NewYork-Presbyterian
Performing Provider System

DSRIP Meeting Agenda

Date and Time	March 16, 2016, 3:30pm-5:00pm	**Meeting Title**	NYP PPS Project Advisory Committee
Location	Visiting Nurse Service of New York, 1250 Broadway (at 32nd Street), Room 7A &7B	**Facilitator**	Anne Sperling
Go to Meeting	None	**Conference Line**	Dial In: 855-640-8271 Passcode: 24545434

Attendees	
Shawn McCollister (NYP)	Yaffa Ungar (Isabella)
Marcy Thompson (ASCNYC)	Maria Perez (Methodist Home for Nursing and Rehab)
Faith Chambers-Gordon (Lutheran Social Services of NY)	Sandy Merlino (VNSNY)
Lauren Alexander (NYP)	Isaac Kastenbaum (NYP)
David Alge (NYP)	Anne Sperling (NYP)
Andy Nieto (NYP)	Emilio Carrillo (NYP)
Alessia Daniele (Weill Cornell Medicine)	Agnes Peterson (NYP)
Carlos Molina (Hostos)	David Baily (NYS Senator Adriano Espaillat)
Steve Muchnick (Upper Manhattan Mental Health Center)	Daniel Lowy (Argus)
Dan Johansson (ACMH)	Fern Hertzberg (ARC Ft. Washington Senior Center)
Deborah Katznelson (Y of Washington Heights)	Ana Garcia (NYP)
Jennie Overell (NYP)	Mary Hanrahan (NYP)
Eva Eng (ArchCare)	Chui-Man Lai (NYP)
Michael Andrews (1199 SEIU Training and Employment Funds)	Dana Lennon (Hostos)
Tony Ercolano (NYP)	Christine Duffy (St. Mary's Healthcare)
(?) Carter Burden Center for Aging	Vilma Linares-Vaughn (1199 SEIU Training and Employment Funds)

Meeting Objectives	**Time**
1. Welcome and Introductions (Anne Sperling)	3:30-3:40pm
2. VNSNY Welcome/Overview of Services (Sandy Merlino)	3:40-3:50pm
3. Capital Update (Isaac Kastenbaum)	3:50-3:55pm
4. PAC Member Presentations • ACMH, Inc. (Dan Johansson) • Argus (Dan Lowy)	3:55-4:25pm
5. Behavioral Health Project Update/Discussion (Mary Hanrahan, Jennie Overell)	4:25-5:00pm

Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**
Schedule meeting regarding availability of services for the geriatric population	Andy Nieto	3/16/2016	5/1/2016	In-progress

MINUTES:

- Anne Sperling opened the meeting and thanked VNSNY for hosting. She welcomed everyone and asked attendees to go around and introduce themselves. She also provided an overview of the new meeting format. Going forward, each meeting will be centered around a theme. In addition, each meeting will feature presentations by several collaborator organizations in an effort for community groups and organizations to learn more about one another. She noted the theme of this meeting was focused on behavioral health.
- Sandy Merlino of Visiting Nurse Service of New York provided an overview of the services offered by VNSNY.
    - Faith Chambers-Gordon asked if VNSNY provides services for children.

- Isaac Kastenbaum provided an update on capital funding which included a recap of the Capital Restructuring Financing Program, associated timeline and NYP PPS submission. He then provided an overview of the NYP PPS capital response as well as an excerpt of the response to non-recipients.
- Dan Lowy provided an overview of the services provided by Argus as well as some thoughts on their experiences related to serving the behavioral health population.
    - Anne Sperling asked if Argus has been seeing more opioid addiction in the city.
    - Fern Herzberg shared some thoughts around the fact that substance abuse and older adults in an issue of concern that is not being adequately addressed in this population. She asked what types of programs exist for older adults to address this issue, where organizations should go in terms of advocacy and what coverage of services looks like with regard to Medicare.
    - Carlos Molina asked what Argus's workforce looks like with regard to number of staff and associated roles.
    - Mary Hanrahan asked about the future of Argus's Continuing Day Treatment Program (CDTP).
    - Steve Muchnick inquired as to whether Argus provides Home and Community Based Services (HCBS). He also asked about how HARP assessments will be handled by Argus.
- Dan Johansson provided an overview of the services provided by ACMH, Inc. as well as some thoughts on their experiences related to serving the behavioral health population.
    - Andy Nieto asked about the opportunity/availability for placement in the various ACMH, Inc. programs.
    - Marcy Thompson commented on the limited availability of housing programs for HCBS and the advocacy needed around this.
    - Fern Hertzberg asked Dan to speak about service availability as it relates to older adults.
- Emilio Carrillo spoke about the upcoming CMMI grant opportunity focused on the Accountable Health Communities Model.
- Jennie Overell and Mary Hanrahan provided an overview of the NYP PPS behavioral health projects: Crisis Intervention and Primary Care Integration. They highlighted the HUB model, which is a central component of the Crisis Intervention project. This will entail creating a psychiatric triage HUB in an ambulatory setting.
    - Fern Hertzberg asked how the services of the behavioral health projects will be made available to the geriatric population.
    - Deborah Katznelson asked about the services that will be available from the mobile crisis team and the referral process.
    - Fern Herzberg noted the limited specialty services available to the geriatric population in the Washington Heights area. Deborah Katznelson also underscored the need for these types of services. They both noted the importance of creating a better awareness of the services that are available and how to tap into them. Dan Johansson noted that there might be an opportunity for advocacy related to this. Andy Nieto said he would reach out to schedule a meeting for further discussion. Steve Muchnick suggested the use of an open house/health fair as one vehicle for promoting what exists in the community and how to make referrals. Isaac Kastenbaum suggested we might want to consider how to sustain network development and support human connections across the network as a topic for the next PAC meeting.
- Anne Sperling closed the meeting. She thanked the presenters for their presentations and VNSNY for hosting. She encouraged PAC members to reach out to us with any ideas on future PAC meetings.

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Performing Provider System

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Attendees	
Project Advisory Committee Membership	

Meeting Objectives	**Time**
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• ACMH, Inc. (Dan Johansson)	
• Argus (Dan Lowy)	
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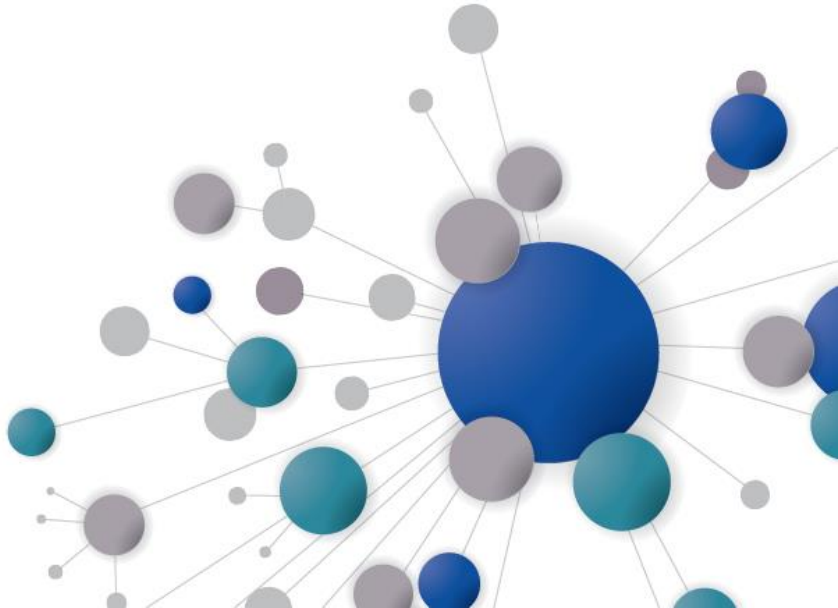
Action Items				
Description	**Owner**	**Start Date**	**Due Date**	**Status**

