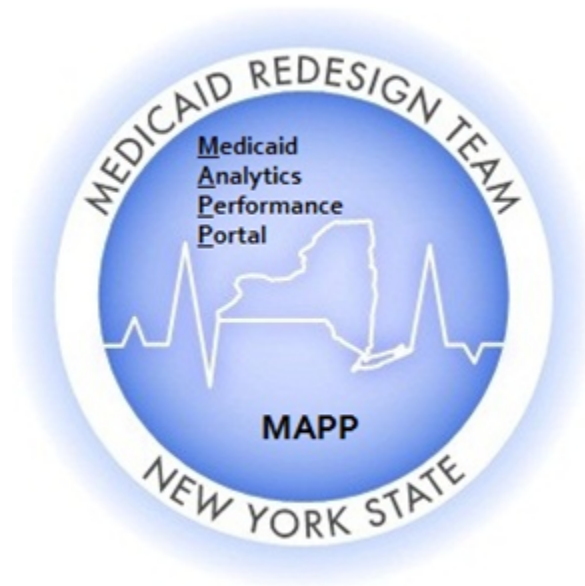# New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Maimonides Medical Center

Maimonides Medical Center (PPS ID:33)

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

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This application is divided into 11 sections: Sections 1-3 and 5-11 of the application deal with the structural and administrative aspects of the PPS. These sections together are worth 30% of the Total PPS Application score. The table below gives you a detailed breakdown of how each of these sections is weighted, within that 30% (e.g. Section 5 is 20% of the 30% = 6 % of the Total PPS Application score).

In Section 4, you will describe the specific projects the PPS intends to undertake as a part of the DSRIP program. Section 4 is worth 70% of the Total PPS Application score.

Section Name	Description	% of Structural Score	Status
Section 01	Section 1 - EXECUTIVE SUMMARY	Pass/Fail	✅ Completed
Section 02	Section 2 - GOVERNANCE	25%	✅ Completed
Section 03	Section 3 - COMMUNITY NEEDS ASSESSMENT	25%	✅ Completed
Section 04	Section 4 - PPS DSRIP PROJECTS	N/A	✅ Completed
Section 05	Section 5 - PPS WORKFORCE STRATEGY	20%	✅ Completed
Section 06	Section 6 - DATA SHARING, CONFIDENTIALITY & RAPID CYCLE EVALUATION	5%	✅ Completed
Section 07	Section 7 - PPS CULTURAL COMPETENCY/HEALTH LITERACY	15%	✅ Completed
Section 08	Section 8 - DSRIP BUDGET & FLOW OF FUNDS	Pass/Fail	✅ Completed
Section 09	Section 9 - FINANCIAL SUSTAINABILITY PLAN	10%	✅ Completed
Section 10	Section 10 - BONUS POINTS	Bonus	✅ Completed

By this step in the Project you should have already completed an application to designate the PPS Lead and completed various financial tests to demonstrate the viability of this organization as the PPS Lead. Please upload the completed PPS Lead Financial Viability document below

*File Upload: (PDF or Microsoft Office only)

Currently Uploaded File: **33_SEC000_MMC_PPS Lead Financial Viability Document.pdf**
Description of File
File contains: the financial test, Attestation form, Exhibit E phase 3 narrative, and application
File Uploaded By: ajberman File Uploaded On: 12/20/2014 04:14 PM

You can use the links above or in the navigation bar to navigate within the application. Section 4 **will not be unlocked** until the Community Needs Assessment in Section 3 is completed.

Section 11 will allow you to certify your application. **Once the application is certified, it will be locked.**

If you have locked your application in error and need to make additional edits, or have encountered any problems or questions about the online Application, please contact: DSRIPAPP@health.ny.gov

Last Updated By:	ssuchoff
Last Updated On:	12/22/2014 03:28 PM

Certified By:	dc314127	Unlocked By:
Certified On:	12/22/2014 03:31 PM	Unlocked On:
Lead Representative: David I Cohen		

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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,

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#	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

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#	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

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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

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#	Regulatory Relief(RR)	RR Response
		obtain a certification from OASAS if it provides any substance abuse services. Under Project 3.a.i, Art. 28 providers will increase their provision of mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is highly likely that some of the providers participating in 3.a.i will cross the OMH threshold, and all Art. 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would conflict with the goals of 3.a.i. Going through the certification process would be an unnecessary administrative burden and could materially slow implementation of needed new capacity to serve the attributed population. Further, having to comply with multiple licenses would force Art. 28 providers to comply with new rules that would have little benefit to patients. For example, Art. 28 providers are already required to maintain medical records that meet DOH standards; requiring their records to also meet OMH standards would not improve patient care. Forcing providers to comply will new and unnecessary administrative processes and rules will discourage providers from providing such integrated care. - Potential alternatives: Providers could avoid OMH and OASAS licensure by keeping their provision of mental health services below the OMH threshold and avoiding any substance abuse care. However, it would likely be difficult for certain providers to stay below the 30% limit, particularly if they are located in areas with a high behavioral health need, and trying to stay within that limit could result in turning away patients needing mental health care. Although the draft Integrated Outpatient Services regulations could address some of these issues, this and related requests are being sought because it is unclear how those new rules might be implemented. - Patient safety: Waiving licensure requirements is not likely to endanger patient safety because Art. 28 providers are already required to comply with a detailed regulatory regime aimed at ensuring patient safety. Nevertheless, working with OMH and OASAS, Art. 28 providers that increase their provision of mental health and substance abuse services under 3.a.i will examine their policies to determine if any further policies need to be developed to ensure patient safety given the service changes. If any further policies are required, they will be modeled on OMH and OASAS regulatory requirements.
2	10 NYCRR §§ 401.2(b), 401.3(d)	Article 28 Facilities' Sharing of Space Project(s): 2.a.i, 3.a.i - Reason for request: Section 401.2(b) allows the operating certificate of an Article 28 provider to be used only by the Article 28 operator at the Article 28 provider's site of operation. DOH has interpreted this to mean that the operator must have exclusive site control and cannot share the site with another entity. Section 401.3(d) prohibits an Article 28 provider from leasing or subletting any portion of its facility unless the entity that leases the facility conforms with all of the requirements imposed on Article 28 providers. At the very least, these two provisions prohibit Article 28 providers from sharing space with any provider not licensed under Article 28—including a physician group practice, a clinic licensed by OMH, or a substance abuse clinic licensed by OASAS. This would prohibit Article 28 providers from allowing other providers with expertise in mental health care or substance abuse services to provide care in their facilities, thereby limiting their options at integrating care. These two provisions could also be interpreted to bar an Article 28 provider from sharing space with another Article 28 provider. This interpretation would prevent residential care facilities from sharing space with primary care clinics, a possible aspect of Project 2.a.i. - Potential alternatives: Article 28 providers could avoid these rules by declining to share space altogether and instead relying on their own expertise to provide behavioral health care. While some providers in the PPS are likely to do so, others lack expertise in behavioral health care. This

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#	Regulatory Relief(RR)	RR Response
		latter group of Article 28 providers would then be forced to refer patients to behavioral health providers in other locations, making it less likely that the patients would receive the care they need. Similarly, if residential health care facilities were unable to share space, they would have to rely on their own personnel to provide primary and urgent care services, even though an Article 28 clinic might be able to offer greater expertise and a higher level of care. - Patient safety: The purpose of the relevant regulations is to ensure that an operator has control of the site and therefore can maintain an environment that is conducive to patient safety. Article 28 providers who receive these waivers will have agreements in place with the leasing provider that give the Article 28 provider sufficient authority over the leased space to ensure patient safety in that space. Moreover, these providers will develop whatever written plan for the sharing of space that may be required by DOH. Finally, the providers will comply with federal regulations on shared space, to the extent they are applicable.
3	14 NYCRR §§ 599.5(c), 599.12(a)(6)	Article 31 Facilities' Sharing of Space Project(s): 3.a.i - Reason for request: The regulations cited above allow mental health providers licensed by OMH (Article 31 providers) to share program space only if they have a written space sharing plan that has been approved by OMH. As part of the behavioral health integration project, providers licensed by OMH are likely to share space with providers of physical health services. The PPS's implementation plan will indicate which providers are planning to share space, and assuming DOH approves that implementation plan, DOH will approve the space sharing plans. Providers should not have to obtain a separate approval from OMH. - Potential alternatives: Article 31 providers could follow the regulatory requirements and obtain OMH approval prior to sharing space. However, doing so could result in delays in the implementation of DSRIP projects, particularly since OMH resources may be stretched given the likely demand for such approvals as a result of DSRIP implementation. - Patient safety: In cases where OMH providers do share space, they will develop a space sharing plan, and that plan will require that the OMH provider has sufficient authority over the leased space to ensure patient safety in that space. These providers will share the space sharing plan on request, and will modify the plans if OMH or DOH raise any concerns.
4	10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1; 790.16, 791.2, 791.8	Certificate of Need for Medical Facilities and Certified Home Health Agencies Project(s): 2.a.i, 2.b.iii, 3.a.i, 3.b.i - Reason for request: When medical facilities seek to undertake certain projects, the certificate-of-need ("CON") regulations cited above require those facilities to submit applications to DOH, demonstrate a public need for their projects, and obtain DOH prior approval. The projects listed above are likely to require providers to undertake construction and service changes implicating CON rules. In particular: a) Project 2.a.i requires a large investment in primary care (PC) capacity and some providers will need to expand operations to meet that enhanced capacity; this may include the addition of primary care sites at residential care facilities; b) Project 2.a.i also requires investment in health information technology infrastructure as well as renovation at hospices, and some HIT investments enacted by providers—a group of providers that includes residential health care facilities—will fall within the scope of CON regulation; c) Project 3.a.i will likely require construction and renovation at Art. 28 providers to create new spaces for behavioral health care, and likewise some Art. 28 providers may provide services at new sites; and d) Projects 2.b.iii and 3.b.i will likely require the creation of new spaces to handle the increased demand for

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#	Regulatory Relief(RR)	RR Response
		urgent care and cardiovascular services. Requiring a demonstration of public need and a separate application for these projects is unnecessary. DOH approval of the DSRIP projects and their implementation plans should be sufficient, particularly in light of the fact that the PPS has conducted a community needs assessment, and used the results of that assessment to inform its project selection. If DOH is unwilling to waive these regulations in full, DOH should at least provide a highly expedited review process to ensure that DSRIP projects are not delayed. - Potential alternatives: The alternative to a regulatory waiver would be to continue to require providers to demonstrate public need for DSRIP projects. Doing so, however, would be highly duplicative of the DSRIP application process itself, as DOH's approval of the above projects demonstrates DOH's belief that the projects are in the public's interest. - Patient safety: Waivers of CON regulations would not implicate patient safety in this context. CON regulations are designed to prevent the overutilization of services. While overutilization of services can cause patient harm in some circumstances, the potential for harm is much more likely when providers seek to increase the provision of surgeries, imaging, and other intensive services. There is little threat to patient safety when there is a potential increase in the provision of PC services, as the Public Health and Health Planning Council recognized in its Dec. 2012 recommendation of eliminating CON review for PC facilities. The projects listed above all involve PC services.
5	OMH: 14 NYCRR §§ 551.6, 551.7: OASAS: 14 NYCRR §§ 810.6, 810.7	Prior Approval Review for OMH and OASAS Providers Project(s): 3.a.i - Reason for request: Section 551.6 requires Article 31 providers who are licensed by OMH to undergo prior approval review if they undertake certain projects, including the establishment of a new satellite location and the expansion of caseload by 25 percent or more for clinic treatment programs. Section 551.7 requires a demonstration of public need as part of this review. Similarly, Section 810.6 requires Article 32 providers who are licensed by OASAS to undergo prior approval review if the provider offers services at a new location or increases capacity of a service where capacity is identified in the provider's operating certificate, and Section 810.7 requires the applicant to demonstrate public need for its project as part of the review. Project 3.a.i is likely to fall within the reach of these regulations. As part of behavioral health integration, Article 31 and Article 32 providers are likely to provide services at new locations—more specifically, they may provide care within an Article 28 facility. While establishing a new satellite location is technically subject to "E-Z PAR" review, in practice this process is not easy for providers: they must obtain a letter of support from a local government unit to demonstrate there is a public need for the project, and the process can be lengthy. Requiring prior approval review for the behavioral health integration project would be duplicative of the DSRIP process itself, since the PPS will already have to submit its implementation plan to the state for review. There is no need to impose a separate prior approval review process on top of the review process embedded into DSRIP itself. - Potential alternatives: The PPS could avoid this requirement by relying on Article 28 providers to provide mental health and substance abuse services on their own. But Article 28 providers would need waivers to do so, as discussed above. Moreover, Article 31 and 32 providers have expertise on behavioral health care, and the PPS should have the option on utilizing those providers with a deep behavioral health knowledge base in its implementation of the behavioral health integration project. - Patient safety: Foregoing a demonstration of public need will not have an impact on patient safety. To the extent OMH and OASAS have any concerns about Article 31 and Article 32 providers expanding their

