worked closely with them to lead the planning and development of the Clinical Operation Plan (COP), the implementation guidance for this project. However, the planning process took longer than expected due to a very intensive development and review and approval process involving the Asthma Transitional Work Group, whose membership included several physicians.

This was not the only cause of delays. BPHC has made—and continues to make—a strong effort to structure its projects in a non-siloed, integrative strategy. While we firmly believe that this approach is cost-saving, more effective and sustainable, the downside is that delays in one area can have a ripple effect throughout our DSRIP implementation. In this instance, delays in the implementation of a PPS-wide care coordination system (CCMS) delayed the asthma project because we had planned to use the CCMS system to make closed-loop referrals to a.i.r. bronx.  Developing an alternative closed-loop process was a significant challenge (and cost) we did not anticipate. We worked hard to find a solution that would accommodate convenience for our partners while minimizing the administrative burden for a.i.r. bronx, so their staff could focus on patient care.  While the solution developed was ultimately accepted by all partners, the delivery of home-based services to clients/families was delayed by about two months for across our PPS, and a few key partners are still working to securely transmit referrals. We are also aware that our planned implementation is delayed to transmit data from the community health workers (CHWs) from the CCMS back to the PCP to integrate the asthma action plan and data collected during asthma home visits into a care planning tool and the patient's medical record.

Delays in hiring for team-based care positions have also created challenges for the Asthma project.  We designed the workflow for referrals to a.i.r. bronx to align with the workflow for referrals to care management, since the patient populations overlap. We planned to use these care management resources—implemented as part of the Health Home at Risk project—to make the referrals to a.i.r. bronx, as the referrals are rather time-consuming. Delays in hiring mean that the volume of referrals to a.i.r. bronx is lower than anticipated, and our patient engagement targets are a greater challenge than expected.

This project is heavily reliant on a.i.r. bronx being able to conduct home visits to inspect homes and engage and educate the target population. Achieving buy-in from our partner organizations has been a greater challenge than anticipated, partly due to confusion with other asthma resources that provide complementary but distinct services. Additionally, we recently learned that Affinity Health (a Managed Care Organization) is offering a program to their members that is similar to the services provided by a.i.r. bronx. While we welcome the additional services devoted to asthma, this requires some referral workflow redesign so that patients do not receive duplicative outreach attempts or services.

## Efforts to mitigate challenges identified above:

In order to mitigate the challenges presented by our delayed launch of the home-based services, we are working hard to engage additional partners, outside of the ambulatory care sources of referral we first rolled the program out to. This includes working with our Health Home partners to develop referral workflows and reaching out to smaller and solo primary care practices. We are also using the PCMH TAs that BPHC is funding, to distribute information about and as advocates for the program, particularly at smaller primary care practices.

BPHC has been working to overcome the challenges associated with developing a PPS-wide CCMS. All necessary system and business requirements have been defined with the IT subcommittee and a CCMS Pilot Development Work Group. The work group mapped existing and future-state workflows for care management in the Health Home, Health Home At-Risk, Care Transitions, and ED Care Triage project contexts, which will allow rapid development and roll out of the BPHC CCMS platform. BPHC will work with a vetted vendor capable of developing an electronic care coordination management tool that will be made available to BPHC partners and comprehensively integrate all care coordination and transitional care management plans created across the PPS. The pursuit of interfaces between the BPHC CCMS, the Bronx Regional Health Information Organization (RHIO) and the various partner EMRs will ensure the robust exchange of care management planning information and greatly enhance clinical integration across BPHC providers.

We are also integrating referrals to our home-based asthma program into two critical asthma patient contact points: hospital emergency departments (EDs) and discharge planning (DP) units.  To address this, BPHC has included training on the home-based asthma program for staff involved in the ED Care Triage and 30-day Care Transitions programs. This includes a clinician orientation, to educate ED and DP staff on the goals, strategies, tactics and proven value of the intervention, and workflows for referring patients to a.i.r. bronx. We have included these sites in our project planning and have an initial roll-out meeting schedule with stakeholders from ED and Care Transitions in summer. Additionally, we are working with the Bronx RHIO to identify patients who had an inpatient or ED visit associated with asthma at a hospital NOT in our PPS.

