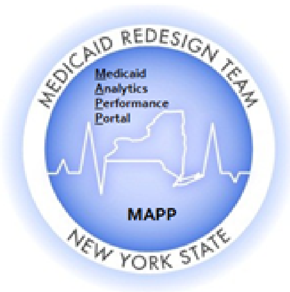


SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:
The DSRIP PPS Organizational Application must include an executive summary clearly articulating how the PPS will evolve into a highly effective integrated delivery system. This section will also include questions about any application(s) for regulatory relief the PPS is pursuing.

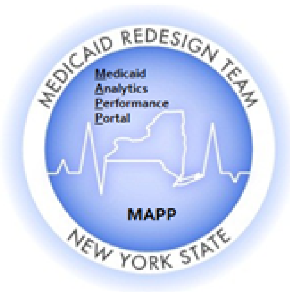
Scoring Process:

This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

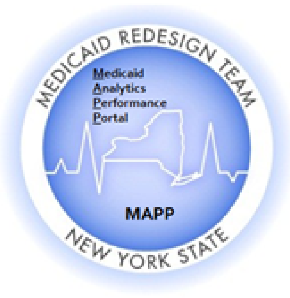
Section 1.1 - Executive Summary:

***Goals:**
Succinctly explain the identified goals and objectives of the PPS. Goals and objectives should match the overall goals of the NY DSRIP waiver and should be measurable.

#	Goal	Reason For Goal
1	Fundamentally transform how Brooklyn residents participate in their health care system	Maimonides and the nearly 400 diverse organizations and thousands of providers that form the Community Care of Brooklyn (CCB) PPS view DSRIP as a powerful change agent, enabling fundamental transformation of how low income Brooklyn residents participate in the health system. In the present system, there is insufficient access to medical care, poor communication and coordination among various caregivers needed to provide comprehensive services to the chronically ill, and inadequate integration of social services affecting health and access to services. CCB's vision is to transform this system, as measured by reduced preventable hospital use and improved patient satisfaction, primary care access, and eventually health outcomes by using shared IT, common care standards, and quality management. CCB will leverage existing resources, experience, and infrastructure built over the last 10 years by Maimonides and a group of over 50 CCB partners to quickly launch projects and achieve our goal.
2	Create an integrated system of care across multiple sectors and improve population health management	Our Community Needs Assessment (CNA) found that 25% of Brooklyn's population is in fair-poor health, 24% in poverty, and there are significant disparities for minority groups (65% of Brooklyn residents). Chronic conditions drive preventable hospital use and cause premature death. Primary care shortages are stark—Brooklyn has 9 federally-designated underserved areas. Half of Brooklyn's population receives Medicaid. Given these findings, an integrated, systematic approach to addressing gaps in health services, care delivery and social needs is required. CCB's integrated delivery system (IDS) will focus on high-risk communities and patients. Our goal is to implement a new model of care to integrate physical, behavioral and social needs into a single coordinated care plan and use a team-based approach to manage care, with success measured by the Domain 2 metrics for the IDS project. Our Central Services Organization (CSO) will provide centralized support as we rapidly deploy our IDS.
3	Facilitate and increase access to community-based care coordination and care management services	The CNA identifies systemic challenges for CCB patients—poverty, long work days, lack of family/social contacts, and special stressors on minority and behavioral health populations pose barriers to effective care. CNA respondents noted a lack of resources to assist with basic social needs, and that providers often fail to recognize or address these connections, looking instead to "quick but possibly ineffective medical solutions." CCB's goal is to connect patients to community supports and coordinate medical care by expanding our network and workforce for care management,