VNSNY: Transforming Home Healthcare for Today's Needs

Presented to the
NYP PPS Project Advisory Committee

March 16, 2016



Home and community based healthcare in a dynamic healthcare environment

Home healthcare provides important benefits to hospitals & physicians

- Supports healthcare providers in their quest to:
  - Increase patient satisfaction
  - Reduce unplanned re-hospitalization, length of stay and un-billable admissions
  - Reduce ED visits
- Ensures a safe transition to the home or community while providing continuity of care
  - Strengthens relationship between discharge planning and home care
  - Monitors medications for potential interactions, improves adherence
- Improves quality of care and clinical outcomes

Who is an appropriate candidate for home healthcare?

- Adults and children who:
  - Are recuperating from acute illness or are disabled
  - Are chronically ill
  - Are depressed or cognitively impaired
  - Have a post-op surgical care need
  - Have been diagnosed with terminal illness
  - Have complex medication regimens
  - Have multiple co-morbidities that require self-management
  - Have somewhat diminished capabilities but elect to live independently at home

Home healthcare services

- Skilled Nursing (Registered Nurses)
  - Assess health status
  - Monitor symptoms
  - Coordinate care across many disciplines and transitions
  - Educate patient and family about self-care, disease treatment and prevention
  - Reconcile and monitor complex medication regimens
  - Provide injections, IV therapy, wound and other specialized care, including behavioral health

Home healthcare services (cont.)

- Rehabilitation Therapies
  - Physical (PT)
    - Restore mobility/strength
    - Teach transfer and walking techniques
  - Occupational (OT)
    - Improve/restore function in ADL (eating, bathing, dressing, household tasks, toileting)
    - Cognitive retraining
  - Speech Language Pathology (SLP)
    - Develop/restore speech (as a result of trauma, surgery or stroke)
    - Retrain in breathing, swallowing, muscle control

Home healthcare services (cont.)

- Certified Home Health Aide Services
  - Assist with Activities of Daily Living (ADLs) with RN supervision
- Social Work
  - Evaluate social and emotional factors
  - Provide counseling
  - Assist with entitlements
- Long Term Care
  - Provide skilled nursing and case management oversight for chronically-ill and elderly patients

About VNSNY: Core Competencies

Unparalleled scale and scope of operations

- VNSNY is the largest not-for-profit home healthcare organization in the United States
- About 65,000 patients and health plan members under direct or coordinated care on any given day
  - Care for 22,000 patients daily in all five New York City boroughs plus Nassau, Suffolk and Westchester Counties
  - Manage the care of more than 40,000 VNSNY CHOICE Medicare and Medicaid Health Plan members
- 17,000 employees including almost 2,000 Registered Nurses and Licensed Practical Nurses
- 2,276,690 total paraprofessional (clinical) visits in 2013
- Clinical staff speak 50+ languages
- The operational scale to successfully implement quality care innovations across the care continuum

Deep clinical expertise in complex and chronic care

- Patients with chronic illnesses, disabilities and co-morbidities
  - Heart failure
  - Hypertension
  - Stroke
  - COPD
  - Asthma
  - Wound Care
  - Pneumonia
  - Diabetes
- History of treating vulnerable, high-risk populations has provided strong expertise with medically complex and psychosocially complex patients
- Complex Care Management is a key part of VNSNY's care coordination portfolio

VNSNY Population Health Management

- ACA incentivizes providers to improve population health outcomes
- VNSNY program core principles:
  - Promote health to prevent low-risk patients from becoming high- or rising-risk
  - Emphasize patient-centered, team-based care
  - Engage patients in their own health
  - Provide longitudinal rather than episodic care
  - Use EMRs and other technologies to promote timely reporting and sharing of data
  - Coordinate care across the continuum
- VNSNY RNs receive advanced training for certification as Pop Health Coordinators through Duke School of Nursing

About VNSNY: Programs and Capabilities

VNSNY Hospice and Palliative Care

- Compassionate, comfort-oriented care dedicated to improving quality of life for patients and families
  - Pain management, symptom control and emotional support
- Appropriate for a wide variety of patients, including those diagnosed with dementia, cardiopulmonary disease, kidney disease, cancer and other terminal diagnoses
- Customized care wherever patients reside:
  - Home, nursing home, assisted living facility, hospital (GIP care)
  - VNSNY Haven Hospice, a short-term, in-patient specialty care facility in a Manhattan Midtown East hospital
  - Shirley Goodman and Himan Brown Hospice Residence on Manhattan's Upper East Side
- 24/7 access to hospice experts for referrers, hospice patients and their families

Partners in Care (Private Pay Services)

- Flexible, private pay services to improve patient outcomes with additional care or special services
  - Arrange care quickly for a safe transition from institution to home
  - Provide care for those not eligible for insured services or desiring supplemental/extended care beyond Medicare or other insured coverage
  - Short-term or ongoing; live-in or round-the-clock care
- Broad array of services at home, in hospital, in-patient rehab or nursing facility
  - Skilled nursing (administering meds or immunizations, infusion, catheter, wound care or tube feeding)
  - Rehab therapies
  - Personal care and companionship
  - Ambulatory escort
  - Geriatric care management

VNSNY Research Center: A Unique Asset

- Considered to be the only Research Center of its kind in home care
  - PhD scientists generating and applying new knowledge about home and community-based care
- Dedicated to rigorous scientific investigation that promotes high-quality, cost-effective care in the home and community
- Analyzes trends and models to inform future healthcare policy and research
- Helps translate scientific evidence into everyday practice in managing chronic conditions
- Developed proprietary VNSNY risk stratification algorithm to predict patient risk of rehospitalization

VNSNY Health Innovation Partnerships

- VNSNY is collaborating across the continuum with providers on a wide variety of innovative initiatives to achieve the goals of the Triple Aim
  - Bundled Payments with major NYC medical center
  - Cardiothoracic Post-Op Program with major NYC medical center to reduce wound infections and length of stay
  - Hospital-at-Home Program with NYC academic medical center to reduce admissions for patients with potentially short stays
  - Capability Maturity Model Integration (CMMI) grants for process improvement and enhanced service delivery
  - VNSNY a community health collaborator in virtually every Performing Provider System initiative under DSRIP