School-Based Health Programs represent another source of referrals that we are targeting. We are setting up meetings with the three partner organizations associated with the bulk of our School-Based Health Programs to take place in summer.

In order to build buy-in for the program, BPHC has been "marketing" a.i.r. bronx services to elevate their "brand" as a trusted partner to practitioners, schools, and community organizations that have earned a high degree of community trust. As part of establishing this link, a.i.r. bronx is conducting orientations on its services for sites identified as key referral sources to the project. A tactic includes incorporating logos of trusted PPS partners on outreach and educational materials disseminated to patients. We are also including an article about a.i.r. bronx in the July issue of a patient-targeted health magazine distributed by SBH which reaches 6500 households.

Regarding the other asthma programs, BPHC has worked to provide clear messaging distinguishing the services provided by a.i.r. bronx from the work of other related  but distinct programs, for example NYCDOHMH's Healthy Homes program. Regarding the Affinity program, we are working with our partners to update their workflows as described above.

## Implementation approaches that the PPS considers a best practice:

BPHC developed a Clinical Operations Plan (COP) for all its projects, which acts as a foundational document and a guide for implementation. The COP is based on the DSRIP Domain 1 and 3 requirements and measures and was developed with input from our workgroups. The COP section on asthma was first distributed in March 2016 and the second edition was released in June 2016, having been developed and using input from the Asthma Transitional Work Group (TWG). The COP includes the evidence-based recommendations of the *Task Force on Community Preventive Services* for home-based, multi-trigger, multi-component interventions with an environmental focus.  It includes chapters on target population, evidence-based guidelines, referral protocols, patient flows, care team roles, patient/caregiver education (self-monitoring, medication use and engagement), and home environmental trigger reduction. The COP also includes procedures for the referral of patients to a.i.r. bronx, as well as the training that a.i.r. bronx's community health workers (CHWs) receive to perform such an assessment and the template for the Asthma Action plan which outlines steps to be taken to reduce exposure. Our Chief Medical Officer held a Clinical Leadership Forum on Evidence Based Guidelines with clinical leadership from our largest 7 primary care and hospital-based partners to discuss best practices for adoption and spread of EBGs, including but not limited to the EBGs adopted by BPHC for asthma from NAEPP3 as well as the Global Initiative for Asthma (GINA) guidelines.

As mentioned above, BPHC has worked with closely with a.i.r. bronx from the earliest planning phases, a clear best practice. This has allowed us to leverage a.i.r. bronx's deep experience and credentials in the field of asthma home-based services. For example, a.i.r. bronx developed the training curriculum and guide for this project, "Training & Practicum for Asthma Care Delivery in the Home Setting." This guide contains thorough references to peer-reviewed literature to support its training and education strategy and complies with the national standards for asthma self-management education.

Additionally, BPHC is working to identify clinical champions for a.i.r. bronx at our partner sites. These clinical champions could be members of our Asthma Implementation Work Group or members of the partner sites' Site-Specific Implementation Teams.

Another useful approach that might be considered a "best practice" is the establishment of a Pharmacy Workgroup. The kickoff for this group was held on February 25th and included representatives from 7 of the 10 BPHC pharmacy partners. This workgroup is brainstorming strategies to support the medication-related measures associated with this project (Asthma Medication Ratio (5 - 64 Years), Medication Management for People with Asthma (5 - 64 Years) - 50% of Treatment Days Covered and Medication Management for People with Asthma (5 - 64 Years) - 75% of Treatment Days Covered).  For example, the workgroup members are currently collaborating with BPHC's partner organizations to produce reports identifying individuals who never filled or are overdue for asthma controller medications.  We are also exploring the pharmacies' best practices– including opt-in care management services provided by pharmacies, whereby patients will be alerted by the pharmacy in the event of a missed prescription refill and may elect to have the pharmacy contact the prescribing physician to resolve medication prescription issues.

Lastly, as described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice).