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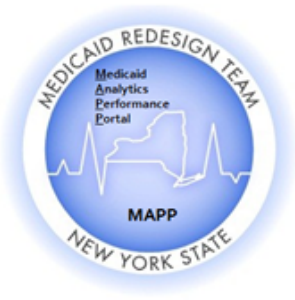| #	Regulatory Relief(RR)	RR Response
		operations into primary care settings, the PPS will work with these agencies to develop policies to assure patient safety.
6	10 NYCRR §§ 702.3, 710.9, 711.2, 712-2.4, 715-2.2, 715-2.4	Construction Standards and Pre-Opening Surveys Project(s): 2.a.i, 2.b.iii, 3.a.i, 3.b.i - Reason for request: Sections 702.3 and 711.2 set construction standards for medical facilities in general, Section 712-2.4 provides specific standards for hospitals, and Sections 715-2.2 and 715--2.4 set standards for freestanding ambulatory care facilities. In addition, Section 710.9 requires a preopening survey after the completion of a construction project. In order to fulfill the goals of Project 2.a.i to provide more primary care services to underserved areas, there will be an expansion of the capacity of primary care providers, which will likely require new construction and renovation. Hospitals with aging facilities may also undertake upgrades in order to increase their provision of primary care services. Likewise, Projects 2.b.iii and 3.b.i may require an investment in primary care infrastructure; some facilities may have to be renovated in order to provide more urgent care and cardiovascular services, and it is also possible that new sites may need to be constructed. In addition, Project 3.a.i will require a reconfiguration of spaces of primary care providers in order to provide behavioral health care services at those sites, or for Article 31 or 32 sites to provide space for primary care services, and substantial construction is likely to occur at some facilities under these projects. The design of these new spaces under these projects may conflict with particular regulatory requirements for the design of clinics and hospitals. Such regulatory requirements incorporate provisions of the Guidelines for the Design and Construction of Health Care Facilities, which set out detailed rules for these facilities. Having to follow all of these requirements could be particularly problematic in the context of the behavioral health integration requirement given that these standards where not written with physical and behavioral health integration in mind. Moreover, having to undergo the preopening survey process could lead to delays in the opening of the new unit, and therefore at the very least an expedited survey process is necessary. - Potential alternatives: The PPS could follow all of these construction standards. However, doing so may result in design decisions that are suboptimal to the goals of the projects. - Patient safety: Certain provisions of the construction standards, such as parts of the Life Safety Code, are designed to ensure patient safety. The PPS will work with DOH to ensure that all standards that directly relate to patient safety are followed.
7	10 NYCRR § 600.9(c)	Revenue Sharing Project(s): All projects. - Reason for request: Section 600.9(c) prohibits a medical facility from sharing gross income or net revenue with an individual or entity that has not received establishment approval. This could be interpreted as prohibiting a hospital that receives DOH funds under DSRIP from distributing those funds to non-established providers who are in the same PPS. Such an interpretation would be contrary to one of the key elements of DSRIP: the distribution of funds by the lead coalition provider to other providers participating in the PPS. - Potential alternatives: Alternatives are not feasible, since following a strict interpretation of Section 600.9(c) would prevent lead coalition providers from distributing state funds to the PPS participating providers. - Patient safety: Waiving this regulation would have no impact on patient safety.
8	10 NYCRR § 405.9(f)(7)	Hospital Discharges and Transfers Project(s): All projects.

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#	Regulatory Relief(RR)	RR Response
		- Reason for request: Section 405.9(f)(7) requires hospitals to ensure that patients may not be discharged or transferred to another location based upon source of payment. This regulation could be interpreted to prohibit hospitals from transferring their patients to other providers within the same PPS, since the hospital would have a financial relationship with the other provider. For example, if one hospital in a PPS were to transfer a patient to the lead coalition provider because the lead coalition provider specializes in treating the patient's condition, this could be viewed as a transfer based on source of payment since the lead coalition provider distributes DSRIP funds to the transferring hospital. - Potential alternatives: Alternatives are not feasible. If Section 405.9(f)(7) were interpreted in this strict way, it would mean that hospitals could not transfer their patients to the lead coalition provider, and possibly other transfers would be restricted as well. This would harm patient care, as the lead coalition provider specializes in care that PPS patients need. - Patient safety: To the extent that such policies do not yet exist, providers in the PPS will adopt policies and procedures to ensure that transfers to other facilities are made based on patient need and not based on financial relationships. Hospitals will be allowed to transfer patients to the lead coalition provider and other providers within the PPS, and they will be encouraged to do so when it is in the best interest of the patient. However, these policies will emphasize that providers should never transfer a patient based on source of funding when another destination is more appropriate for the patient's care.
9	DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)	Home Visits and Other Visits Provided Off-Site by Licensed Facilities Project(s): 2,a.i, 2.b.iv, 3.a.i, 3.b.i, 3.d.ii - Reason for request: Section 86-4.9(c)(8) prohibits freestanding ambulatory care facilities from billing for services provided off-site. Section 401.2(b) allows an Article 28 facility to use its operating certificate only for services at its designated site of operation, which has been interpreted as prohibiting providers from providing services off-site. Sections 599.14 and 822-3.1(b) impose similar rules on mental health and substance abuse providers, respectively. Providers would benefit from the ability to provide services off-site in carrying out multiple DSRIP projects. This ability would be particularly beneficial in carrying out Project 2.a.i: allowing facilities to provide care in alternative settings would help promote an integrated delivery system and would discourage facilities from providing care in silos. Similarly, as part of the care transition project, a patient who is treated by a professional in a hospital may benefit from seeing that same professional at home (2.b.iv). Projects 3.b.i and 3.d.ii aim to improve cardiovascular and asthma care, and facility-based practitioners may seek to provide services in the home as part of that enhanced care. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home (3.a.i). In short, providers seek the flexibility to provide needed care in the setting that is most conducive to treatment. - Potential alternatives: The PPS could rely on providers that are licensed to provide services in the home or non-credentialed practitioners to provide home-based care under DSRIP projects. For example, the PPS plans to utilize a community-based organization and community health workers to provide care under the asthma home-based self-management program. The PPS plans to utilize these workers to the greatest extent possible. However, there likely will be instances where a patient needs a more intensive level of care and the services of a registered nurse, nurse practitioner, or physician employed by an Article 28 provider to preserve continuity of care with the Medical Home care team. Article 28 providers should have the ability to be reimbursed for these services when patients need them in their homes. - Patient safety: Practitioners are required to protect their patients no matter

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#	Regulatory Relief(RR)	RR Response
		the location of care, and therefore allowing those practitioners to provide services off site is not a threat to patient safety. To the extent that DOH believes that providers need to take measures to protect patients receiving care in the home, the PPS will work with DOH to develop provider policies in this area.
10	10 NYCRR § 766.4(a), (b)	Ordering of Home Care by Physician's Assistants Project(s): 2.b.iv, 3.b.i, 3.d.ii, 3.g.i - Reason for request: Section 766.4 allows doctors, midwives, and nurse practitioners to order licensed home care services, but it does not allow physician's assistants (PAs) to order such care. As part of their efforts to keep patients out of the hospital, the DSRIP projects listed above are likely to involve orders for home care. Patients often are in need of home care services back at home after staying in a hospital (2.b.iv) or receiving palliative care (3.g.i). Patients who receive cardiovascular care (3.b.i) also may need home care services (3.b.i). Likewise, on some occasions patients with asthma symptoms may need home care to help manage their symptoms back at home (3.d.ii). Allowing PAs to order home care as part of these projects would make it easier for these providers to order such care and thus could potentially play a role in reducing inpatient admissions. - Potential alternatives: PPS providers could avoid the need for this waiver by relying on physicians, midwives, and nurse practitioners to order licensed home care services. For providers that employ few PAs, complying with Section 766.4 is not a great concern. Some providers, however, rely heavily on PAs in their everyday practice. For these providers, forcing PAs to find the appropriate physician or nurse practitioner to order care would be an inefficient use of resources. - Patient safety: PAs often are given the same scope of authority as nurse practitioners. Granting physicians' assistants the power to order home care—a power already granted to midwives and nurse practitioners—is not a danger to patient safety.

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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

Description:

An effective governance model is key to building a well-integrated and high-functioning DSRIP PPS network. The PPS must include a detailed description of how the PPS will be governed and how the PPS system will progressively advance from a group of affiliated providers to a high performing integrated delivery system, including contracts with community based organizations. A successful PPS should be able to articulate the concrete steps the organization will implement to formulate a strong and effective governing infrastructure. The governance plan must address how the PPS proposes to address the management of lower performing members within the PPS network. The plan must include progressive sanctions prior to any action to remove a member from the Performing Provider System.

This section is broken into the following subsections:
    2.1 Organizational Structure
    2.2 Governing Processes
    2.3 Project Advisory Committee
    2.4 Compliance
    2.5 Financial Organization Structure
    2.6 Oversight
    2.7 Domain 1 Milestones

Scoring Process:

This section is worth 25% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
    2.1 is worth 20% of the total points available for Section 2.
    2.2 is worth 30% of the total points available for Section 2.
    2.3 is worth 15% of the total points available for Section 2.
    2.4 is worth 10% of the total points available for Section 2.
    2.5 is worth 10% of the total points available for Section 2.
    2.6 is worth 15% of the total points available for Section 2.
    2.7 is not valued in points but contains information about Domain 1 milestones related to Governance which must be read and acknowledged before continuing.

☑ Section 2.1 - Organizational Structure:

Description:

Please provide a narrative that explains the organizational structure of the PPS. In the response, please address the following:

*Structure 1:

Outline the organizational structure of the PPS. For example, please indicate whether the PPS has implemented a Collaborative Contracting Model, Delegated Model, Incorporated Model, or any other formal organizational structure that supports a well-integrated and highly-functioning network. Explain the organizational structure selected by the PPS and the reasons why this structure will be critical to the success of the PPS.

The Maimonides-led Community Care of Brooklyn (CCB) PPS builds from an already strong, multi-stakeholder structure, which has been deployed to manage successful population health collaboratives. Maimonides and these clinical and social service partners effectively govern the Brooklyn Health Home and other multi-stakeholder initiatives, including a State managed care program (HARP) and a Federal grant program (CMMI), both aimed at integrating physical and behavioral care services and enhancing care management. CCB starts from a position of experience having already effectively navigated through emerging care and reimbursement models such as those envisioned under DSRIP.