Community Mental Health Services: Adult Programs

Program	Description	Population	Location	Payor Source
Mobile Crisis	• In-home mental health assessment and crisis intervention services – average of 2-3 visits. • Average length of stay (ALOS) 7 days. • Served by: social workers, psychiatrist • Accepts community referrals	Adults in psychiatric crisis	Bronx, Queens, Manhattan	NYS Office of Mental Health and NYC Dept. of Health and Mental Hygiene
Parachute Program (attached to Mobile Crisis Program)	• A continuum of community-based services, including: Mobile Crisis Team, Crisis Respite Centers and a "Warm Line" referral service • Accepts community referrals	Individuals ages 16-65 with serious mental illness (SMI) who are experiencing symptoms of psychosis	Bronx, Queens, Manhattan	NYS Office of Mental Health and NYC DOHMH
Health Home	• Comprehensive care coordination program integrating medical and behavioral health service needs. • Serves Medicaid-eligible members with a serious mental illness and/or two of the following: substance abuse problems, HIV/AIDS and/or multiple chronic illnesses. • Accepts community referrals	Seriously mentally ill (SMI), substance users, HIV/AIDS, multiple chronic illnesses	Manhattan, Bronx, **Brooklyn**	
Geriatric Mental Health and Outreach	• Short-term case finding, assessment and mental health treatment for adults 60 years or older. Clients seen once weekly • ALOS is 7 weeks. • Served by: social workers, RNs, psychiatrist	Seniors, 60 years and above	Upper Manhattan Bronx	NYC DOHMH and NYC City Council

Community Mental Health Services: Adult Programs

Program	Description	Population	Location	Funding Source
Assertive Community Treatment (ACT)	• Comprehensive, community support and treatment program for adults with an SMI diagnosis. Long-term program, responsible for total outpatient psychiatric care. Clients seen 1-3 times a week. • Must demonstrate history of multiple hospitalizations (3 in the past 2 years) • Served by: social workers, RNs, psychiatrist	Seriously mentally ill (SMI) who have a history of long-term psychiatric hospitalizations	Bronx, Queens, Manhattan	NYS Office of Mental Health and NYC Dept. of Health and Mental Hygiene
Behavioral Health Community Transitions Program	• Assist patients transitioning from inpatient psychiatric hospitalization to the community • In home weekly psychotherapy for patients who are unable or unwilling to go to psychiatric outpatient treatment for a during of 6 months or more, dependent on clinical need • Help prevent rehospitalization by ensuring patient has their medication, appointment and understands their treatment plan.	Adults and children with Axis I diagnosis that are currently in an inpatient psychiatric unit or recently discharged from an inpatient psychiatric unit	All Boroughs, Westchester, Nassau, and Suffolk	
Comprehensive Care Management (CCM)	• Case management and vocational rehabilitation to adults who are on public assistance and have substance abuse issues. Clients seen weekly • ALOS is 4 months • Served by social workers, vocational specialists	Substance users on public assistance	Manhattan, Queens, Staten Island	NYC Human Resources Administration

AMAZING THINGS ARE HAPPENING HERE

NYS CRFP Update

PPS Project Advisory Committee
March 16, 2016

NewYork-Presbyterian
Performing Provider System

NYS CRFP Overview (recap)

In conjunction with, and to further support the goals of the Delivery System Reform Payment ("DSRIP") Program, the Capital Restructuring Financing Program ("CRFP") was established pursuant to Section 2825 of the Public Health Law as a new State of New York grant program to be jointly administered by the Department of Health ("DOH") and the Dormitory Authority of the State of New York ("DASNY"). A total of $1.2 billion is expected to be available over the next six years for capital projects that will enhance the quality, financial viability and efficiency of the health care delivery system in New York State (the "State") by transforming the system into a more rational patient-centered care system that promotes population health and improved well-being for all New Yorkers.

NYS CRFP Timeline (recap)

Milestone	Date
RFA (v1) Release Date	11/18/2014
RFA (v1) Application Due Date	12/22/2014
RFA (v1) Disqualification Letters Distributed	6/29/2015
RFA (v2) Request for Re-Application Release Date	8/11/2015
RFA (v2) Application Due Date	9/1/2015
RFA (v2) Application Notification Date	3/4/2016

NYP PPS CRFP Submission (v1 and v2)

Organization	Project Name	Description	Revised Request	Proposed Match %	Proposed Match $	Funding Sought
ACMH, Inc.		8-bed crisis respite unit in Upper Manhattan for primary psych	$ 3,235,872	31%	$ 1,000,000	$ 2,235,872
ASCNYC		Build Peer Training Center to train CHWs to serve PPS	$ 600,000	50%	$ 300,000	$ 300,000
Community Healthcare Network		10k sf primary care clinic (Upper Manhattan)	$ 3,061,000	50%	$ 1,530,500	$ 1,530,500
Community Healthcare Network		10k sf primary care clinic (LES)	$ 3,061,000	50%	$ 1,530,500	$ 1,530,500
Harlem United/Upper Room AIDS Ministry		Clinic renovation/expansion @ West 124th	$ 1,522,865	50%	$ 761,433	$ 761,433
Harlem United/Upper Room AIDS Ministry		IT infrastructure to support care management	$ 330,862	50%	$ 165,431	$ 165,431
The Hebrew Home at Riverdale		EarlySense bed technology	$ 400,000	25%	$ 100,000	$ 300,000
Isabella		16-bed Hospice inpatient unit operated by MJHS	$ 6,458,382	25%	$ 1,589,065	$ 4,869,317
Methodist Home for Nursing and Rehab		Conversion of 40 beds from general purpose to acute step-down plus 14-bed dialysis unit and enhanced ancillaries, including telemedicine	$ 5,800,000	52%	$ 3,000,000	$ 2,800,000
St. Mary's Center Inc.		Clinic renovation @ West 126th to add Art 28, 31 and 32 capacity	$ 818,268	60%	$ 490,960	$ 327,308
Network Members		0.530674424	**$ 25,288,249**	**41%**	**$ 10,467,889**	**$ 14,820,361**
NYP	DSRIP IT Infrastructure	Assets to support DSRIP Program	$ 6,546,278	50%	$ 3,273,139	$ 3,273,139
NYP	ACN Expansion	Renovations/upgrades of ACN and related facilities	$ 15,818,512	50%	$ 7,909,256	$ 7,909,256
		0.469325576	**$ 22,364,790**		**$ 11,182,395**	**$ 11,182,395**
NYP PPS TOTAL			**$ 47,653,039**	**45%**	**$ 21,650,284**	**$ 26,002,756**

$47M in total projects; $26M sought from NYS

NewYork-Presbyterian
Performing Provider System

NYS DASNY CRFP Response to Non-Recipients

Re: Capital Restructuring Financing Program (CRFP) – RFA #15-04100252
Project [redacted]

Dear [redacted]

As a result of a competitive procurement process performed in accordance with the procedures and criteria set forth in the legislation establishing the Capital Restructuring Financing Program, Section 2825 of the Public Health Law and Section 1680-r of the Public Authorities Law ("CRFP"), and the Request for Applications #14-10100351, originally released on November 18, 2014, as amended and reissued (the "CRFP RFA"), at this time, we are unable to make a funding award for [redacted]

Due to the large number of applications received in response to the CRFP RFA, only about 20 percent were awarded funding. Your application was reviewed in accordance with the procedures and criteria referenced above and was ranked [redacted] in the "**New York City**" group. The lowest ranking application that received a CRFP grant award letter in the "**New York City**" group from this procurement was [redacted].

Applications that were awarded CRFP funds have been informed that they must provide information to the Dormitory Authority of the State of New York (DASNY) and its bond counsel to demonstrate that their requested CRFP grant award will be used for expenditures that are capital in nature and able to be funded from proceeds of State-supported bonds. It is possible that as a result of this review process or because an applicant cannot meet other conditions of their award, applications that scored below the rank of [redacted] may become eligible for CRFP funding.