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

As described above, BPHC has worked hard to structure its projects as a non-siloed, integrative strategy. For example, asthma was identified as one of the priority conditions for BPHC's Health Home At-Risk (2.a.iii) work. Since the implementation of team-based care is foundational to BPHC's primary care projects, 2.a.iii launched last January to

allow sites time to begin building their teams and making selected hires to build capacity for PCMH and Domain 3 (Chronic Disease Management) requirements, including asthma.

While this approach has led to some unexpected delays, as outlined above, we still believe it is a best practice as asthma patients eligible for a.i.r bronx services will almost certainly benefit from care management. Additionally, the care coordination team can help mitigate the challenges of communicating with the a.i.r. bronx team. For patients in care management, the Care Coordinator provides an accessible and logical point of contact. Our recommendation is that to streamline, referrals to a.i.r. bronx should go through PCMH Care Coordination team. Care Coordination teams will confirm eligibility and refer patients to a.i.r bronx, and Health Home as appropriate, using closed loop referral tracking and warm handoffs where possible.

Additionally, we are facilitating partner pilots of the RHIO Encounter Notification System (a requirement of the 2.b.iii and 2.b.iv) to address some of the measures associated with the asthma project: Pediatric Quality Indicators # 14 and #15 (Number of admissions with a principal diagnosis of asthma). We also plan to leverage these alerts to expand follow-up services as part of Milestone 6 (Root cause analysis after asthma-related ED/hospital visit).

BPHC is continuing to develop an overarching, cross-project strategy for referrals to and communication between Health Home care managers, PCPs, PCMH Care Coordinators, specialty providers, contracted CBOs and potentially clinical pharmacists. Independent of the DSRIP work, HealthFirst is piloting a program with a.i.r. bronx to fund home-based asthma care, which may serve an impetus for other managed care organizations (MCOs) to similarly fund these services. BPHC's Chief Medical Officer has made the topic of partnership/agreements with Medicaid MCOs a priority topic at the regularly scheduled cross-PPS meetings hosted by Greater New York Hospital Association (GNYHA), so some of these agreements may be in collaboration with other PPSs.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project. The GNYHA Clinical Leadership Forum gathers CMOs of PPSs to cover various topics including clarification on state guidance, plans for meeting P4P targets, understanding various vendor platforms.

Additionally, a critical component of the Asthma Home-Based Self-Management project is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

While this project has always targeted both children and adults, the bulk of referrals to date has, somewhat unexpectedly, been for adults. This is due, in part to the embrace of the program by practitioners in our PPS who treat adults, and perhaps speaks to the relative lack of previous services for adults with asthma.

As a result of the number of adults with asthma a.i.r. bronx is meeting with, the project has had an uptick in requests for referrals to services targeting adults, specifically services for treatment of depression and substance abuse. To serve this need, BPHC is working to train the a.i.r. bronx community health workers to administer the PHQ-9 screen for depression. Based on the results of that screening, qualifying individuals would be connected to Depression Care Management programs being implemented as part of the IMPACT model and substance use services provided as part

of the Behavioral Health into Primary Care work (Project 3.a.i Integration of Primary Care and Behavioral Health Services).

# DSRIP Mid-Point Assessment - Project Narratives
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health System

**Project:** 4.a.iii

## Challenges the PPS has encountered in project implementation:

The primary challenge that BPHC has encountered thus far is the delay in meeting as a cross-PPS workgroup. The contracting process with the lead agency, The Jewish Board, took longer than expected, and therefore delayed our work. Another challenge encountered was in the project design. The PPSs reconsidered whether to adopt an 'a la carte' menu of service which would allow for individual PPS regional differences but ultimately decided to stick to "core" service component which would be better suited for the project evaluation participating PPSs had planned. The school selection process also took on a lengthy deliberation involving the PPSs, DOE and DOHMH, until selection criteria was determined and finalized. As a PPS we wanted schools with School-Based Health (SBH) programs from the critical zip codes within our PPS to be selected for the project. However, at this time, only elementary schools are served by SBH, a population out of the scope of this project. All of these challenges are being addressed to ensure PPS buy-in beyond the pilot phase.