CCB will form a well-integrated and high-functioning PPS network by ensuring the health care providers and other community organizations that participate in the CCB PPS (Participants) have a solid understanding of roles, responsibilities and expectations of performance, and that these standards are developed through a collaborative and inclusive structure. CCB is implementing a Collaborative Contracting Model governed by a Master Services Agreement (MSA) that will be entered into by and among (1) Maimonides,

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as lead applicant; (2) the CCB Central Services Organization (CSO), an LLC established by Maimonides to provide centralized services and management and operational support to CCB Participants; and (3) the Participants that will comprise CCB. A detailed term sheet for the MSA has been developed and approved by the planning Steering Committee. Full contracts will be in place by April 1, 2015.

CCB selected the Collaborative Contracting Model based on prior experience with running large-scale population management initiatives and with input and approval from Participants through our planning governance process. The model is critical to the success of the CCB PPS because it is designed to maximize participant buy-in and willingness to fundamentally change the way care is provided to chronically ill, complex patients. Maimonides' transparent, inclusive model will maximize participation by a range of stakeholders in addition to our 400 clinical, social, and community-based organizational Participants, ensuring that Brooklyn's diverse patient populations will be represented and served by CCB.

CCB will be governed centrally by an Executive Committee and Sub-Committees, and locally by 3 to 5 Hub Steering Committees, discussed later. The CSO will provide a range of centralized services to CCB, including but not limited to: clinical supervision to service providers; call center support; information technology (IT) services; staffing for CCB operations; trainings for Participant staff on goal achievement; data analytics; and back office and administrative services.

Among other things, the MSA will have schedules identifying clinical protocols, IT requirements, program requirements and funding and incentives plans. Schedules will be developed by the relevant Committees, be transparent, and will evolve over time, leading to greater clinical and financial integration of the Participants. By binding Participants through an MSA, CCB will create a high-performing network that is capable of successful risk contracting.

Maimonides, as fiduciary, will be ultimately responsible for fulfilling the terms of the State DSRIP contract.

The operational structure will focus on providing oversight of DSRIP program milestones, enforcing participant obligations, and evaluating/tracking CCB and participant performance relative to established metrics. CCB will continuously evaluate its governance and organizational structure to ensure it is evolving to meet the needs and objectives of Participants, and larger organizational and financial goals.

In addition, please attach a copy of the organizational chart of the PPS. Please reference the "Governance How to Guide" prepared by the DSRIP Support Team for helpful guidance on governance structural options the PPS should consider.

File Upload: (PDF or Microsoft Office only)

Currently Uploaded File: **33_SEC021_Final Governance Diagram.pdf**

Description of File

Figure 1. CCB Organizational Governance Structure

File Uploaded By: ajberman

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*Structure 2:

Specify how the selected governance structure and processes will ensure adequate governance and management of the DSRIP program.

CCB governance is built around an inclusive committee structure, representative of all sectors of the health care/social service community. To ensure adequate governance and management, the structure features centralized and community-based governance to maximize participant engagement, provide centralized leadership and processes, and ensure CCB meets community needs and achieves DSRIP goals.

CCB will organize into "Hubs" comprised of Participants located within defined geographic areas and responsible for project implementation at the local level. CCB will have 3 to 5 Hubs. Participants with locations in multiple geographic areas may be part of more than one Hub.

CCB will be governed by an Executive Committee, which will be responsible for strategic leadership. It will review and approve Hub Plans and Budgets (discussed below) and funding distribution methodologies, evaluate performance, and oversee CCB's compliance program.

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Section 2.2 has detail on the diverse, representative membership envisioned for the Executive Committee.

The Executive Committee will be supported by 3 Sub-Committees with defined areas of responsibility for successful DSRIP projects. The Business and Operations Sub-Committee will monitor implementation of the funds flow model, the provision of CSO services, and workforce and sustainability planning. The Information Technology Sub-Committee will expand the Dashboard (Maimonides' web-based interdisciplinary IT platform) to all Participants and build out the robust data, analytics and risk stratification capabilities already embedded in the Dashboard needed to support DSRIP projects. The Care Delivery and Quality Sub-Committee will oversee implementation of DSRIP project plans and quality improvement. Other sub-committees may be established as needed by the Executive Committee to meet specific DSRIP project goals. A Nominating Committee will be responsible for recommending members of the Executive Committee, Sub-Committees and Hub Steering Committees.

All Committees will use a consensus-based process (see Section 2.2), to build support and buy-in for decisions, making CCB more effective. The decisions made by the Executive Committee and the Sub-Committees will be binding upon Hubs and Participants. CCB will also have a Project Advisory Committee (see Section 2.3), which provides a mechanism for all Participants to raise issues and advise CCB, providing feedback on specific interventions and their impact on patients and providers.

To ensure community needs are represented in decision making, each Hub will have a Hub Steering Committee with representatives of Participants in the respective Hub (e.g. hospital(s), providers, community organizations, unions). Hub Steering Committees will be responsible for review and approval of the Hub Plan and corresponding budget before such plans and budgets are sent to the Executive Committee. The Hub Steering Committees will meet at least quarterly to, at a minimum: review the Hub's progress against the local Hub Plan and budget; provide updates to the Executive Committee on the Hub's progress; and suggest changes to the Hub Plan and budget as necessary.

In addition to establishing governance structures and processes at the centralized and Hub levels, operations will be supported by the CSO and Maimonides leadership, which have significant experience implementing and operating large-scale system transformation projects, and deep knowledge of the healthcare needs and challenges faced by Brooklyn providers and patients.

Maimonides, as fiduciary, is ultimately accountable to the State for CCB's performance on DSRIP goals. Maimonides will have oversight and final approval over CCB's governance. Maimonides will exercise this authority at its discretion and in the event any governing bodies come to a stalemate or should the program's success be in jeopardy.
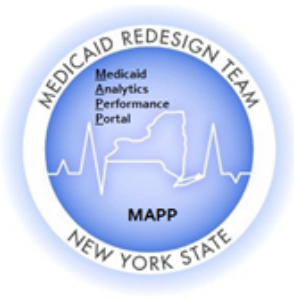
*Structure 3:
Specify how the selected structure and processes will ensure adequate clinical governance at the PPS level, including the establishment of quality standards and measurements and clinical care management processes, and the ability to be held accountable for realizing clinical outcomes.

Maimonides understands that the development and use of clinical and IT capabilities and requirements is essential to creating the integrated, patient centered care delivery system DSRIP aims to achieve. Maimonides is well positioned to establish the clinical, quality and IT capabilities necessary to succeed in DSRIP. By establishing the Brooklyn Heath Home and the CMMI project (previously defined), Maimonides created the framework to enable providers from multiple institutions to coordinate care, breaking down barriers that impede care delivery to extremely vulnerable patient populations.

CCB will establish a Care Delivery and Quality Sub-Committee to ensure appropriate clinical governance at the PPS level. This Sub-Committee will be led by the CSO's Chief Medical Officer, and will include senior clinical and social experts and community providers, drawn from a range of Participants, and representatives of CCB's two Health Homes. The Sub-Committee will design clinical programs and establish common evidence-based protocols for DSRIP projects, and will monitor and assess CCB and Participant performance against established outcome and quality metrics.

CSO staff will support the Sub-Committee, gathering industry-accepted evidence-based protocols for review and vetting by the Sub-Committee to ensure successful deployment of all projects. The CSO will monitor performance against targets at a Participant, Hub and PPS level (see Section 6, Rapid Cycle Evaluation), will bring this information to the Sub-Committee, and assist in implementing corrective actions, as needed.

The Sub-Committee may establish workgroups on condition-specific issues, if necessary. The Sub-Committee must notify the Executive

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Committee and Hub Steering Committees when Participants fail to meet quality goals and monitor corrective action plans (CAPs) relating to clinical care management (see Section 2.6), and interface with Participants and other members of the governing body on clinical issues.

*Structure 4:

Where applicable, outline how the organizational structure will evolve throughout the years of the DSRIP program period to enable the PPS to become a highly-performing organization.

CCB recognizes the PPS governance and organizational structure will need to change as the DSRIP program objectives and goals evolve toward sustainability and value-based contracting in the later years of the program. The initial operational structure will take effect April 1, 2015 and will provide for centralized, transparent governance with significant local participation.

The goals for DSRIP year (DY) 1-2 will focus on building a governing structure with significant Participant buy-in and support, providing oversight of DSRIP program milestones, enforcing Participant obligations, and evaluating/tracking PPS and Participant performance relative to established metrics.

CCB envisions it will begin the transition to risk-based contracting in DY 2, and by DY 5 the goal is to have over 90% of all lives in value-based contracts. During this transition, CCB anticipates that Participants will become fully integrated and possess strong capabilities to manage outcomes and quality. As this occurs, CCB will evaluate vehicles (ACO, IPA, etc.) for contracting with payers and the timing and type of value based payment models (bundled, shared risk, full capitation). The organizational structure will evolve to enable negotiation with payers, oversight for risk-based contracting and even greater transparency into performance.

CCB will continuously evaluate its governance and organizational structure to ensure it is evolving to meet the needs and objectives of Participants as well larger organizational and financial goals. The milestones for evolving the governance structure are described in detail in the IDS project plan. The move to risk-based contracting will occur as CCB's governance and organizational structure is increasingly equipped to ensure a successful transition, with minimal disruption to patient populations.

☑ Section 2.2 - Governing Processes:

Description:

Describe the governing process of the PPS. In the response, please address the following:

*Process 1:

Please outline the members (or the type of members if position is vacant) of the governing body, as well as the roles and responsibilities of each member.

CCB's Executive Committee will have 15-25 members, representing all sectors, similar to our Planning Steering Committee, which included:

Asher Fogel, Ohel
Barry Stern, NY Community Hospital
Boris Vilgorin, FEGS
Charles King, Housing Works
Cheryl Hall, Caribbean Women's Hlt Assoc
David Cohen, MD, Maimonides
Donna Colonna, SUS/CBC
Eliza Carbone, NYSNA
Harvey Lawrence, Brownsville Family Hlt Ctr
Ian Shaffer, MD, Healthfirst
Jay Gormley, MJHS
Kathryn Hasanger, JASA
Kevin Muir, CAMBA
Lazetta Duncan-Moore, Brooklyn Plaza
Linda Brady, MD, Kingsbrook

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Lisa Zullig, God's Love We Deliver
Neil Pessin, VNSNY
Ngozi Moses, Brooklyn Perinatal Network
Ramon Rodriguez, Wyckoff
Steven Korf, Interfaith
Thomas McIntyre, 1199

The Executive, Sub, and Hub Steering Committees will represent all sectors, including physicians, long term care services providers, safety net providers, social service organizations, payers and unions. CSO leadership will participate in the Committee structure.

Individual Participants involved in the Executive, Sub (15-20 members), and Hub Steering Committees (8-12 members) must possess relevant expertise and have leadership roles in their communities and organizations.

*Process 2:

Please provide a description of the process the PPS implemented to select the members of the governing body.

Maimonides has engaged highly experienced and motivated leaders representing a range of medical, health care, and social service providers in Brooklyn from the outset of the DSRIP project planning process. During the planning stage, all Participants were asked to submit nominations and a brief biography for placement on the following planning committees: Steering; Business, Operations, Analytics and Technology Committee; and Care Model and Program Planning. Nominees were selected based on relevant experience, leadership roles in their communities, understanding of how to coordinate care among diverse patient populations, and ability to eventually bind their organizations – and inspire employees, staff and patient populations – to participate in CCB's transformative work.