A debriefing of this determination is available within ten days of the date of this letter. If you would like to request a debriefing, please contact the NYS Department of Health through the CRFP mail box at CRFP@health.ny.gov. Include in your subject line "CRFP Debriefing Request" and the following project reference number [redacted]

NewYork-Presbyterian
Performing Provider System

NYP PPS Capital Response

Organization	Project Name	Description	Revised Request	Proposed Match %	Proposed Match $	Funding Sought
Harlem United/Upper Room AIDS Ministry	0	Clinic renovation/expansion @ West 124th	$ 1,522,865	50%	$ 761,433	$ 761,433
Methodist Home for Nursing and Rehab	0	Conversion of 40 beds from general purpose to acute step-down plus 14-bed dialysis unit and enhanced ancillaries, including telemedicine	$ 5,800,000	52%	$ 3,000,000	$ 2,800,000
St. Mary's Center Inc.	0	Clinic renovation @ West 126th to add Art 28, 31 and 32 capacity	$ 818,268	60%	$ 490,960	$ 327,308
Network Members		0.266870568	**$ 8,141,133**	**52%**	**$ 4,252,393**	**$ 3,888,741**
NYP	DSRIP IT Infrastructure	Assets to support DSRIP Program	$ 6,546,278	50%	$ 3,273,139	$ 3,273,139
NYP	ACN Expansion	Renovations/upgrades of ACN and related facilities	$ 15,818,512	50%	$ 7,909,256	$ 7,909,256
		0.733129432	**$ 22,364,790**		**$ 11,182,395**	**$ 11,182,395**
NYP PPS TOTAL			**$ 30,505,923**	**51%**	**$ 15,434,788**	**$ 15,071,136**

Collaborators will now continue conversations with New York State; webinar on next steps to be held in the upcoming weeks.

NewYork-Presbyterian
Performing Provider System

ACMH . . . *Outreach, Engagement, Care Coordination, Housing, Skills Building, Respite, Wellness & Recovery*

ACMH, Inc.
Mission Statement

Promotes the wellness and recovery of persons with mental illness living in New York City

ACMH: Our Vision

- Promote the integration of its consumers into the community
- Empower its consumers to grow and achieve their goals
- Assist families to support consumers
- Become a benchmark for innovation and excellence
- Be the workplace of choice in the community mental health
- Expand to serve more people in more communities

ACMH: Our Values

- Team Work
- Professionalism
- Mutual respect
- Continuous learning
- Commitment to excellence

Outreach

Special Outreach Initiatives

- Shelter Initiative: Partner with 4 shelters in Manhattan to link clients to Health Home care management services.
- Inpatient Initiative: Collaborate with Mt. Sinai and New York Presbyterian Hospital staff to expedite ground-up enrollments and to participate in discharge planning.
- State Psychiatric Center Initiative: In-reach into Creedmoor Psychiatric Center.
- Prison Initiative: Supportive housing & services for individuals with SMI returning to New York City from prisons upstate.

Engagement

Eliciting client's participation in service

- The assessments and care planning are client centered and the clients drive the process from beginning to the end.
- Upon enrollment, all clients are oriented to the Client Grievance Process, which outlines the ways in which clients are able to voice their concerns.
- Client satisfaction and feedback is elicited through client focus groups and the Client Advisory to the Board of Directors

NYP PPS Community Health Worker (CHW) Initiative

- Target Individuals with Serious Mental Illness
- High Utilizers of ED & Inpatient
- Facilitate Care Transitions to Reduce Readmissions
- Home & Community Visits
- Follow-up with discharge plan/adherence
- Linkage to ambulatory care, social services, entitlements
- Linkage to care management
- Education, self-management
- ***Person-centered, goal driven, recovery oriented***
- Etc. . . . . .

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Care Coordination

Care Management Services Program

- During 2015, ACMH, Inc.'s Care Management staff served over 500 enrolled members in Manhattan, Queens and the Bronx through five Health Home leads.
- Individualized services are provided to members in their homes and in the community.
- Care Management Services are able to serve members that speak a variety of languages including English, Spanish, Portuguese and Creole.
- As a legacy provider Care Management Staff are also able to serve high need Seriously Mentally Ill (SMI) individuals in addition to members with 2 chronic medical conditions. Some of the high need SMI individuals are also AOT members.

Staffing and Responsibilities

- **Health Navigator/Care Coordinator-** Responsible for the overall management of member's care plan, including coordinating all aspects of care; monitoring and supporting adherence to care plan goals including medications and other treatments; and documenting care plan progress towards goals .
- **Senior Care Coordinator-** Seasoned Health Navigator/Care Coordinator that carry a reduced caseload as they assists the Program Director in training and supervising staff, reporting & liaising to health Home leads, conducting internal case record reviews, monitors and reviews weekly AOT progress notes and monthly AOT service verification logs.
- **Enrollment Specialist**-Care Coordinator with a reduced caseload who are responsible for enrolling clients. The Enrollment Specialist works with member to establish rapport and conduct all initial assessments and care plans.
- **Outreach Specialist**-Locates and engages eligible care management enrollees and supports the care team in the delivery of care management, care coordination, health promotion, transitional care, client and family support, and linkages to community and social services.
- **Program Director**-Ensures delivery of program services in compliance with OMH, NYC DOHMH and Medicaid regulatory guidelines and Health Home standards.
- **All care management staff-**have been trained to conduct the Community Mental Health Assessment for HARP Enrolled individuals and are responsible for developing & monitoring patient-centered Plans of Care.

Caseload

The average Caseload size varies:

- Health Navigators/Care Coordinators with no Assisted Outpatient Treatment (AOT) clients average 40 members.
- Health Navigators/Care Coordinators with AOT clients average 30 members.
- The Enrollment Specialists have average 25 members.
- The Senior Care Coordinators average 20 members.

Approach to Community Relationship Building

- The nature of our work at Care Management Services is to provide individualized services to members in the community.
- Staff will frequently accompanies members to appointments in an effort to promote the services provided by the program as well as establish working relationships with community providers.
- Staff identifies potential barriers to member's care and work with community providers to identify solutions and ways that staff can assist the member in meeting their needs.
- Program Director actively participates in all Health Home Lead provider meetings and is active in Quality Management initiatives with Health Home leads.
- Senior Management serves on a variety of Health Home Lead & PPS workgroups and committees.

Method for Reviewing Program Services and Incidents

- Special Review Committee: convenes monthly to review all incidents and incident investigations to explore deficiencies and avenues to improve services.
- Senior care coordinator is tasked reviewing charts and inform Program Director of any deficiencies.
- Annual Management/ Program Report: reviews annual trainings, emergency cell phone utilizations and safety and emergency services.

Method for Ensuring Commitment to Health Home Standards

- Weekly, monthly, and quarterly data-driven supervision and quality improvement initiatives:
  - -Hospitalization and ER Utilization Report
  - -Timeliness of Documentation
  - -Timeliness of Assessments
  - -Contacts with Other Providers & Collaterals
- Review Gaps in Care and the Healthcare Effective Data and Information Set (HEDIS) reports to ensure that members have access to services and to improve health care quality.
- Review of Care Management dashboards to track enrolled members, members who are HARP eligible, completion of and assessments, and Plan of Care.