## Efforts to mitigate challenges identified above:

Due to the delay in meeting as a cross-PPS workgroup, the group has worked quickly since the on-boarding of The Jewish Board to put out a Request for Proposals (RFP). The RFP outlined the work that the chosen community-based organization will do in our schools. The PPSs have also begun driving the conversation about the program, insisting that there be at least one "core" element that will be standardized across all the schools for evaluation purposes. The PPSs have also engaged their workgroups to guide future school selection to reflect schools in our PPSs. The schools chosen after the initial selection will include schools in our PPS with no behavioral health programs. These schools will also be selected based on not replicating services from other organizations, such as the DOHMH and DOE. The workgroup will also continue to provide expert consult on the development of an operations plan, as required by the state, for review by the cross-PPS collaborative and The Jewish Board. The operational plan will cover many components of this project including staffing, sub-contracting, training, evidence-based guidelines, and other relevant topics related to implementation.

## Implementation approaches that the PPS considers a best practice:

Bronx Partners for Healthy Communities (BPHC) staff have participated in all meetings of the cross-PPS collaborative. BPHC CSO Staff and members have provided input on engaging community-based representatives, as well as subject-matter experts, including The New York Academy of Medicine (The Academy). At the MHSA Joint Planning Meeting, on February 13, 2015, Rahil Briggs from BPHC introduced Montefiore's Behavioral Health Integration Program (BHIP). The audience included representatives from the PPSs, the Department of Health and Mental Hygiene (DOHMH), the Office of School Health (OSH), a joint program of the New York City Department of Education (DOE) and the DOHMH that provides health and preventive services to DOE students, and Manatt consultants. The introduction led to further discussion about extending Montefiore's model to the school-based setting.

BPHC committed to the cross-PPS collaborative, including agreeing to the 'DSRIP MHSA Collaboration Agreement,' which outlines the governance structure of the cross-PPS workgroup. BPHC also included the DOHMH, DOE, and the OSH in process of developing the collaboration agreement. Roles and responsibilities for all involved parties were defined and will guide the collaboration going forward. The inclusion of the city and state agencies in this process ensured subject-matter experts were participating and MHSA will be bolstered by their other initiatives on an ongoing basis. Currently, the cross-PPS workgroup is discussing designing programs for young adults- adult-interfacing programs with the lead agency, JBFCS. Initial project outlines have been created.

The cross-PPS workgroup selected and finalized the contract with the lead agency, The Jewish Board, who will manage the implementation of this shared project. The selected organization, in collaboration with the DOE and the four participating PPSs, has outlined the process of identifying evidence-based guidelines, training plans, school recruitment, staff recruitment, and project launch. DOHMH, DOE, and OSH, are program are key stakeholders in MHSA, as their current efforts will be bolstered, while also informing them of additional needs in the community.

BPHC completed an analysis of the existing programs and community-based organizations (CBOs) that are providing MHSA services to adolescents in schools. There was special attention paid to programs and CBOs that focus on screening for depression and drug/alcohol abuse. Upon the review, BPHC recommended that the cross-PPS utilize Montefiore Medical Center's (MMC's) Behavioral Health Integration Program (BHIP) to inform the development of this project. The integrated program by MMC is the largest program for youth/adolescents in the country, which offers mental health services to more than 90,000 children across 19 clinics in the Bronx. In addition to BPHC's recommendation, the MHSA workgroup reviewed Maimonides Medical Center's Urgent Evaluation Service (UES), the Children's Hospital of Eastern Ontario's (CHEO) Urgent Care Service, and the rapid screening tool Home, Education, Activities/Peers, Drugs/Alcohol, Suicidality, Emotions/Behavior, Discharge Resources (HEADS ED). The workgroup stressed that the core universal interview should focus on better equipping school-based staff to address MHSA needs. The workgroup also suggested the use of a collaborative care-based model, like those reviewed could be adapted to fit this school-based intervention. The findings, along with workgroup suggestions, were incorporated into the concept paper.

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

The project implementation efforts are fully detailed in the PPS Quarterly reports.