When operational, CCB will be governed by an Executive Committee, whose membership is described in detail above and will be primarily selected from the Planning Steering Committee. The Executive Committee will include representatives from the Hub Steering Committees, and will include representatives from Participants serving large numbers of patients, to create an effective and streamlined governance structure, as well as informed governing bodies that are engaged in the implementation of DSRIP projects in their communities. The necessity of including leaders of large Participant organizations will be balanced with the need to represent a diverse range of Participants, including physician practices, long term care services providers safety net providers, social service organizations, payers and union representatives, and staff.

Following the submission of the DSRIP Project Plan Application and after consulting with the planning Steering Committee, Maimonides will appoint the members who will comprise the Executive Committee as of April 1, 2015, for a one year term. Until this appointment, the Steering Committee will continue to function in its current leadership capacity.

The Nominating Committee will be charged with selecting candidates who have relevant education and experience, who are leaders in their communities and organizations, who are committed to the success of CCB and DSRIP in general, and who are willing and able to make the time commitment necessary to ensure the meeting of CCB and DSRIP goals. The Executive Committee will also include one representative from Maimonides and one from the CSO.

There will be no limits on the number of terms served for Committee members, so leadership may be consistent from year-to-year; however, it is anticipated that leadership may change as CCB transitions to risk-based contracting, and as other entities are added to executive-level leadership.

A similar approach to that used to appoint the Executive Committee will be undertaken to appoint members of the Sub-Committees and Hub Steering Committees.

*Process 3:

Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

To ensure sufficient representation, all interested stakeholders were invited to participate in CCB planning. CCB hosted 2 in-person meetings and 3 webinars to outline the planning process and report on progress. All Participants were invited to nominate members of the planning committee structure. During the planning phase, more than 40 organizations were represented on committees. Committees and

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workgroups met more than 25 times to make decisions regarding the CCB DSRIP planning process.

The operational Project Advisory Committee (PAC) will feature representation from across key Participants, including union, workforce and beneficiaries. In addition to adopting an inclusive PAC committee structure, the final operational Committee structure (the Executive Committee, Sub-Committees and Hub Steering Committees) will be comprised of at least 40 organizations, including physicians, nurses, union representatives, community based and social services organizations, payers, and hospitals.

*Process 4:

Please outline where coalition partners have been included in the organizational structure, and the PPS strategy to contract with community based organizations.

Coalition partners, including community-based organizations and unions, comprised the committees for the planning process and will be included in the CCB organizational structure through the Executive Committee, Sub-Committees and Hub Steering Committees that will be operational across DSRIP Years 1-5. Coalition partners representing hospitals, primary care providers, housing, nursing homes, social services and other providers have and will continue to serve on Committees that drive governance, operations, and DSRIP project implementation at central and local levels.

Coalition partners have been included at all stages of the DSRIP planning process, as CCB developed its strategy to address community needs and to identify focus areas for DSRIP. Further information on coalition partners' role in the PAC process, particularly during the planning phase, is described in 2.3.

CCB will also contract with CBOs to support training, outreach, peer education and project implementation.

*Process 5:

Describe the decision making/voting process that will be implemented and adhered to by the governing team.

CCB will have consensus-based (75% of present members) decision-making at all levels. Supermajority approval ensures that decisions have broad buy-in from CCB leadership. Further, based on prior experience, CCB believes that consensus-based decision-making ensures accountability, transparency and informed participation at all levels of the governing body.

Consensus-based decision-making will be effectuated in the following manner: Actions by the Executive Committee that are consensus-based will be submitted to Maimonides for approval. Actions by the Hub Steering Committees and Sub-Committees that are consensus-based will be submitted to the Executive Committee for review, and if approved, to Maimonides for final sign-off. The process for resolving conflicts in instances where decisions are not consensus-based is discussed below.

While Maimonides is the fiduciary and must retain the ability to serve as final sign-off on CCB decision-making, it does not intend to disrupt or block consensus-based decisions achieved by the Executive Committee, Hub Steering Committees, or Sub-Committees. Maimonides will have a representative on the CCB Executive Committee that will be charged with flagging any decisions that may harm the financial stability or overall health of CCB for Maimonides leadership. Maimonides anticipates playing an active role when its designee flags a decision for review or when the Executive Committee, Hub Steering Committees, or Sub-Committees fail to reach consensus, or in exceptional circumstances. Final Maimonides approval will be made by the CEO, or an appointee of the CEO subject to Board oversight.

*Process 6:

Explain how conflicts and/or issues will be resolved by the governing team.

For Hub Steering Committee or Sub-Committee actions that are not consensus-based, the relevant Hub Steering Committee or Sub-Committee will submit to the Executive Committee a summary of issues on which consensus has, and has not, been reached. The Executive Committee will work with the relevant Hub Steering Committee or Sub-Committee to reach consensus. If consensus is still not reached, the Executive Committee will prepare summaries of issues of agreement and contention and a recommendation for Maimonides review. Maimonides will evaluate this proposal and work with the Executive Committee to establish consensus. In the rare case collaborative consensus cannot be reached, Maimonides, as fiduciary, will determine the appropriate course of action. Final Maimonides approval will be made by the CEO, or an appointee of the CEO subject to Board oversight.

If the Executive Committee does not reach consensus, the Committee will follow the same process.

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*Process 7:

Describe how the PPS governing body will ensure a transparent governing process, such as the methodology used by the governing body to transmit the outcomes of meetings.

A transparent, inclusive governance model will ensure stakeholder buy-in to CCB goals and projects. CCB will create opportunities for stakeholders to engage with governing bodies, educate and motivate stakeholders, and collaborate to change how care is delivered to our population.

The CSO will use its website and other media to share program information, including project status reports among governing bodies, Participants, stakeholders and the public. All Committees and Hub Steering Committees will disseminate meeting summaries, materials, important decisions, and developments for public review via email and the website. Feedback will be solicited through online surveys and reported and discussed at meetings of the relevant governing body.

Charters will be available for review, including each Committee or Hub Steering Committee's scope, membership qualifications, key deliverables, and expected timeline for achieving deliverables. Meetings will be open when appropriate.

*Process 8:

Describe how the PPS governing body will engage stakeholders on key and critical topics pertaining to the PPS over the life of the DSRIP program.

Stakeholders, including Medicaid beneficiaries, will be able to receive information about CCB through a dedicated website and regular email communications. The CCB website will offer stakeholders the option of signing up to learn more about CCB's DSRIP efforts via "push emails." At times, stakeholders will be solicited for feedback both through the website and via surveys deemed appropriate by CCB leadership.

PAC meetings will be open to the public and advertised to stakeholders and Medicaid beneficiaries, offering another venue for feedback and engagement. Engagement of Medicaid beneficiaries will also be done via the Care Delivery and Quality Sub-Committee which will have one Medicaid beneficiary who actively engages with the CCB PPS.

☑ **Section 2.3 - Project Advisory Committee:**

Description:

Describe the formation of the Project Advisory Committee of the PPS. In the response, please address the following:

*Committee 1:

Describe how the Project Advisory Committee (PAC) was formed, the timing of when it was formed and its membership.

CCB launched an alternative PAC structure in July 2014 for the DSRIP planning period (through March 31st, 2015), and it is representative of our Participants. An alternative structure (one that is representative of Participants rather than one that includes all Participants) was selected so that representatives from over 400 diverse organizations would have an effective way to collaborate while also driving to decisions. The planning PAC consists of three Committees: the Steering Committee, the Care Model and Program Planning Committee, and the Business, Operations, Analytics and Technology Committee. More than 40 partner organizations are currently represented in CCB's PAC committee structure (see Section 2.2 for more details), and include hospitals, physician practices, long term care services providers, safety net providers, social service organizations and other community organizations, payers, and union representatives.

These committees have met more than 10 times during the planning process to date, and PAC members were involved in all facets of CCB's planning efforts. CCB's Steering Committee has overseen all DSRIP program planning and implementation efforts throughout the planning period. The Steering Committee also oversaw the other committees and sub-committees, and was responsible for leading the development of CCB's operational organizational structure.

CCB took an inclusive and integrated approach to PAC participation. Maimonides selected the PAC members following a nominations process. Each Committee is similarly representative of the full PAC, including key PPS partners, and union/workforce representation.

In addition to these Committees, all PAC members were invited to participate in three regular all-partner meetings. This provided a forum

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to ensure all partners and stakeholders remained involved in project planning and decision-making, and helped to bolster effective and transparent communication across CCB.

*Committee 2:

Outline the role the PAC will serve within the PPS organization.

The role and composition of the PAC will change in the operational phase. The PAC will be solicited for feedback and advise the Committee, Sub-Committee and Hub Steering Committee structure previously discussed on specific interventions and their impact on patients and providers, and on the implementation process and associated Domain 1 metrics, and outcome metrics on Domains 2,3,4. The PAC will meet at least twice annually. Effective April 1, 2015, the PAC will consist of representatives of all Participants that have signed MSAs. The PAC will also include at least one Medicaid beneficiary. PAC members serving during the operational phase will be selected consistent with DSRIP requirements and based on commitment to DSRIP, project-related expertise, and community leadership. PAC members will also serve to educate and inform stakeholders and the community on DSRIP project implementation, goals and progress.

*Committee 3:

Outline the role of the PAC in the development of the PPS organizational structure, as well as the input the PAC had during the Community Needs Assessment (CNA).

During the planning process, the PAC spearheaded the development of the operational governing structure for CCB. The Steering Committee, in particular, was responsible for reviewing and approving the planning and operational governance structures, and took into account feedback from other PAC members and discussions held at all-partner meetings.

CCB discussed the progress on, and the results from, the Community Needs Assessment at every Committee meeting. The Steering Committee oversaw the CNA process, and CCB further solicited feedback from other PAC members – and partner organizations in general – at all-partner meetings. The participation of a broad base of community providers during the CNA process was designed to ensure that the assessment touched all community groups in CCB, and that population needs were accurately and comprehensively identified. PAC members were also solicited for feedback on current resources and capacity within their respective areas of specialty.

*Committee 4:

Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

During CCB's planning phase, the PAC included more than 40 members and was carefully selected to represent our broad range of partners (medical, behavioral/mental, social support, community-based organizations, payers and unions/workers), and each PAC Committee was representative of the full PAC. CCB also ensured broad-based participation through all-partner meetings, which provided a forum for participation and representation of the full PAC and other stakeholders, and helped CCB identify individuals whose leadership and commitment recommended them for inclusion in CCB governance at higher levels. During our operational phase, starting on April 1, 2015, CCB's PAC will be more expansive and inclusive, with representatives from all Participants with signed MSAs in addition to a Medicaid beneficiary.

☑ Section 2.4 – Compliance:

Description:

A PPS must have a compliance plan to ensure proper governance and oversight. Please describe the compliance plan and process the PPS will establish and include in the response the following:

*Compliance 1:

Identify the designated compliance staff member (this individual must not be legal counsel to the PPS) and describe the individual's organizational relationship to the PPS governing team.

The Interim Chief Compliance Officer is Caroline Greene, and will be an employee in the CSO. Ms. Greene is not a lawyer and will not be providing legal counsel to CCB. She will be charged with overseeing the compliance program, reporting directly to the CEO of the CSO, and will also be responsible for preparing and presenting reports directly to CCB's Executive Committee. This structure will ensure compliance can be monitored and enforced quickly, that the officer will have direct access to and support from the data and monitoring

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capabilities and rapid cycle evaluation activities of the CSO, and that the officer will have direct access to the highest level of CCB decision-making.