#	Goal	Reason For Goal
		leveraging the work done already by our two partner Health Homes. Further, CCB will implement the Health Home At Risk project to expand access to these services for those with a single chronic condition or other risk factors, and deploy an advanced IT solution for care coordination, described below. Success will be measured by achievement against the Domain 2 DSRIP metrics for the Health Home At Risk project.
4	Facilitate communication between providers and patients through a shared IT platform, the Dashboard	To facilitate the goals identified in this summary, CCB believes that seamless and meaningful communication by providers, including medical, social, and community-based, is critical. CCB's web-based, easily accessible care coordination and population health management IT solution (the Dashboard) will enable care team members to store and share information, and collaborate on a single integrated care plan, regardless of location and organization. The Dashboard is interoperable with existing clinical systems/EHRs, and the RHIO (Healthix), and provides advanced analytics, care coordination applications, and alerts at critical transitions in care, e.g. when patients are admitted to and discharged from the hospital, are discharged from the criminal justice system, etc. This solution is currently in use with the Brooklyn and CBC Health Homes and over 50 Health Home partners, and CCB's goal is to extend it to all Participants, as measured by number of locations actively using the Dashboard.
5	Increase primary care and urgent care capacity and improve access to primary care for our population	Brooklyn faces primary care shortages—much of the borough is a health professional shortage area or medically underserved area. Outpatient care sites including FQHCs and clinics are unevenly distributed and insufficient in areas with moderate-high Medicaid populations such as Greenpoint, Canarsie, and East New York. CCB's goal is to expand access to care via new primary care and urgent care sites, more hours, and a larger, more patient-focused, better trained workforce. We will also support all new and existing primary care sites in achieving 2014 NCQA Level 3 standards (a key DSRIP goal, and the metric by which our success will be measured). This work will lay a strong foundation for all of CCB's selected projects.
6	Foster collaboration among Brooklyn providers through transparent and inclusive governance	To achieve the integrated, comprehensive, and highly collaborative health care system we have described thus far, CCB believes it must engage both our community and our diverse network of providers, community-based organizations, and other partners including payers and unions. Over the last several years, Maimonides has led collaborative work on population health management with a growing consortium of over 50 medical, care management and social service organizations, major payers and healthcare labor unions. Building upon its longstanding work, CCB's goal, which is described in detail throughout this application, is to establish a transparent and collaborative governance structure and a diverse and representative PAC that engages stakeholders, old and new. This goal will be measured by completion of our Master Services Agreements with each CCB Participant (before implementation), standing up our operational governance structure, and convening our PAC, as described in Section 2.
7	Reduce preventable hospital use and shift to use of outpatient and community services	Brooklyn contributes to New York's high rates of preventable ED visits (PPVs) and preventable readmission (PPRs). The CNA notes that nearly three quarters of Medicaid ED visits in Brooklyn were preventable in 2013, amounting to over 347,000 preventable ED visits. Further, in 2012, there were 8,878 potentially preventable readmissions in Brooklyn; 2,870 were at CCB hospitals and on average our hospitals had observed/expected PPR ratios of 1.03. CCB's goal, and the primary goal of DSRIP overall, is to reduce readmissions and preventable ED visits by 25%, as measured by our PPR and PPV metrics, and shift care to outpatient settings. CCB will do this through all of our projects, but particularly through our Care Transitions and ED Triage projects, and by increasing access to and coordination of community-based and primary care services, as described above. CCB will also develop a comprehensive plan for bed reduction and rationalization as this goal is achieved.
8	Use evidence-based practices to improve	CCB recognizes the need to tackle chronic disease through comprehensive



New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

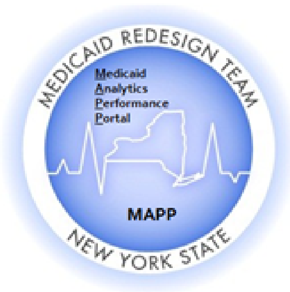
Maimonides Medical Center (PPS ID:33)

#	Goal	Reason For Goal
	management of chronic diseases	and coordinated care. In Brooklyn, the CNA notes that chronic conditions are the largest driver of potentially preventable admissions, particularly for respiratory and cardiovascular diseases, and there are gaps in the community resources needed to comprehensively care for these patients. Health centers with specialty services for chronic disease care are sparse in neighborhoods with high chronic disease-related preventable hospitalizations. CCB's goal is to address through our selected projects, including Health Home At Risk, Behavioral Health Integration, Asthma Home-Based Self-Management, Cardiovascular Disease Management and Access, Palliative Care Integration, and Retention in HIV Care. Success will be measured using the DSRIP metrics for each of these projects.
9	Integrate behavioral health and primary care services	The CNA identified a critical shortage in behavioral health services in Brooklyn: In 2012, of the almost 220,000 Brooklyn Medicaid enrollees with behavioral health-related service utilization throughout the year, nearly a third had an inpatient admission. More than half of adult behavioral health clients under age 65 and almost 90% of those over 65 had at least one co-morbid chronic condition. CNA focus groups were concerned about anxiety, depression, and substance abuse, and emphasized the link between behavioral and physical health. CCB's goal is to successfully implement our Behavioral Health Primary Care Integration project in order to address these gaps and improve care for this high need, high risk population, as measured by the DSRIP metrics for that project. Many of our other projects, including Health Home At Risk, Care Transitions (which includes the CTI intervention for psychiatric patients) and ED Triage will also help address our goal of improving care for this population.
10	Improve access to culturally and linguistically appropriate care	CCB will serve many diverse communities in Brooklyn, where 65% of residents represent minority groups. The CNA identified barriers to care, particularly for immigrant populations, including linguistic challenges (25% of residents speak English less than "very well," nearly half speak another language at home), eligibility for insurance, and lack of familiarity with the US healthcare system. The CNA also found a lack of culturally and linguistically competent specialists and multi-specialty centers, particularly for behavioral and mental health. CCB's goal is to implement intensive training for our providers on cultural and linguistic competency, as described in Section 7 of this application. This goal supports all of CCB's projects, and will be implemented through our CSO (which provides central support across all projects). Initial success will be measured by completed trainings and longer term success will be measured by improved health outcomes in minority groups.
11	Transition payment to value-based arrangements with managed care organizations	Recognizing that one of DSRIP's overall goals to sustain quality gains is to shift payment to value-based arrangements, CCB will engage with Medicaid Managed Care Organizations (MCOs) to rapidly move to value-based payments and provide contracting, analytics, and performance reporting to support the transition. This goal is described in more detail in the Executive Summary Section, in our IDS project description and in Section 9. Maimonides has already begun conversations about value-based purchasing with several leading MCOs, including HealthFirst and Emblem, and believes that, with the support of the State, it will be successful in creating win-win value-based purchasing arrangements to sustain these new programs and the transformative ways of doing business that DSRIP is spawning. This goal will be measured by the number of value-based contracts managed through and supported by the CCB PPS, in addition to the number of lives covered under those contracts.