In addition to the cross-PPS collaborative agreement, Bronx Partners for Health Communities (BPHC) participated in the forming of the Request for Proposals (RFP) for community-based organizations (CBOs), mental health services organizations (Article 31), and substance abuse services organizations (Article 32). The RFP outlines the many facets of the project including the training of school-based staff to identify behavioral indicators of subclinical MHSA needs and implement universal, selected, and targeted intervention for students to address those issues, integrating an adaptation of the Collaborative Care model into schools by training school support staff to perform assessments and interventions for students with mild to moderate MHSA clinical needs, and for students with higher acuity MHSA needs, training school support staff to form effective linkages to community mental health, substance use, and care coordination services and other community-based services, and strengthen existing linkages. Upon review of the proposals, Astor Services for Children and Families, an Article 31, was selected to implement the project in the schools beginning this fall.

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

The populations that were proposed to be served through this project have not changed. The initial focus will be on adolescents, ages 12 to 18. The second cohort will be young adults, ages 19 to 25.

**DSRIP Mid-Point Assessment - Project Narratives**
PPS must submit a narrative in each
section for every project the PPS is implementing

**PPS Name:** SBH Health System

**Project:** 4.c.ii

## Challenges the PPS has encountered in project implementation:

The Bronx is a recognized leader in HIV testing and facilitating linkage to care, however, containing costs while meeting the needs of our communities continues to be one of our greatest challenges and the areas of retention in care and viral load suppression (VLS), continue to be areas where improvements still need to be made. Many providers have indicated that retention might be improved with the addition of staff, and in particular embedding Credentialed Alcoholism and Substance Abuse Counselors (CASAC) at care delivery sites. While not explicitly named, this role can be accommodated by the BPHC care coordination infrastructure model. It will remain with each partner organization receiving BPHC funds to determine how they will address this request. BPHC will also explore how this need can be addressed through the development of alliances and partnerships.

Another challenge brought up by our HIV providers is that HIV-positive individuals within the PPS service area can be difficult to locate; this is the chief concern among our PPS partners participating in this project. HIV patients have a high prevalence of substance use disorder (SUD), homelessness, chronic trauma, behavioral health diagnoses and other chronic co-morbid conditions (e.g., diabetes, cardiovascular disease). Moreover, HIV disproportionately impacts ethnic/racial and gender minorities who often face stigma both in their communities and by providers. As a result, they may have to travel far from their community to receive culturally responsive care. Again the Bronx is known for high rates of linkage to care, but the needs exceed the resources. An additional challenge is that PPSs will work in silos, which will potentially create a duplication of efforts and confusion for downstream providers. This is particularly evident in the variance in use of the Bronx RHIO and the push towards increasing consent rates, as well as methods of care coordination. We did fully execute a contract in DY1Q4 with the Bronx RHIO to support registry development and PHM. However, we continue to negotiate with our leading care coordination management system (CCMS) vendor, Acupera. Delays on their part have contributed to our inability to fully execute a contract to acquire their CCMS. We will likely sign a contract for a CCMS by September 30, 2016 (end of DY2Q2).

Finally, a major challenge to project progress is building the collaborations, both within the PPS and across the PPSs. Building buy-in and consensus through partnership development is a time-intensive challenge requiring implementation and timeline alignment with multiple providers across various settings and systems and may require adjustment to the timeline we initially envisioned. Activities for building educational campaigns and addressing cultural competency will be forthcoming and will be pursued along with activities for identifying opportunities to improve access to community-based supports such as peer navigation, peer support groups, and case management.