*Compliance 2:

Describe the mechanisms for identifying and addressing compliance problems related to the PPS' operations and performance.

CCB will leverage Maimonides' compliance experience for the compliance program, customizing existing practices as needed. The compliance plan goals will be to deter non-compliance, detect violations and ensure that responses to a violation are appropriate. CCB's plan will be administered by the CSO, conform with NYS Social Services Law 363-d and include, at a minimum:
- Written standards of conduct, policies, and procedures promoting compliance (e.g., including compliance as an element in evaluating Participants) and addressing areas of potential fraud
- Training for Participants and CSO staff, modeled on existing trainings at Maimonides and CCB (described next)
- A process to receive complaints anonymously, and protect whistleblowers
- A system to respond to improper/illegal activities and enforce disciplinary action against individuals violating compliance policies, applicable laws/regulations, and program requirements
- Regular audits to monitor compliance and reduce identified problem areas
- Investigation/remediation of identified systemic problems, and development of policies on non-employment or retention of sanctioned individuals
- Procedures for ongoing monitoring

*Compliance 3:

Describe the compliance training for all PPS members and coalition partners. Please distinguish those training programs that are under development versus existing programs.

CCB will implement regular, effective education, training and re-training programs for CCB Participants, coalition partners and CSO staff. Existing compliance training programs, such as HIPAA, will be customized for DSRIP and CCB if available, and implemented as soon as available. Where provider-specific compliance programs have not been developed, CCB will work with relevant Participants, the Chief Compliance Officer, the CSO, Maimonides and/or outside counsel as necessary to develop such program(s). CCB anticipates implementing a comprehensive training program during the first quarter of DSRIP Year 1 and completing initial training of all participant, coalition partners and CSO employees within six months of implementation.

*Compliance 4:

Please describe how community members, Medicaid beneficiaries and uninsured community members attributed to the PPS will know how to file a compliance complaint and what is appropriate for such a process.

CCB will establish, publicize, distribute (using beneficiary materials) and maintain a process, such as a hotline, to receive compliance complaints from attributed members, including Medicaid beneficiaries and other attributed community members, as described in Section 2.6, Oversight 4. CCB's website will also note that, at any time, if an individual or organization feels their (or its) rights have been violated, or that the PPS is acting in conflict with its obligations under DSRIP, the individual or organization may contact the Chief Compliance Officer, or a representative, in writing or via email. The appropriate contact information will be included on the website, along with contact information for relevant state and city oversight entities such as the NYS DOH or OMIG. CCB will also implement and publicize a non-retaliation policy with regard to complainants. CCB will also adopt policies and procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

☑ Section 2.5 - PPS Financial Organizational Structure:

Description:

Please provide a narrative on the planned financial structure for the PPS including a description of the financial controls that will be established.

*Organization 1:

Please provide a description of the processes that will be implemented to support the financial success of the PPS and the decision making of the PPS' governance structure.

Maimonides, as fiduciary, will use its extensive internal compliance and auditing functions to receive, track and oversee all DSRIP funds from the State. Maimonides will develop a detailed financial management plan during the implementation planning phase, building, where

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appropriate, on existing internal control and financial management policies and procedures.

CCB's Business and Operations Sub-Committee will be responsible for developing budgets, defining the processes to support the financial structure of CCB and submitting these recommendations to the Executive Committee in order to ensure financial success of CCB. CCB's compliance process, described above, will be used to detect and address non-compliance with applicable rules and MSA terms.

Maimonides will contract with the CSO to distribute DSRIP funds to Participants via the funds flow methodology developed and approved by CCB's governance structure. The CSO's Controller is responsible for all DSRIP financial functions, including establishing internal accounting and auditing functions, and contracting with external auditors on an annual basis for audited financial reports, discussed below.

*Organization 2:
Please provide a description of the key finance functions to be established within the PPS.

CCB's vision is to ensure financial success by tying payment to DSRIP goals and ensuring responsible financial management. Our CSO will establish the ability to track funds flow, gauge performance against DSRIP goals, generate reports on financial performance and distribute payments to Participants. Specific functions within the financial organizational structure include:
- Appropriate segregation of duties so no one person can authorize, approve and disburse funds
- Procedures for review and approval of transactions by individuals other than those who initiated the transaction
- A conflict of interest disclosure policy to identify related-party transactions
- Checks to ensure interested parties are not involved in decisions in which they have a conflict
- Ability to securely receive and process payments
- Appropriate document recordkeeping and storage policies on financial transactions
- Appropriate supervision of activities, with increasing supervision and buy-in for decisions considered material to the finances of the organization
- Development of annual operating plans and budgets, and monthly top level reviews of performance against budgets
- Management of risk contracts

*Organization 3:
Identify the planned use of internal and/or external auditors.

CCB will use internal auditors to complete critical compliance functions, including: conducting risk assessments, assessing the integrity of controls and processes, developing an annual audit plan, and tracking performance against the plan. CCB will retain an external auditor to review its annual financial reports and, at the outset, assess the proposed approach to establishing internal controls. Audits will address financial controls, HIPAA privacy and security, fraud and abuse, and billing compliance (as relevant). CCB anticipates additional audit controls will be required as we transition into risk-based contracting, and on an as-needed basis.

The Chief Compliance Officer within the CSO will develop and present to the Executive Committee an annual report of Conflicts of Interest, Internal Audit and Compliance Activities. Maimonides will apply the same rigor to audits of CCB as it does to audits of its internal processes. Maimonides's external auditor, a major public accounting firm, has provided positive feedback on Maimonides' annual financial statements, and has identified no weaknesses in internal controls; the same is true of public funders supporting Maimonides' work.

*Organization 4:
Describe the PPS' plan to establish a compliance program in accordance with New York State Social Security Law 363-d.

As described elsewhere in Section 2.4, the CSO will also have a Chief Compliance Officer who will be responsible for implementing necessary compliance policies and procedures, building on existing policies and procedures developed by Maimonides as available. The Chief Compliance Officer will implement a plan for meeting the required elements of New York State Social Security Law 363-d, including required training and written policies and procedures. CCB's compliance structure will leverage Maimonides' robust, existing corporate compliance program to deter non-compliance, detect violations of the law and ethical standards when they occur and ensure that any responses to violations are prompt and appropriate. The Chief Compliance Officer will work with external auditors, corporate counsel, or others, to establish the compliance program and oversee fulfillment of its requirements.

☑ **Section 2.6 – Oversight:**

Description:

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Please describe the oversight process the PPS will establish and include in the response the following:

*Oversight 1:

Describe the process in which the PPS will monitor performance.

Supported by information from the CSO, the Executive Committee will be responsible for monitoring overall performance of the PPS and ensuring that, when problems arise, Participants comply with their responsibilities under the MSA. Leveraging the Dashboard, the existing IT infrastructure, and current reporting capabilities, CCB will implement a DSRIP-specific rapid cycle evaluation process, overseen by the Care Delivery and Quality Committee, to identify and subsequently work with underperforming providers though corrective action programs and technical assistance.

Similar to the existing process for Health Home oversight, CCB will routinely monitor performance to assess entity effectiveness, member engagement, and to flag issues that require re-training, additional monitoring and corrective action. CCB's rapid-cycle evaluation program, described in Section 6, will build off the Dashboard to systematically collect and report on established PPS measures, metrics and milestones at a Participant and Hub Level. Lower-performing Participants will be flagged for training and technical assistance to improve performance, as discussed below.

*Oversight 2:

Outline on how the PPS will address lower performing members within the PPS network.

Similar to the existing Brooklyn Health Home process, in the event of underperformance by a Participant, the Executive Committee will issue a written warning describing the underperformance and may require the Participant to develop and submit a Corrective Action Plan for review and approval of the Executive Committee. The Corrective Action Plan will set forth steps for remediating the underperformance, and will include milestones for determining successful implementation of the Plan and dates by which milestones must be completed. The Participant will be required to submit periodic reports to the Executive Committee describing the status of compliance with the Plan, including attestations that the Participant has completed each milestone by the milestone completion date.

Failure to comply with the Corrective Action Plan may lead to suspension of DSRIP funds to the participant, temporary suspension of the Participant's participation in CCB or, as a last resort, removal of the participant from CCB and in accordance with DSRIP requirements.

*Oversight 3:

Describe the process for sanctioning or removing a poor performing member of the PPS network who fails to sufficiently remedy their poor performance. Please ensure the methodology proposed for member removal is consistent and compliant with the standard terms and conditions of the waiver.

When a Participant has been documented by the CSO as not performing to the DSRIP standards, CCB will work directly with the Participant to address quality concerns. In the event of continued non-performance, the Executive Committee will convene a closed session meeting with the Participant to review and discuss performance relative to the MSA, and a Corrective Action Plan. The Participant will be asked to prepare a formal response, and will be given the opportunity to present evidence to the contrary.

If the Participant is not able to address the causes of underperformance to the Executive Committees' satisfaction, a formal recommendation will be prepared for Maimonides, which will either request further time for the Participant to operate under a modified Corrective Action Plan or recommend the removal, suspension, or revocation of funding from the Participant. If the Executive Committee recommends removal of a Participant, and Maimonides (CEO or appointee of the CEO, with oversight of the Board) agrees, Maimonides will forward the recommendation to the State.

Should a Hub Steering Committee identify a Participant that has failed to comply with a Corrective Action Plan, it will recommend further action to the Executive Committee. The Executive Committee will review the Hub Steering Committee's recommendations and follow the process described above to address the Participant's performance.

At any point in the corrective action process, the Participant will be permitted to appeal the Corrective Action Plan to the next-highest level of CCB's governance. CCB will develop procedures for appeal, leveraging existing appeals procedures at Maimonides and other Participants.

Members of any Committee and Hub Steering Committee may be removed for cause upon the vote of 75% of the members. Among other

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things, the termination of a member's affiliation with a Participant will be considered cause for removal, if the relevant Committee or Hub Steering Committee determines that such removal is in the best interest of CCB.

Maimonides uses a very similar process, successfully, for the Brooklyn Health Home. This experience will help ensure a smooth implementation for DSRIP.

*Oversight 4:
Indicate how Medicaid beneficiaries and their advocates can provide feedback about providers to inform the member renewal and removal processes.

CCB will develop beneficiary materials – in appropriate languages and at appropriate reading levels – to solicit feedback about providers and care delivery, and to inform beneficiaries about the Participant renewal and removal process. Advocate-specific materials will be generated as necessary to assist advocates in conveying critical information to beneficiaries, and highlighting key dates for follow-up.

Materials will be provided at Participant locations, explaining the Participant's participation in CCB, how that will impact beneficiaries, where individuals may go to learn more about CCB (and about DSRIP), and how Medicaid beneficiaries and their advocates may provide feedback. Beneficiaries will be informed that they may submit feedback through a toll-free compliance hotline, via the PPS website and/or via a designated email address. CCB participant staff will be trained on routing communication through appropriate channels. Beneficiary and advocate feedback will inform the Participant renewal and removal process.

*Oversight 5:
Describe the process for notifying Medicaid beneficiaries and their advocates when providers are removed from the PPS.

CCB will establish a process for notifying Medicaid beneficiaries and their advocates when providers are removed from the PPS and of when their providers retire or change facilities. CCB can leverage processes already in place at Maimonides, and other CCB participants, for notifying individuals when their providers retire or change facilities. CCB will post relevant information on the website and provide Medicaid beneficiaries with both written and telephone communication regarding the change, as appropriate. To the extent the beneficiary is already aligned with a care manager, they will be directed to work with their care manager to find a new provider as necessary. Beneficiaries who do not qualify for care management will temporarily be assigned a care navigator to oversee the transition.