***Formulation:**

Explain how the PPS has been formulated to meet the needs of the community and address identified healthcare disparities.

CCB is formulated to meet community needs and address disparities through diverse partners, central support, and carefully selected projects. Our partners, organized into community-centric hubs, span the full continuum of care and reach the neediest communities. CCB



will cover Brooklyn and an adjacent community in Queens that falls within the catchment area of Wyckoff Hospital.

We have identified that 25% of Brooklyn is in fair-poor health, 24% in poverty, and there are disparities on preventable hospitalizations and premature death for minority groups, who comprise 65% of Brooklyn residents. Chronic conditions (respiratory, cardiovascular, and diabetes) drive preventable admissions and have high mortality, and resource gaps exacerbate these concerns. Patients with behavioral health/substance abuse problems have high utilization and preventable admissions, and over half have a co-morbid chronic condition. Coney Island, Williamsburg/Bushwick, Crown Heights, East New York, Borough Park, Sunset Park, and Flatbush are hot-spots on these metrics. Our projects address these needs by targeting chronic disease, integrating behavioral health care, and improving care management/transitions.

***Steps:**

Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.

As described in our IDS section, CCB envisions a comprehensive strategy for sustainability. We will create partnerships with MCOs, leverage the capabilities of those companies and, at the same time, provide sustainable funding for the infrastructure and capabilities built with DSRIP and other funds. CCB will provide a next-generation approach to care management, which goes well beyond the current capabilities of MCOs by working in the community as team members with primary care providers and other clinicians, yielding better cost and quality results. CCB Participants will be clinically integrated and financially sustainable, providing MCOs with a high performing care delivery network that replaces today's disjointed, episodic system. Maimonides has already begun conversations about value-based purchasing with several leading MCOs, including HealthFirst and Emblem, and believes that, with the support of the State, it will be successful in creating win-win value based purchasing arrangements to sustain these new programs, and the transformation that DSRIP is generating.

***Regulatory Relief:**

Is the PPS applying for regulatory relief as part of this application? Yes

For each regulation for which a waiver is sought, identify in the response below the following information regarding regulatory relief:

- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the waiver request, including a description of how the waiver would facilitate implementation of the identified project and why the regulation might otherwise impede the ability of the PPS to implement such project;
- Identify what, if any, alternatives the PPS considered prior to requesting regulatory relief; and
- Provide information to support why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) would not risk patient safety. Include any conditions that could be imposed to ensure that no such risk exists, which may include submission of policies and procedures designed to mitigate the risk to persons or providers affected by the waiver, training of appropriate staff on the policies and procedures, monitoring of implementation to ensure adherence to the policies and procedures, and evaluation of the effectiveness of the policies and procedures in mitigating risk.

PPS' should be aware that the relevant NYS agencies may, at their discretion, determine to impose conditions upon the granting of waivers. If these conditions are not satisfied, the State may decline to approve the waiver or, if it has already approved the waiver, may withdraw its approval and require the applicant to maintain compliance with the regulations.

#	Regulatory Relief(RR)	RR Response
1	14 NYCRR §§ 599.3(b), 599.4(r), (ab); 14 NYCRR §§ 800.2(a)(6), (14), 810.3, 810.3(f), (l)	Provision of Mental Health and Substance Abuse Services by Article 28 Facilities Project(s): 3.a.i - Reason for request: OMH regulations require Article (Art.) 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30% of the provider's annual visits and the total number of visits is at least 2,000 visits annually (the OMH threshold). OASAS regulations require an Art.icle 28 provider to