## Efforts to mitigate challenges identified above:

To mitigate these challenges, we have begun to work closely with BPHC partners to launch a borough-wide quality improvement project focused on retention to care and VLS. The NY Links Bronx Regional Group will meet quarterly to identify small areas of improvement that will improve case management, enhance data tracking and management, and expand the adoption of best practices in the areas of behavioral health screenings including addressing substance use and tools for evidence-based point-of-care. Another focus of the group is to improve tracking those lost to care. In

addition to NYSDOH's contribution to establishing this regional group, NYCDOHMH has agreed to join and will be working with this group to develop better mechanisms for identifying patients lost to care or in care elsewhere. BPHC is actively participating in meetings with the cross-PPS HIV Coalition. The cross-PPS Coalition is working towards establishing standing committees around topics where the PPSs can collaborate. The DSRIP HIV Coalition holds quarterly membership meetings; additionally, standing committees have been developed to launch learning labs around project implementation. There will be Standing Committees for each of the following topics: VLS, data usage, HIV testing and linkage, peer workforce development, and pre-exposure prophylaxis (PrEP) implementation. For the data usage standing committee, the City University of New York (CUNY) School of Public Health will provide a series of presentations around data usage for VLS interventions, which will be available online.

Additionally, through the Bronx Regional Group, we will focus on how to create stronger clinical-community linkages, so as to better address social determinants that may be affecting VLS. To address the needs around cultural competency, we are working with our Workforce Development lead around training in cultural competency for providers and support staff, to expand the number of welcoming care delivery sites for HIV-positive individuals, particularly for the LGTBQ population. Finally, we intend to establish peer support programs, particularly in ethnic/racial minority communities, as peers are often more effective in helping patients overcome cultural barriers to care. Peer education programs will work in collaboration with Health People to ensure any education campaigns directed at community-based HIV awareness, testing, and treatment are evidence-based and relevant to the population. To assess the scope of need for CASACs in care delivery settings, we will work with our clinical and community providers through NY Links to identify partnership opportunities that can improve access to CASACs in care delivery settings. BPHC will explore how to leverage existing or external resources to improve access to treatment for drug and alcohol abuse among HIV positive individuals. BPHC will continue working with the Citywide DSRIP HIV Coalition, formed by the PPSs during the planning phase, and now led by NYCDOHMH. Through this group we will continue to raise awareness about our HIV project, share information about our quality improvement initiative launched with NY Links, and pursue a cross-PPS education campaign.

Our partnership with the Bronx RHIO, which including improving consent rates, and the borough-wide NY Links Bronx Regional Group promotes collaboration and information sharing between partners and supports our ability to improve health information exchange. Extensive investigation was completed to identify the data-sharing needs, which included evaluating participating providers' electronic health records (EHRs). Also, an initial draft of registry items was presented to Quality and Care Innovation Subcommittee (QCIS) and was approved to take to the Executive Committee (EC). We have a strategy in place for care management which includes the uses of registries, EHRs, Care Coordination Management Systems, and referral tracking systems. Our major partners which account for 87% of BPHC PCPs and 81% of non-PCPs, are already sharing clinical data to varying degrees with the Bronx RHIO and anticipate the quality and quantity of this data to increase. We reviewed DSRIP performance measures and Quality and Care Innovations Subcommittee recommended registry fields, and have been working with BxRHIO to further define which are most feasible to build out and release to our largest partners in DY2. Bronx RHIO has conducted a gap analysis on data currently in the RHIO and identified missing and other data quality issues relevant to those initial proxy measures and registries. Bronx RHIO has already begun development of Spectrum, its population health management (PHM) and analytics tool, which the PPS will utilize as part of our PHM solution.

We will also continue to meet with providers, colleagues and stakeholders to ensure that we remain coordinated, sharing challenges and best practices across all providers. Finally, we will continue meeting with the citywide DSRIP HIV Coalition to foster continued collaboration and sharing of promising practices, leveraging the workgroup to make progress toward alignment on common language and best practices whenever possible, in order to promote a standard for HIV-providers across the city and improve access to community-based supports.

**Implementation approaches that the PPS considers a best practice:**

BPHC brought together content experts to form an HIV Retention to Care Implementation Work Group (IWG) who identified evidence-based guidelines for retention to care and VLS. Members have made recommendations for additional community and resource-based partners to join the Work Group. The guidelines identified by the group have been documented in meeting minutes and take into account existing City, State, and Federal initiatives.