### ☑ Section 2.7 - Domain 1 – Governance Milestones:

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

- Implementation plan outlining the PPS' commitment to achieving its proposed governance structure (Due March 1, 2015).
- Periodic reports, at a minimum semi-annually and available to PPS members and the community, providing progress updates on PPS and DSRIP governance structure.
- Supporting documentation to validate and verify progress reported on governance, such as copies of PPS bylaws or other policies and procedures documenting the formal development of governance processes or other documentation requested by the Independent Assessor.

☑ Please Check here to acknowledge the milestones information above
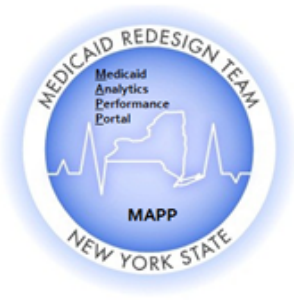
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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

Description:

All successful DSRIP projects will be derived from a comprehensive community needs assessment (CNA). The CNA should be a comprehensive assessment of the demographics and health needs of the population to be served and the health care resources and community based service resources currently available in the service area. The CNA will be evaluated based upon the PPS' comprehensive and data-driven understanding of the community it intends to serve. Please note, the PPS will need to reference in Section 4, DSRIP Projects, how the results of the CNA informed the selection of a particular DSRIP project. The CNA shall be properly researched and sourced, shall effectively engage stakeholders in its formation, and identify current community resources, including community based organizations, as well as existing assets that will be enhanced as a result of the PPS. Lastly, the CNA should include documentation, as necessary, to support the PPS' community engagement methodology, outreach and decision-making process.

Health data will be required to further understand the complexity of the health care delivery system and how it is currently functioning. The data collected during the CNA should enable the evaluator to understand the community the PPS seeks to serve, how the health care delivery system functions and the key populations to be served. The CNA must include the appropriate data that will support the CNA conclusions that drive the overall PPS strategy. Data provided to support the CNA must be valid, reliable and reproducible. In addition, the data collection methodology presented to conduct this assessment should take into consideration that future community assessments will be required.

The Office of Public Health (OPH) has listed numerous specific resources in the CNA Guidance Document that may be used as reference material for the community assessment. In particular, OPH has prepared a series of Data Workbooks as a resource to DSRIP applicants in preparing their grant applications. The source of this data is the Salient NYS Medicaid System used by DOH for Medicaid management. The PPS should utilize these Workbooks to better understand who the key Medicaid providers are in each region to assist with network formation and a rough proxy for Medicaid volume for DSRIP valuation purposes. There will be three sets of workbooks available to the PPS, which will include:

Workbook 1 - Inpatient, Clinic, Emergency Room and Practitioner services
Workbook 2 - Behavioral Health services
Workbook 3 - Long Term Care services

Additionally, the New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2017 objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2017 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the annual progress for each indicator. Historical (trend) data can be easily accessed and county data (maps and bar charts) are also available for each Prevention Agenda tracking indicator. Each county in the state has its own dashboard. The county dashboard homepage includes the most current data available for 68 tracking indicators.

Guidance for Conducting Community Needs Assessment Required for DSRIP Planning Grants and Final Project Plan Applications
http://www.health.ny.gov/health_care/medicaid/redesign/docs/community_needs_assessment_guidance.pdf

In addition, please refer to the DSRIP Population Health Assessment Webinars, Part 1 and 2, located on the DSRIP Community Needs Assessment page
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_community_needs_assessment.htm

This section is broken into the following subsections:
3.1 Overview on the Completion of the CNA
3.2 Healthcare Provider Infrastructure
3.3 Community Resources Supporting PPS Approach
3.4 Community Demographics
3.5 Community Population Health & Identified Health Challenges

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> 3.6 Healthcare Provider and Community Resources Identified Gaps
> 3.7 Stakeholder & Community Engagement
> 3.8 Summary of CNA Findings.

Scoring Process:

This section is worth 25% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

> 3.1 is worth 5% of the total points available for Section 3.
> 3.2 is worth 15% of the total points available for Section 3.
> 3.3 is worth 10% of the total points available for Section 3.
> 3.4 is worth 15% of the total points available for Section 3.
> 3.5 is worth 15% of the total points available for Section 3.
> 3.6 is worth 15% of the total points available for Section 3.
> 3.7 is worth 5% of the total points available for Section 3.
> 3.8 is worth 20% of the total points available for Section 3.

☑ Section 3.1 – Overview on the Completion of the CNA:

Description:

Please describe the completion of the CNA process and include in the response the following:

*Overview 1:

Describe the process and methodology used to complete the CNA.

> CCB, in partnership with other PPSs, contracted with NYAM to conduct a borough-wide CNA. To inform the primary data collection, CCB provided a list of key informants and collaborating organizations, offered feedback on the primary data collection instruments and closely reviewed iterative drafts of the CNA analysis. NYAM's detailed process for conducting the CNA starts on page 94 of Section F of the attached documents.
>
> Oversight of the CNA process was conducted by a CNA Committee consisting of representatives from each of the collaborating PPSs. For CCB, oversight was conducted by our Steering and Care Model and Program Planning Committees (including representatives of community based organizations, providers, Health Homes and payers). CCB Committees, Subcommittees, and Work Groups repeatedly reviewed the findings of the CNA analysis to inform project selection and interventions. The Stakeholder meeting provided an overview of DSRIP, reviewed the CNA findings and addressed questions on the impact system-wide transformation will have on Brooklyn. CCB also held an All Partner Meeting on October 20 (roughly 150 attendees) to engage partners and other interested stakeholders on CNA findings, and held large CNA-focused meetings with HHC partners on October 9 (roughly 130 attendees), and with Lutheran/HHC, and community-based groups on December 12 (roughly 150 attendees).
>
> The Brooklyn CNA informed CCB's vision, project selections and design, and implementation strategy. For example, the CNA highlights key neighborhoods of focus for our project, resource, and infrastructure development; identifies community organizations and providers that are critical to our network; and provides insight into the views of the community, the challenges faced by our enrollees and providers, and improvements Brooklyn residents would like to see in their care. Our aim is to be responsive to this important document.

*Overview 2:

Outline the information and data sources that were leveraged to conduct the CNA, citing specific resources that informed the CNA process.

> The Brooklyn CNA is valuable because of the collective input and expertise it represents from our community.
>
> The CNA included extensive primary data collection, including more than 680 Resident Surveys focused on demographics, health concerns, community resources, and care barriers. Respondents represented all Brooklyn neighborhoods and socio-demographic characteristics were well varied. Nearly 30 Key Informant Interviews were conducted with those with population-specific (e.g immigrants, older adults) or issue-specific (e.g. substance abuse, care coordination) expertise. Informants provided perceptions of community health, barriers/facilitators to health, health service needs, and recommendations for beneficial services for the population. 24 Focus Groups, conducted using a semi-structured guide, spoke to community health perceptions, utilization of services, access, and recommendations for change. Participants were from low-income neighborhoods and had unique health/service needs related to behavioral health, LGBTQ, and immigration status (more details in Section 3.7).

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NYAM also aggregated and analyzed public, de-identified data to assess health care and community resources, disease prevalence, demographic characteristics, and social determinants of health, supplementing these analyses with a literature review, including reports from Brooklyn providers, NYS DOH, NYC Departments of Health and City Planning, and academic institutions. Data sets included: NYS Community Health Indicator Reports; Behavioral Risk Factor Surveillance System; Prevention Quality Indicators; Potentially Preventable Emergency Visits; Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits; Medicaid hospital inpatient Potentially Preventable Readmission Rates; NYS Prevention Agenda 2013-2017 tracking indicators; Mental Health Services Utilization and Co-morbidities; Serious Crime rate and Serious Housing Violations; and NYS Prison admissions, among others.

☑ **Section 3.2** – **Healthcare Provider Infrastructure:**

Description:
Each PPS should do a complete assessment of the health care resources that are available within its service area, whether they are part of the PPS or not. For each of these providers, there should be an assessment of capacity, service area, Medicaid status, as well as any particular areas of expertise.

*Infrastructure 1:
Please describe at an aggregate level existing healthcare infrastructure and environment, including the number and types of healthcare providers available to the PPS to serve the needs of the community. Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Provider Types.

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
1	Hospitals	14	6
2	Ambulatory surgical centers	119	2
3	Urgent care centers	21	4
4	Health Homes	4	2
5	Federally qualified health centers	19	14
6	Primary care providers including private, clinics, hospital based including residency programs	8817	2811
7	Specialty medical providers including private, clinics, hospital based including residency programs	3890	2607
8	Dental providers including public and private	1888	113
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	73	49
10	Behavioral health resources (including future 1915i providers)	6036	3121
11	Specialty medical programs such as eating disorders program, autism spectrum early	280	3
12	diagnosis/early intervention	20	2
13	Skilled nursing homes, assisted living facilities	64	36
14	Home care services	554	56
15	Laboratory and radiology services including home care and community access	42	15
16	Specialty developmental disability services	493	26
17	Specialty services providers such as vision care and DME	223	5
18	Pharmacies	140	3
19	Local Health Departments	1	1
20	Managed care organizations	12	5
21	Foster Children Agencies	55	12
22	Area Health Education Centers (AHECs)	19	14

Note: Other should only be utilized when a provider cannot be classified to the existing provider listing.

*Infrastructure 2:

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Outline how the composition of available providers needs to be modified to meet the needs of the community.

Brooklyn's health care resources are not evenly distributed, contributing to overuse of emergency rooms for non-urgent or preventable conditions. To develop specific recommendations for DSRIP investment, CCB supplemented the CNA analysis with clinical project planning, provider surveys, stakeholder engagement and secondary research including recommendations of the Brooklyn MRT Work Group.

Several neighborhoods in Brooklyn have no hospitals, including Greenpoint, East New York, and Bensonhurst-Bay Ridge. The MRT report found only 71% of Brooklyn's 6,389 licensed hospital beds are occupied; if 1,000 beds were closed occupancy would remain below the 85% standard. CCB recognizes that DSRIP could reduce inpatient use and create excess bed capacity. As described in the IDS Project section, we plan to bring together key hospital systems and skilled nursing facilities to develop a comprehensive plan for bed reduction and rationalization.

There is a dearth of FQHCs in East Flatbush and Flatbush, highly populated areas with high rates of uninsured. There are 9 federally-designated primary care shortage areas in Brooklyn—Bed-Stuy, Bushwick, Coney Island/Gravesend, Crown Heights, East New York, Midwood, Redhook, Sunset Park and Williamsburg. The MRT report suggests that Brooklyn's high rates of preventable inpatient and ED use are the result of insufficient primary care capacity and poor geographic distribution. Only 55% of Brooklyn CNA survey respondents said that they access non-emergency health care services at a primary care doctor's office and one-quarter reported that primary care medicine was "not very available" or "not available at all." One of the primary goals, underlying each project, is to ensure access to quality primary care and community based providers for our patients, focused on the shortage areas identified above. CCB will increase the number of ambulatory providers, extend PCP hours on weekends/evenings, develop new models of patient-centered care, and integrate providers into larger health systems.

There are also shortages in behavioral health resources. Less than half of CNA informants (47%) reported mental health services were "available/very available" in Brooklyn, and 59% identified substance abuse services as being "not very available/not available." There are very few alcohol/drug use programs located in Flatbush, Canarsie-Flatlands and Southwest Brooklyn, and Brooklyn has only 536 psychiatrists (21.1/100,000 compared to 49/100,000 in NYC).

Behavioral health capacity is a key CCB focus; through our Behavioral Health Integration project, we will integrate behavioral health with primary care, and implement the IMPACT model. Other related project selections include Projects 4.a.iii, 2.b.iv, and 2.a.iii.