Health Information Technology (HIT)

- ACMH uses several HIT platforms to document the services that are being provided and to ensure communication between providers.
- The systems features a dashboard interface: Care Coordination plans, Assessments, progress notes
- Some of the HIT platforms connect with RHIO where we receives various alerts.
- ACMH is connecting its EHR to Healthix in 2016

HIT Platforms

- GSI Health
- Care Director
- Roster Wrangler (RMA)
- Crimson
- AWARDS

PPS Collaborations

- New York-Presbyterian
- Mount Sinai
- OneCity
- Bronx Health Access
- Bronx Partners for Healthy Communities
- Advocate Community Partners

It's all about care coordination and access to services.

ACMH . . . *Outreach, Engagement, Care Coordination, Housing, Skills Building, Respite, Wellness & Recovery*

PPS Projects

- Care Transitions
- Crisis Stabilization
- Medication Adherence
- Community Health Navigation
- Disease Management for CVD
- Disease Management for Adult Diabetes
- Health Home at Risk

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Housing

Housing

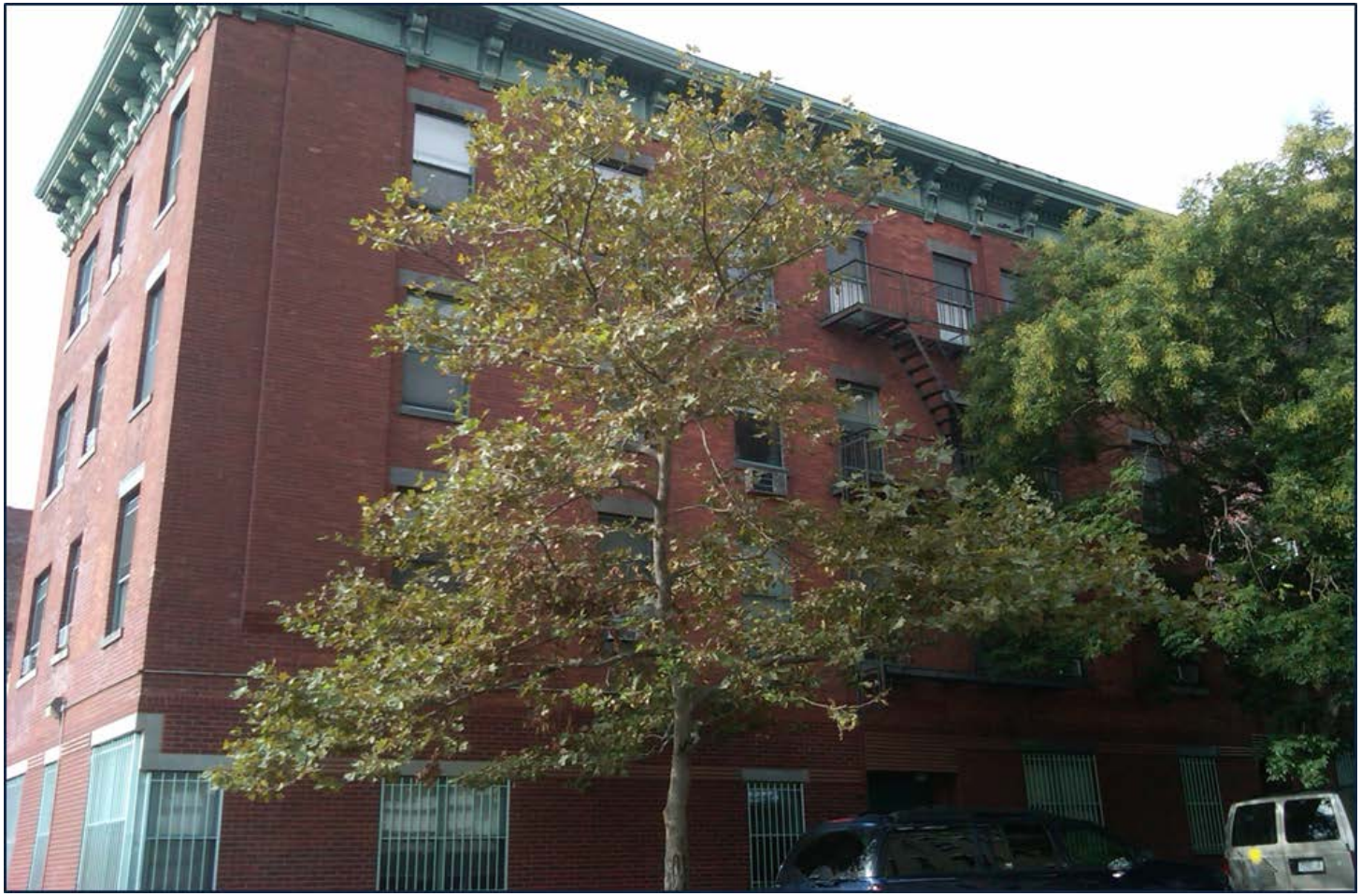
Housing

Housing

Housing

Housing

Housing



Housing

Housing

Housing

Housing

ACMH Residential Programs

- ACMH provides housing with case management services to SMI individuals in supportive housing, serving more than 650 individuals and households across 3 boroughs– Manhattan, The Bronx and Queens .

- Specialty Housing:
  - ACMH has 2 housing programs dedicated to serving the needs of youth between the ages of 18-25
  - Asian Initiative at our 74 Avenue A Community Residence in Queens Village provides culturally competent transitional housing services to Asian-American clients coming from PCs or psychiatric inpatient.
  - E. 144th Street Affordable Housing: a mixed use housing program including 18 low-income units for community singles and families.
  - Garden House Respite: a temporary get away for adults, 18+ with a psychiatric diagnosis experiencing a crisis.

Young Adult Housing

Young Adult Housing:

- *Ages 18-24 with SMI*
- *Aging out of residential treatment, Child CRs, leaving State PCs, or*
- *Recently leaving foster care*
- *Peer to peer positive youth development*
- *Education, Employment & Housing*

Crisis Respite

- Peer Run
- Licensed Mental Health Counselor/Care Navigator

Crisis Respite

- 1-7 Day Stays
- Wellness & Recovery Plans

Skills Building

Home & Community Based (HCBS) Services

Skills Building & Support

- ACMH, Inc. is OMH-designated to provide services in home and community settings.
- Services in Manhattan, Queens and the Bronx
- Services for Health and Recovery Plan (HARP) members
  - ❖ Psychosocial Rehabilitation (PSR)
  - ❖ Habilitation/Residential Support
  - ❖ Family Support and Training
  - ❖ Empowerment Services-Peer Supports
  - ❖ Short-Term Crisis Respite

ACMH Demographics & Outcomes Calendar Year 2015

Demographics

	Total Served	Housing	Care Management
Gender			
Female	42%	40%	44%
Male:	58%	60%	56%
Race			
Black:	41%	43%	39%
Latino:	27%	20%	35%
White:	21%	26%	17%
Asian:	5%	7%	2%
Other:	6%	4%	8%
Age			
18-20:	2%	2%	1%
21-25:	5%	6%	4%
26-30:	6%	3%	8%
31-40:	16%	17%	14%
41-50:	22%	21%	23%
51-60:	31%	32%	29%
61-70	16%	17%	17%
71+	2%	2%	3%
Primary Language			
Other than English:	15.3%	11.0%	19.3%
Spanish	11.4%	6.7%	16.4%
Chinese	1.8%	2.6%	0.2%
Other	2.1%	1.7%	2.7%