HIV, Health Home, and Care Management providers have been invited to join the HIV IWG. Partnerships with community-based organizations are being developed and strengthened through the assessment and engagement process with NY Links; BPHC already has an extensive roster of CBOs with whom partnerships will be facilitated for this project. The CSO has been actively engaging partners and the HIV IWG to develop and implement an evidence- and need-based program around retention to care and VLS. Through this engagement clinical champions have been identified and are participating in the IWG, most notably the IWG Chair, Dr. Edward Telzak, who is Chair of SBH Health Systems' Department of Medicine and former HIV Director at Bronx Lebanon. With the approval of the IWG, the CSO has established a collaboration with NY Links of the AIDS Institute to design and implement a Regional Group around performance improvement in HIV care, with a specific emphasis on the State's Prevention Agenda/DSRIP measures. The cross-PPS Coalition is actively identifying priorities and areas of collaboration which will inform how each PPS will implement their local projects.

We are also partnering with the AIDS Institute initiative, NY Links, to establish a regional group working on quality improvement as it relates to retention to care and VLS. In collaboration with NY Links, assessments have been conducted with Bronx Partners for Healthy Communities (BPHC) member organizations that provide HIV care and services. The assessment looked at current rates for linkage, retention, and VLS and current quality improvement efforts. The assessments will help inform topics and resources developed for future Regional Group meetings and improvement activities. NY Links will provide guidance and technical support to participants on implementing improvement projects and strategies.

Utilizing the New York State Department of Health's "Ending the Epidemic," this document outlines expert research on limiting the spread of HIV, along with minimizing new diagnoses. This includes utilizing intake case management triage, integrated care conferencing, and linkage to full-circle behavioral and social supports as needed.

PCMH elements are being identified by BPHC staff and will be integrated into the gap analyses delivered by the PCMH consultants.  As part of this PCMH integration strategy, and in order to leverage the efforts of the consultants and prevent duplication of labor, BPHC developed guidance for the PCMH consultants which outlines the links between the DSRIP projects and the PCMH requirements. For example, the guidance points out the population health management work that targets VLS and HIV-specific preventative care measures aligns with PCMH *Element 6A: Measure Clinical Quality Performance, at least annually the practice measures or receives data on (2) at least two other preventative care measures and, (3) at least three chronic or acute care clinical measures.* As described in the Mid-Point Assessment narrative for project 2.a.i, BPHC has deployed technical assistance groups to aid its primary care practices in achieving Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. PCMH transformation provides the foundation for practice-based care coordination, population health management, and patient-centered access (including non-traditional hours and alternative means of obtaining clinical advice)."

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

The regional group established in the Bronx with NY Links has generated a high level of interest. The quality improvement initiative is inclusive of non-PPS partners as well, so as to ensure we do not work in siloes. Our PPS partners can expect to receive additional technical assistance while working on quality improvement projects. Members of the regional group will meet in-person quarterly and between these meetings webinars will be delivered to highlight strategies for quality dand performance improvement strategies to address topics discussed in the regional group meetings. The group will serve as a networking and partnership development hub to build stronger clinical-community linkages and identify shared solutions to commonly experienced challenges around retention to care and

VLS.

Through the collaboration with NY Links, we will also explore the feasibility of supporting implementation of the Antiretroviral Treatment Access Study (ARTAS) model for increasing antiretroviral adherence. The PPS will be responsive to its partners working on this project and adjust the original plans to reflect the needs expressed by both the clinical and community HIV care providers in the Bronx.

In an effort to share best practices and streamline methodology and contracting where possible and appropriate, BPHC has engaged with other PPSs across New York State to achieve DSRIP goals and align key interventions related to implementation. These cross-PPS fora allow PPSs to develop common risk assessment methodologies, adopt common core partner contracting vehicles, ensure alignment and coordination of standardized protocols, workforce recruitment and training efforts, and selection of culturally competent patient education resources to support this project.

Additionally, a critical component of Project 4.cii is the ability to share data not only within each individual PPS but also across PPSs to collect information about BPHC patients who may access care outside of the BPHC network. BPHC convened the Bronx-Based PPS Group to discuss IT implementation and address Bronx RHIO utilization challenges, including consent strategies, with the other Bronx PPSs.

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

The populations that were proposed to be served through this project have not changed.