Last, the CNA suggests that Brooklyn lacks culturally and linguistically competent PCPs and specialists, so CCB has built training and recruiting of such capacity into each of our project plans (see Section 7).

Data on community resources were not prospectively collected in the CNA to populate the categories subsequently provided by the State. We have made our best judgment regarding categorization.

☑ **Section 3.3 - Community Resources Supporting PPS Approach:**

Description:

Community based resources take many forms. This wide spectrum will include those that provide services to support basic life needs to fragile populations as well as those specialty services such as educational services for high risk children. There is literature that supports the role of these agencies in stabilizing and improving the health of fragile populations. Please describe at an aggregate level the existing community resources, including the number and types of resources available to serve the needs of the community.

*Resources 1:

Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Resource Types.

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	349	22
2	Food banks, community gardens, farmer's markets	407	9
3	Clothing, furniture banks	120	13
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	75	10
5	Community outreach agencies	32	21
6	Transportation services	15	4

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
7	Religious service organizations	61	23
8	Not for profit health and welfare agencies	528	228
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	44	22
10	Peer and Family Mental Health Advocacy Organizations	29	18
11	Self-advocacy and family support organizations and programs for individuals with disabilities	29	14
12	Youth development programs	833	15
13	Libraries with open access computers	60	1
14	Community service organizations	333	228
15	Education	1299	15
16	Local public health programs	40	8
17	Local governmental social service programs	68	1
18	Community based health education programs including for health professions/students	40	15
19	Family Support and training	29	13
20	NAMI	1	1
21	Individual Employment Support Services	100	22
22	Peer Supports (Recovery Coaches)	36	22
23	Alternatives to Incarceration	15	3
24	Ryan White Programs	122	10
25	HIV Prevention/Outreach and Social Service Programs	53	23

*Resources 2:

Outline how the composition of community resources needs to be modified to meet the needs of the community. Be sure to address any Community Resource types with an aggregate count of zero.

Despite the many resources listed above, these services are sometimes disconnected from medical care, and providers haven't worked together to address the full spectrum for Brooklyn's residents. Community resources must be modified to integrate with medical care in order to meet the needs of our community. CCB's vision is to transform care in Brooklyn by integrating health and social services to enhance care delivery, reducing use of costly hospital services, and improving population health. Maimonides has already done this with the Brooklyn Health Home and through its CMMI grant, and will deploy this on a wide-scale basis through our IDS and Health Home projects. The IDS will create a Borough-wide integrated network of medical and social service providers connected through advanced IT infrastructure, and will provide training and other support services to better connect providers and inform them of the value and availability of resources. Our Health Home At Risk project increases access to care management services to connect patients to social and community-based supports. Housing services will also be critical to CCB's success. Many of the non-profit/public agencies and community based organizations that provide housing services to our patients are represented in our planning Governance structure, as described in Section 2.

The CNA notes significant racial, ethnic, and gender disparities in HIV/AIDS and treatment, despite the community resources focused on this population. Bed-Stuy/Crown-Heights, Williamsburg/Bushwick, and Flatbush are most affected. According to key informants, the HIV population struggles with stability/access to resources to meet basic needs; as treatments improve, HIV funding has shifted to medical management, with diminished resources available for supportive services. Through project 4.c.ii (early access to, and retention in HIV care) CCB will invest in expanding access to supportive services for the PLWHA population, as well as training for providers and community workers on nuances in care created by gender, cultural, and racial differences in patients.

Preventing asthma exacerbations/ED visits starts with controlling the home environment. Under our Asthma Home-Based Self-Management program, CCB will invest in interventions to expand access to free pest management and legal support for tenants, and focus on home-based self-management and indoor trigger reduction.

CCB also recognizes the importance of all community resources. In some cases we have not yet recruited certain resources into our PPS (e.g. libraries, schools); however, as we develop our implementation plan, we will outreach to these resources and involve them in our

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patient and stakeholder outreach efforts.

Data on community resources were not prospectively collected in the CNA to populate the categories subsequently provided by the State. We have made our best judgment regarding categorization.

✅ Section 3.4 – Community Demographic:

Description:

Demographic data is important to understanding the full array of factors contributing to disease and health. Please provide detailed demographic information, including:

*Demographics 1:

Age statistics of the population:

Brooklyn's population of 2.5 million comprises one-third of NYC's population, and roughly 13% of statewide population. Nearly two-thirds of Brooklyn's population are working age adults, aged 18-64; one quarter are children aged 0-17, and just over ten percent are over the age of 65. The age distribution of Brooklyn's population mirrors that of NYC and NYS, with a slightly lower proportion of older adults in Brooklyn (11.6%) than either NYC (12.2%) or NYS (13.6%). Coney Island, in particular, is disproportionately older adults (18% of the population in Coney Island Hospital's service area are over 65, compared to 11% in NYC and 12% in NYS).

*Demographics 2:

Race/ethnicity/language statistics of the population, including identified literacy and health literacy limitations:

Brooklyn's population is racially and ethnically diverse, with significant populations from multiple racial and ethnic groups (e.g. African American, Latino, Caribbean, Chinese, Russian, Polish, South Asian, Orthodox/Jewish and Arab). A third of Brooklyn residents identify as Black/African American (25% in NYC and 15.7% in NYS), a fifth as Hispanic/Latino, and a tenth as Asian. Roughly 17% of Brooklyn residents are not citizens (18% in NYC and 11% in NYS). Foreign-born Brooklyn residents number 950,471 (35% of the population), likely undercounted by surveys due to the number of undocumented individuals. A fourth of Brooklyn residents report speaking English less than "very well," and nearly half speak a non-English language at home (17% Spanish or Spanish Creole, 7% Chinese, 5% Russian). CCB aims to implement targeted and customized programs through community Hubs to address the special needs of our populations. Please see our cultural competency/health literacy plans in Section 7.

*Demographics 3:

Income levels:

Brooklyn faces socio-economic challenges reflective of, and exacerbated by the relationship between income and housing. CNA interviewees frequently pointed out the high cost of living in NYC, making income and poverty guidelines unrealistic for Brooklyn. The median income in the borough is $45,000 per year, lower than NYC ($52,000) and NYS ($58,000); median income in Brooklyn for Hispanic/Latinos and Black/African Americans are even lower, at $36,730 and $40,747 respectively, according to 2013 Census data. According to a 2014 RealtyTrac survey, a Brooklyn resident would need to devote 98% of this median income to afford the payment on a median-priced home of $615,000, making Brooklyn the least-affordable market in the country, topping even San Francisco and Manhattan. Residents with lower incomes, and who struggle the most to find decent, affordable housing, are concentrated in northern and central Brooklyn, especially in areas with large public housing structures.

*Demographics 4:

Poverty levels:

Twenty-two percent of households in Brooklyn live below poverty, compared to just 19% in NYC and 14% in NYS. CNA interviewees and survey respondents frequently pointed out the high cost of living in NYC, making income and poverty guidelines unrealistic. 2013 U.S. Census data for Brooklyn shows 30.4% of Hispanic/Latino residents live below the poverty level, and 12.7% below 50% of poverty. 23.7% of Black or African Americans are below poverty and 11.8% below 50% of poverty. The highest rates of poverty are in Williamsburg-Bushwick, East New York, and parts of Bedford Stuyvesant-Crown Heights, where approximately one in three households have incomes below the federal poverty level (FPL). There are also high rates of poverty in Sunset Park and Coney Island, where approximately 25%-30% of households have incomes below 100% FPL.

*Demographics 5:

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Disability levels:

Disability levels in Brooklyn vary by neighborhood. Ambulatory difficulty among the age 65+ population is concentrated in two clusters, one extending from the far northern tip of the borough in Greenpoint in a southeasterly direction to East New York, and the other from Sunset Park southeasterly through Borough Park to Sheepshead Bay. Ambulatory difficulty rates are much lower for those ages 18-64, but ambulatory difficulty still affects a sizable number of people in this age group, with a similar geographic pattern. In total, more than 37,000 Brooklyn residents received SSI benefits based on disability as of December 2013, according to SSA data. Individuals with physical and/or cognitive disabilities are disproportionately low income and have a high number of co-morbidities.

*Demographics 6:

Education levels:

Eight out of ten Brooklyn residents over age 25 have a high school degree or equivalent, on-par with NYC (79%), but lower than NYS (85%). The proportion of those aged 25 or older who have earned a bachelor degree is lower at 30%, compared to 34% in NYC and 33% statewide. For those in poverty, however, rates are much lower. According to 2013 U.S. Census data for Brooklyn, 34% of those over age 25 and under the poverty line have less than a high school degree, compared to 29.5% for NYS and 33.5% for NYC. In addition, 22.6% of those over 25 and under the poverty line have a high school degree or equivalent, compared to 15.2% for NYS and 20.6% for NYC. These results indicate that educational attainment is a stronger determinant of poverty status in Brooklyn than in NYC or NYS.

*Demographics 7:

Employment levels:

The overall unemployment rate in Brooklyn is 10.3%, roughly equivalent with NYC (10.2%), but higher than NYS (8.7%). According to 2013 U.S. Census data, the unemployment rate in Brooklyn varies widely between ethnic or racial groups: 14.1% of the Black/African American population is unemployed and 12.9% of the Hispanic/Latino population is unemployed, while the rate for White populations is only 6.7%. These statistics are particularly relevant to Brooklyn, given that a third of Brooklyn residents identify as Black/African American, and a fifth identify as Hispanic/Latino. Unemployment in the borough ranges from 6.2% to 17.7% with the highest rates in the northern and central portions of the borough, and Coney Island. In Coney Island, CNA respondents noted that unemployment causes the neighborhood to "suffer greatly economically."

*Demographics 8:

Demographic information related to those who are institutionalized, as well as those involved in the criminal justice system:

The CNA emphasized the diminished life chances resulting from involvement in the criminal justice system. While the number of new NYC Jail and NYS Prison admissions has been steadily declining over the past 15 years, Rikers Island still houses approximately 13,000 people on a given day, a substantial number of whom come from – and will return to – a handful of economically and otherwise disadvantaged communities in Brooklyn. Rates of criminal justice involvement are clustered in areas of low socio-economic status, noted above.

OMH data on residential programs indicated more than 3,000 individuals were in OMH residential programs in Brooklyn in 2012 (including congregate, apartment, supported housing, and other support programs).

File Upload (PDF or Microsoft Office only**):**

*As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
33_SEC034_CCB DSRIP Application_Continued Responses to Question (b.) of Section 5.docx	12/22/2014 10:15:48 AM	Additional responses to Question (b.) of Section 5 in project application sections
33_SEC034_Project 3.b.i,Question 4c,CCB.docx	12/20/2014 02:51:02 PM	Project 3.b.i,Question 4c,CCB
33_SEC034_Supplemental Data and Resources.pdf	12/20/2014 02:44:40 PM	List of Supplemental Data and Resources Supporting Findings
33_SEC034_CHCANYS_Plan for Expanding Sustainable CHCs_Attachment 5.pdf	12/20/2014 02:44:01 PM	CHCANYS Plan for Expanding Sustainable CHCs_Attachment 5

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File Name	Upload Date	Description
33_SEC034_CHCANYS_Plan for Expanding Sustainable CHCs_Attachment 4.pdf	12/20/2014 02:43:10 PM	CHCANYS Plan for Expanding Sustainable CHCs_Attachment 4
33_SEC034_CHCANYS_Plan for Expanding Sustainable CHCs_Attachment 3.pdf	12/20/2014 02:42:30 PM	CHCANYS Plan for Expanding Sustainable CHCs_Attachment 3
33_SEC034_CHCANYS_Plan for Expanding Sustainable CHCs_Attachment 2.pdf	12/20/2014 02:41:46 PM	CHCANYS Plan for Expanding Sustainable CHCs_Attachment 2
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33_SEC034_New York State Health Workforce Planning Data Guide_Attachment2.pdf	12/20/2014 01:39:48 PM	New York State Health Workforce Planning Data Guide_Attachment2
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33_SEC034_Brooklyn_MRT_FinalReportAttachment1.pdf	12/20/2014 12:51:27 PM	Brooklyn MRT Final Report_Attachment1

☑ Section 3.5 - Community Population Health & Identified Health Challenges:

Description:
Please describe the health of the population to be served by the PPS. At a minimum, the PPS should address the following in the response.