ACMH Demographics & Outcomes Calendar Year 2015

Incidence of Health Conditions

	Total Served	Housing	Care Mgt.	Young Adults
Serious Mental Illness	96%	100%	91%	100%
History of Alcohol/ Substance Abuse	50%	52%	48%	21%
Active Alcohol/ Substance Abuse	16%	12%	21%	21%
Chronic Medical Condition(s)	59%	58%	60%	41%
Cardiovascular Disease	31%	33%	28%	3%
Diabetes	24%	23%	24%	3%
Pulmonary Disease	16%	13%	20%	0
Obesity	15%	17%	12%	35%
Liver disease	6%	5%	6%	3%
HIV/AIDS	2%	1%	2%	0
Cancer	1%	1%	1%	3%

ACMH Demographics & Outcomes Calendar Year 2015

Outcomes

Linkage to Primary and Psychiatric Care (as December 31, 2015):

	Total	Housing	Care Mgt.
Primary Healthcare Provider:	90%	91%	89%
Psychiatric Provider:	87%	93%	84%

ACMH Demographics & Outcomes Calendar Year 2015

Outcomes

Psychiatric Medication Adherence (as of December 31, 2015)*

	Total	Housing	Care Mgt.
Consistently	62%	59%	64%
Most of the Time:	26%	26%	26%
Sporadically or Non-Adherent:	9%	10%	8%
Not Prescribed:	4%	5%	2%

*Adherence to psychotropic medications for those prescribed psychotropic medications residing in independent or scatter site housing only, not congregate settings.

Demographics & Outcomes Calendar Year 2015

Outcomes

Inpatient Utilization

Psychiatric in-patient days as percentage of total client days:

Housing: 2.3% Care Management: 2.3%

Medical in-patient days as percentage of total client days:

Housing: 0.2% Care Management: 0.3%

Thank you!

ACMH Inc.
Care Management & Housing

www.acmhnyc.org

Intake & Referrals: 212-274-8558, ext. 215

ACMH . . . *Outreach, Engagement, Care Coordination, Housing, Skills Building, Respite, Wellness & Recovery*


Argus Community Inc.

History

- Argus was founded in the South Bronx in 1968 by Elizabeth L. Sturz, CASAC.
- We began as a substance abuse treatment provider; in ensuing decades we expanded the scope of our programs to address new challenges raised by homelessness, HIV/AIDS, mental health and welfare reform.
- Argus has received both national and international recognition: Argus programs have been replicated in Washington DC, San Francisco, Albany, Des Moines, and Belfast, Northern Ireland.

Argus Community's Continuum

- Outpatient Mental Health Continuing Day Treatment
  - Psychiatric diagnostic and treatment services
  - Individual and group counseling
  - Psychotropic medication administration/management
  - Case management

- Outpatient Substance Use Disorder Treatment
  - Individual and group counseling
  - Psychiatric services
  - Medical and health services
  - Case management

- Residential Substance Use Disorder Treatment
  - Individual and group counseling
  - Medical and mental health services
  - Case management
  - Rehabilitation of activities of daily living

Argus Community Continuum (Cont.)

- Health Home Care Management
  - Outreach and engagement
  - Assessment and care planning
  - Medical care management
  - Advocacy and entitlements assistance
  - Referral to wrap-around services
  - Patient navigation
  - Money management

- Ryan White HIV Care Coordination
  - Coordination of care with HIV primary care specialists
  - Direct Observed Therapy (DOT)
  - Medical case management
  - Referral to wrap-around services

Argus Community's Continuum (Cont.)

- Career Training
  - Career training in the field of addiction
  - SED and OASAS approved curriculum
  - Internship and job placement
  - DYCD funded Adult Basic Education (ABE) Services

- Youth Services
  - OASAS licensed youth prevention services
  - DYCD funded High School education assistance
  - DOE operated TASC programs
  - DYCD funded youth employment services

Our Approach

- **Same Day/Coordinated Access to Care**
  - **All who come to Argus Community will be screened process the same day**
  - **Argus Community maintains a strong network of partners and all clients who seek services will receive support in finding the place that meets their needs- there is no wrong door**
- **Effective Transitions/Warm Hand-Offs**
  - **Argus Community provides transportation from courts, detox and other referral sources**
  - **Outreach Health Workers, Community Health Workers, and Patient Navigators coordinate with the referring organization and facilitates a warm hand-off between the referent and Argus Community**

Outcomes

- **Outpatient Substance Use Services**
  - 83% of clients are retained in care for 30 Days, 79% at 90 days, and 50% at 180 days
  - 42% of clients discontinue use
  - 39% have maintained or improved employment status
  - 42% of the clients completing the program or referred to an alternate level of care

- **Residential Substance Use and Continuing Day Treatment Services**
  - 80% of clients are retained in care for 30 Days, 83% at 90 days, 75% at 180 days, and 60% at 365 days
  - 85% of clients discontinue use
  - 68% completing the program or referred
  - 52% of the clients completing the program and referred to ambulatory care

Outcomes (Cont.)

- Care Management/Care Coordination
  - On average, 20-25 new members enrolled in care management/care coordination weekly
  - 78% of the members actively address their medical goals
  - 68% of the members actively address their mental health goals
  - 17 % of the members have attained housing and 50% in progress of attaining housing goals
  - Overall member hospitalization rate of only 1.5%
  - 57% received DOT HIV treatment adherence services

Outcomes (Cont.)

- **Argus Career Training Institute**

  - **Since its inception in 1992, The ACT I program is now on its 22nd cycle of training and job placement.**

  - **The ACT I program placed 779 individuals in good jobs with good benefits. The cumulative outcome metrics for the ACT I program are as follows: 1,436 individuals have been enrolled. 864 individuals (60%) completed the program. 779 (90%) were placed in jobs with benefits by ACT I. 664 (85) remain employed as of September 2013.**

  - **In the most recent cycles of the ACT I program, the following annual service and performance outcome metrics were achieved: Of the 168 individuals enrolled, 115 (68%) completed training. 82 of the individuals who completed training (71%) were placed in jobs with benefits by ACT I. 75 of the individuals who completed training (91%) and were placed in jobs by ACT I remain employed after 90 days.**

  - **Overall, the annual starting salaries have been between $25,000 and $35,000, a substantial increase above minimum wage.**

New York - Presbyterian
and
Argus Community

A partnership created by DSRIP

- Argus Community has taken this opportunity to have a voice and impact in how healthcare is delivered in New York
- Strengthened partnerships with other providers in the PPS
- Opportunities to improve infrastructure and delivery system
- Participation in the 3aii Behavioral Health Project
- Participation in the 4cii HIV Population Health
- Participation on the Project Advisory Committee
- Participation on the IT Committee

Learn More About Argus Community

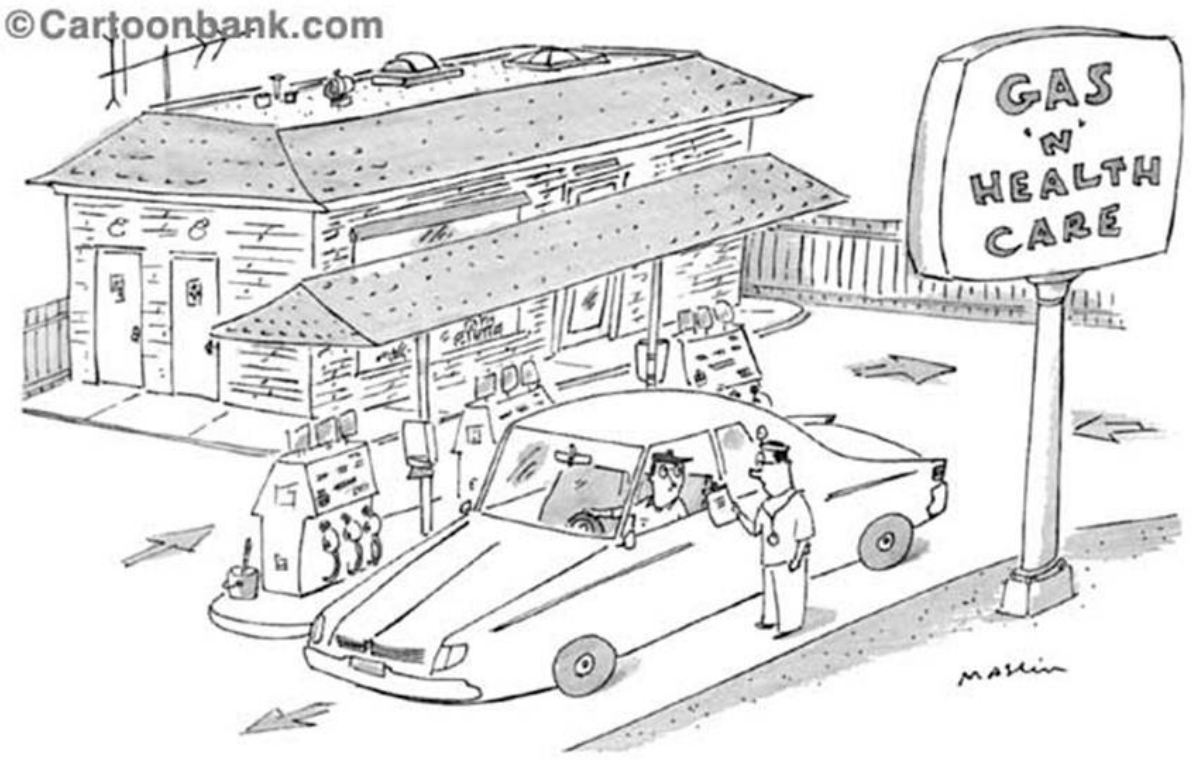
www.arguscommunity.org

AMAZING THINGS ARE HAPPENING HERE

NYP PPS Behavioral Health DSRIP Projects 3.a.i and 3.a.ii PAC Meeting March 16, 2016

NewYork-Presbyterian
Performing Provider System

NYP PPS Behavioral Health DSRIP Projects 3.a.i and 3.a.ii



"Your oil's fine, but your blood-sugar level's a little low."

NewYork-Presbyterian
Performing Provider System

Project Overview

Crisis Intervention

To identify and divert non-emergent psychiatric patients from the medical and psychiatric EDs while linking them rapidly to nearby ambulatory medical, social (housing, etc.), psychiatric, and substance use providers. The goal will be achieved through two distinct interventions:

- Creation of a psychiatric triage HUB in an ambulatory setting
- Implementing a community-based, mobile Critical Time Intervention-like team, linked to behavioral health access points within the hospital and community

Project Overview

Primary Care Integration

To ensure that behavioral health patients receive timely, coordinated, and appropriate primary care services. This project will:

- Embed primary care resources within select BH practices
- Identifying behavioral health patients who currently receive outpatient psychiatric care in the NYP/CU/PI system, and assure that targeted patients are connected to primary care
- Increase communication between patients' primary care, psychiatry and specialty teams

Current State of the Project

Crisis:

- Successful recruitment of psychiatric NPs to initiate rapid referral intervention, initiated recruitment process for SWs, CHWs, Case Managers, Physician
- Placement of administrative lead for project management
- Tracking and analyzing profiles of high utilizing cohort
- Developing partnerships with CBOs
- Contracting with CBOs to embed DSRIP-focused staff at CBO sites

Current State of the Project

Primary Care Intervention:

- Contracts with Columbia University in progress
- Supplies and equipment purchased for primary care sites
- Developing protocols and workflows
- Embedded administrative leadership at sites
- Conducting IT needs assessment and project plans
- Strengthening relationships between behavioral health and primary care clinics at NYP
- Developing and documenting enhanced referral processes
- Participation in KPMG's "MAX" Series for 3.a.i

How Funds Are Being Spent

Crisis:

- Hiring dedicated clinical staff (at NYP and network sites)
- Equipment and supplies
- Hiring administrative staff to support initiative
- Consultation and training

How Funds Are Being Spent

Primary Care:

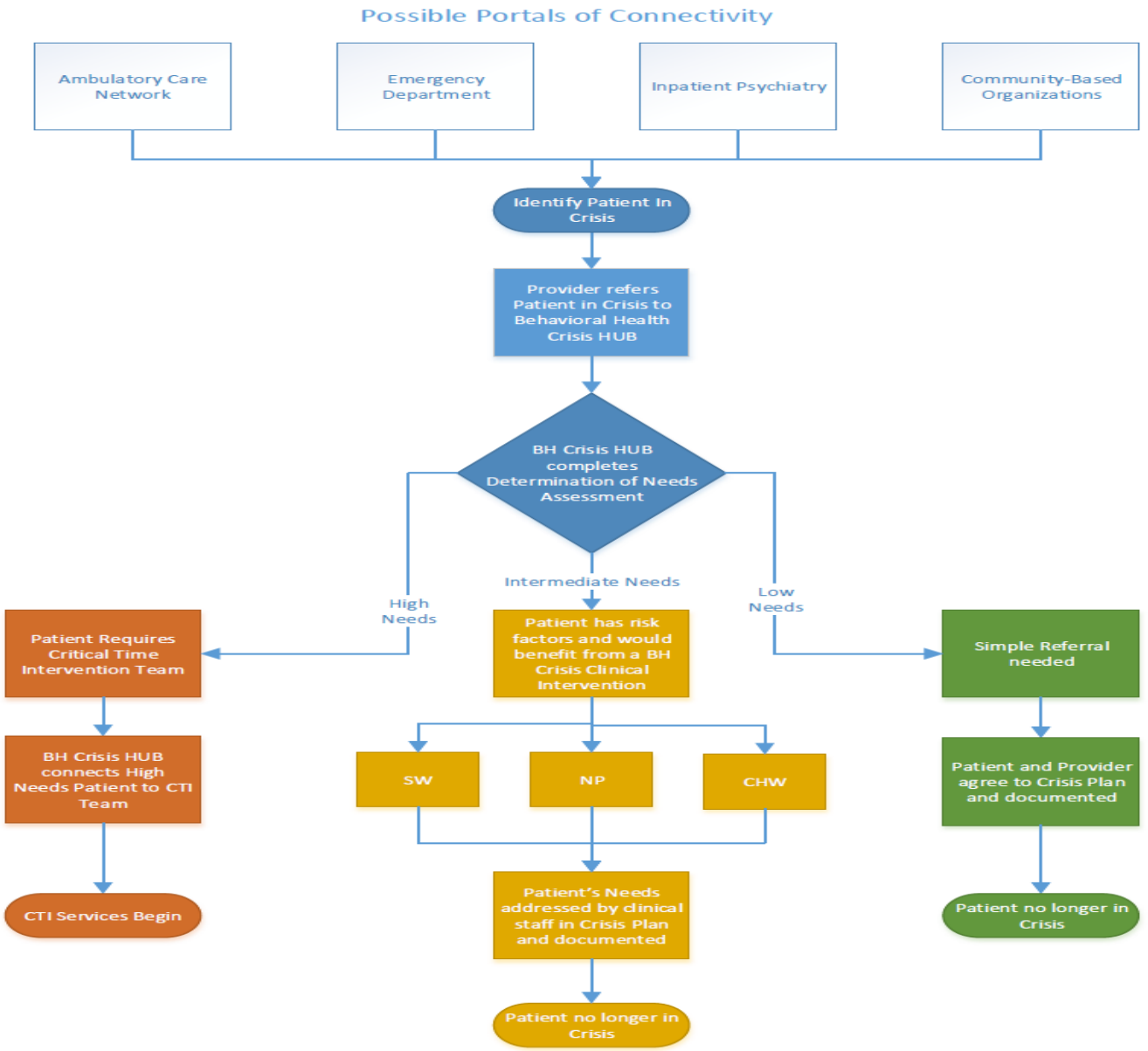
- Hiring primary care clinical staff to embed at PI site
- Medical equipment/supplies
- Hiring administrative staff to support initiative
- Consultation and training

Results to Date

Crisis

- Increased referrals to CBOs and network partners
- Enhanced communication amongst treatment team about alternatives to admission
- Work processes in place for same day referrals
- Developed intervention strategies to allow for enhanced integration of care
- Expansion of navigator support in ED to include psychiatric patients

Behavioral Health Crisis Stabilization Project Redesign
PROPOSED CRISIS HUB MODEL

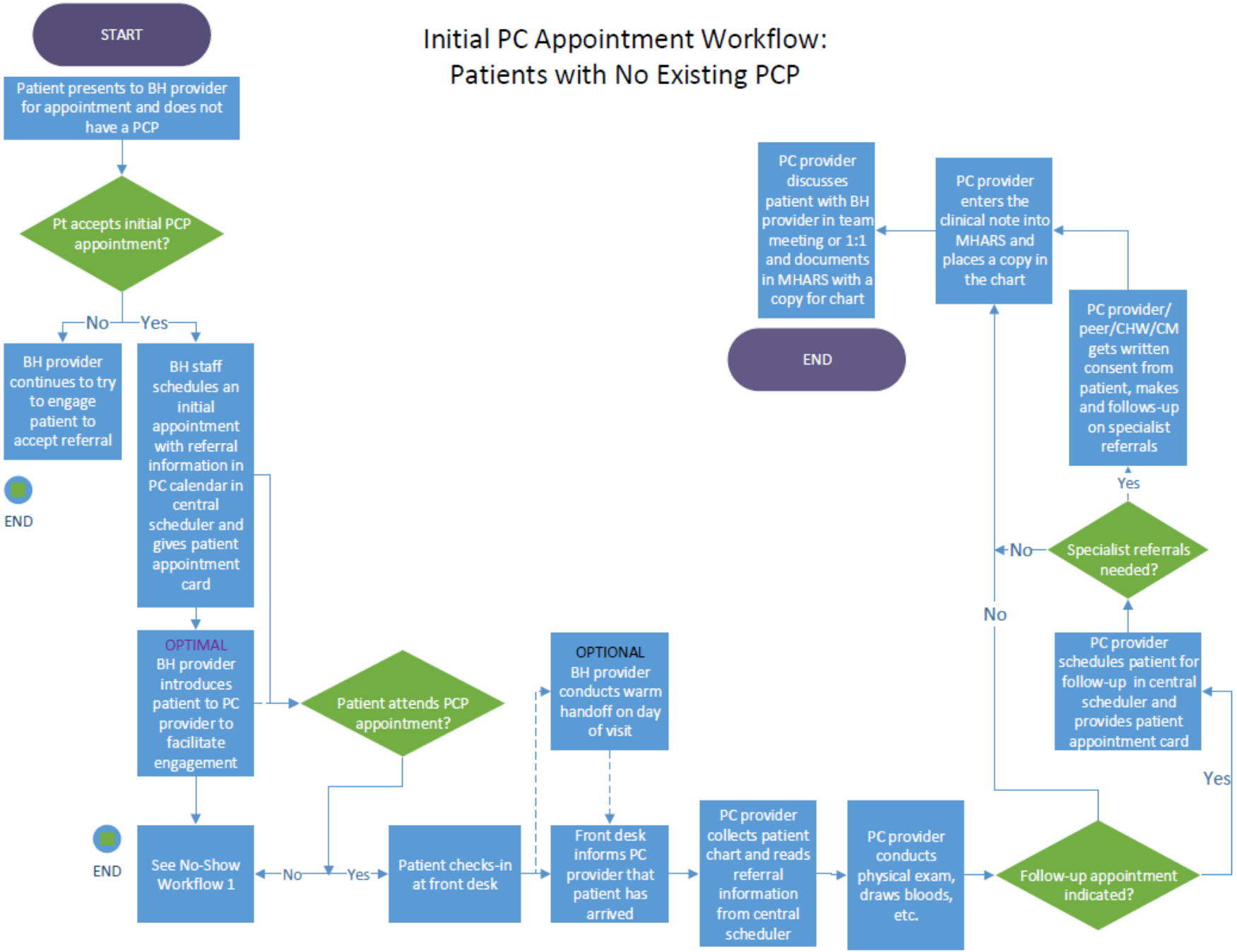


Results to Date

Primary Care

- Clarification of target population including children, adolescents and families
- Workflow and referral process developed
- Contracts with PI site in development
- Initial patient cohort connected to primary care
- Greater attention and awareness of primary care needs in the behavioral health settings

Initial PC Appointment Workflow: Patients with No Existing PCP



Challenges

- Culture of siloed care
- Habituation of care patterns
- Lack of expedited interim or permanent housing and social services
- IT infrastructure limitations and timing
- Privacy and regulatory barriers
- Legal and contractual processes
- Sustainability

Expected Outcomes

- Enhanced access to primary care, all levels of behavioral health care, specialty services and support services
- Better training and education of staff and patients
- Development of protocols and best practices
- Enhanced communication with internal and external team members
- Warm handoffs and appropriate tracking of patients during transitions of care
- Reduction in LOS and ED/Inpatient Utilization by providing access to a richer variety of wrap around services
- Enhanced use of IT for capturing and sharing appropriate patient information with all providers

NewYork-Presbyterian
Performing Provider System

Volume and Revenue Expectations

- At the completion of Year 4, BH Integration will provide collocated primary care and behavioral health services to 2,258 patients annually.
- At the completion of Year 3, BH Crisis Stabilization will provide stabilization services to 1,300 patients annually.
- All “co-located” primary care and behavioral health services will be billable under Article 28 or 31 guidelines
- Exploring billing options for CTI team