*Challenges 1:
Leading causes of death and premature death by demographic groups:

'Diseases of the heart' are the leading cause of death in Brooklyn (at a rate of 196/100,000), so cardiovascular disease is a CCB priority. After cardiac disease, the top causes of death are: cancer (145/100,00), influenza and pneumonia (29/100,000), diabetes (25/100,000), chronic lower respiratory disease, stroke, essential hypertension and renal diseases, accidents except drug poisoning, HIV, and deaths resulting from mental/behavioral disorders, including accidental poisoning and other psychoactive substance use (ranging from 8 – 17/100,000). The leading causes of death in the borough are consistent with those in NYC and NYS. The top five causes of premature death in Brooklyn are cancer (267/100,000), heart disease (201/100,000), unintentional injury (45/100,000), diabetes (38/100,000) and AIDS (29/100,000). This aligns with the top five causes of premature death in NYC, and matches the top three causes of death in NYS. On premature deaths, like many other indicators, minority populations fare worse than white populations; the percentage of Hispanic and Black individuals with premature deaths is more than twice that of White individuals.

*Challenges 2:
Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The majority of PQI admissions for adults and children are for chronic conditions that are targeted by CCB projects. Analysis of zip-code data, reveals that the highest Observed/Expected PQI ratios are consistently found in north-central Brooklyn, Downtown to Bedford-Stuyvesant, Bushwick, and Coney Island. Absolute numbers of PQI admissions are concentrated southeast from these areas to Crown Heights and Brownsville and East New York. There were 3,694 potentially preventable hospitalizations of Medicaid beneficiaries in Brooklyn for circulatory conditions, accounting for more than one in five of such admissions in NYS. Respiratory composite ranked second with 3,686 PQI admissions and Diabetes, with 3,072 admissions. The highest rate of Medicaid PQI hospitalizations among young adults occurs in Williamsburg-Bushwick and Bed Stuy/Crown Heights. Overall rates of hospitalization are higher in Brooklyn than citywide, including for heart disease and diabetes. Hospitalization for coronary disease (2010) was higher for Black and Hispanic populations than

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for White, as was the rate of hospitalization for Diabetes complications, especially for those over age 18.

*Challenges 3:

Rates of ambulatory care sensitive conditions and rates of risk factors that impact health status:

Ambulatory sensitive conditions are often seen in the emergency room, but could be treated by better primary care infrastructure. As such, one measure of these rates are potentially avoidable emergency room visits (PPVs). Brooklyn has fewer PPVs per 100 Beneficiaries than does NYC or NYS. Despite this, the proportion of Emergency Visits that are considered potentially preventable is quite high at 74.5% for Brooklyn as a whole and ranges from 64.6% - 80.4% in certain zip codes. The same areas of the borough with elevated PQI Observed/Expected rates, a north central swath extending from downtown in the west to East New York in the east, have the highest proportions of Emergency Department visits designated as potentially preventable, as do Flatbush and Canarsie, south of the central and eastern part of this area. Risk factors contributing to these rates include barriers to primary care (including appointment wait times and the potential need for multiple visits), chronic conditions, and lack of insurance. CCB's ED Triage program focuses heavily on these factors and was selected given these concerns. Challenges 4 further discusses rates of many ambulatory sensitive conditions.

*Challenges 4:

Disease prevalence such as diabetes, asthma, cardiovascular disease, HIV and STDs, etc.:

Given CNA findings, many CCB projects focus specifically on prevalent diseases (asthma, cardiovascular disease, behavioral health, HIV).

For behavioral health, a CCB priority, in Brooklyn, the age-adjusted percentage of adults with poor mental health for > 14 days is 7.4%, the age-adjusted suicide rate is 4.6%, and 6.1% of all people in Brooklyn report experiencing serious psychological distress, compared to 5.5% in NYC overall. Some of the most common self-reported health problems in Brooklyn were depression or anxiety (22.2%). Over 50% of patients with behavioral health conditions also have chronic physical health conditions. CCB selected Project 3.a.i to address behavioral health, but also to tackle chronic disease such as diabetes. For example, certain antipsychotic medications are associated with "Metabolic Syndrome", which may result in increased blood sugar levels, cholesterol and triglycerides, blood pressure, and weight gain. If left unchecked, this can lead to diabetes and increase risk for cardiovascular disease and associated complications. Project 3.a.i will address this by ensuring these patients have comprehensive care management and access to integrated medical and behavioral health services.

In Brooklyn, the greatest proportion of potentially preventable admissions (PQI) is for chronic conditions including respiratory conditions (asthma, COPD, 3,686 admissions), cardiovascular conditions (heart failure, hypertension, 3,694 admissions), and diabetes (3,072 admissions).

Community members cite "huge" asthma prevalence, due to indoor/outdoor environmental conditions (e.g. poor housing, traffic, industrial). Among Medicaid children in Brooklyn, the asthma rate of 310.87/100,000 is lower than the NYC rate, but higher than the NYS rate. Childhood asthma rates per 100,000 in the borough range from 85.31 in Borough Park to 666.92 in Bed Stuy/Crown Heights. Brooklyn also has a higher asthma ED visit rate than NYC and NYS, and a large number of high number of PQI respiratory composite hospitalizations in North/Central Brooklyn. CCB selected an Asthma project to address these concerns.

Cardiovascular is another CCB project/focus. The rate of age-adjusted heart attacks is higher in Brooklyn (15.9/10,000) than in the city or state. In 2012, the number of potentially preventable hospitalizations among Medicaid beneficiaries for circulatory conditions in Brooklyn was 3,694, accounting for more than one in five of all such admissions in the State, ranked higher than respiratory and diabetes.

CCB also selected an HIV project given HIV prevalence and disparities: in 2011, 26,945 people (Medicaid and non-Medicaid) were living with HIV/AIDS in Brooklyn. The rate of new HIV diagnoses among black/African Americans in Brooklyn is over five times the rate among whites in the borough (and over 2.5 times for Latinos). For other STDs, the rate of new chlamydia diagnoses in Brooklyn is similar to in NYC (there is a 4.7% difference between the two), but chlamydia rates for women were 1.3 times that for NYS in 2012. The incidence of gonorrhea is 134% lower than it is for the city as a whole, but rates vary widely (by over 184%) by neighborhood.

*Challenges 5:

Maternal and child health outcomes including infant mortality, low birth weight, high risk pregnancies, birth defects, as well as access to and quality of prenatal care:

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Over the period 2010-2012, Brooklyn averaged 41,969 live births per year. The overall Low Birth Weight (LBW) rate for Brooklyn over the same time period was 8.2%, compared to 8.5% for NYC and 8.1% for the state. Across zip codes, the LBW rates ranged from 5.2% to 13.4%, with the highest rates found in a large cluster of zip codes extending through the north central, central, and eastern parts of the borough in the neighborhoods of Bedford-Stuyvesant, Crown Heights, Flatbush, Brownsville, East New York, and Canarsie. These neighborhoods also experience the highest rates of infant mortality; in 2011, East New York had among the highest rates in the city, at 8.4/1,000 births (compared to 4.4/1,000 births in Brooklyn overall), according to NYC vital statistics data. Risk factors for poor child health outcomes, especially in high risk pregnancies, include poor access to prenatal care (70% have early access in Brooklyn, according to Prevention Agenda data), chronic disease and social issues. CCB's projects, particularly our IDS, ED Triage, and Health Home At Risk projects, are designed to address these risk factors through investments in communication and coordination.

*Challenges 6:

Health risk factors such as obesity, smoking, drinking, drug overdose, physical inactivity, etc:

Health risk factors are widespread in Brooklyn: 4.8% of Medicaid enrollees had alcohol/drug use-related utilization in 2012, the age-adjusted percentage of adult binge drinking is 16.4%, and in NYC people experiencing psychological distress are more likely to report binge drinking and are over twice as likely to report smoking.

The percentage of smoking among adults in Brooklyn is on par with NYC/NYS, with high rates in Williamburg-Bushwick, Greenpoint, and Bedford-Stuyvesant/Crown Heights. Key informants and focus groups noted smoking is problematic among certain immigrant populations (e.g. Chinese and Arab).

The prevalence of obesity in Brooklyn is higher than in NYC or NYS, with 27% of all adults obese (24.2% in NYC, 23.6% in NYS). Among children/adolescents, one in five is obese, higher than NYS for the same time period, caused in part by physical inactivity.

CCB's projects address these concerns primarily through expansion of care management services to connect individuals to needed social and community supports.

*Challenges 7:

Any other challenges:

Brooklyn faces other challenges, as identified in our CNA. Environmental risk factors, including the presence of pests and mold in the home, harm Brooklyn residents. Rates of serious housing code violations that are considered "immediately hazardous or serious" are prevalent in many of the same neighborhoods with high numbers of preventable respiratory PQI hospitalizations: Bedford-Stuyvesant, Crown Heights, Williamsburg, Bushwick, Brownsville, East New York, and Flatbush/East Flatbush. In Bushwick, the prevalence of asthma is largely attributed to indoor and outdoor environmental conditions, including poor housing conditions, traffic, and the historic industrial base of the community, with likely persistent toxic chemicals. In Sunset Park, there is a history of toxic environments due to 'brownfields,' especially along the industrial waterfront.

The costs incurred for medical care also remains a barrier to effective disease management. The income criteria for Medicaid are described as unrealistic, given the cost of living in New York City, and the working poor who do not qualify for Medicaid cannot afford the insurance premiums offered through the NYS Health Insurance Exchange.

☑ Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

Description:

Please describe the PPS' capacity compared to community needs, in the response please address the following.

*Gaps 1:

Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

The most stark service gaps in Brooklyn are shortages in outpatient and community-based care, especially primary care and behavioral health services, the absence of which contributes to excess hospital use. Addressing gaps in outpatient and community-based care should increase the number of excess beds identified through the Berger Commission and Brooklyn's Medicaid Redesign Team reports.

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For primary care, although most Brooklyn residents have a PCP, 25% of Brooklyn CNA survey respondents reported that primary care was not sufficiently available and 13% said they used the ED because the doctor's office/clinic was closed. While CCB has over 1,200 PCPs in network, PCP capacity is a concern that CCB must address. The CCB will build PCP practices and implement other strategies designed to maximize access to PCP services with a particular focus on Greenpoint, Canarsie, East New York, Williamsburg-Bushwick and East Flatbush.

Behavioral health provider resources are located in areas of high utilization (concentrated in Williamsburg-Bushwick, Bedford-Stuyvesant-Crown Heights, and Sunset Park), however there are still capacity shortages, especially for psychiatrists. Under half of CNA informants (47%) reported mental health services were "available/very available." Similar to Primary Care services, while CCB contains over 75 behavioral health providers, we expect issues with meeting demand. To address these issues CCB will implement a BH project to streamline access to behavioral health services.

Both the Berger Commission and the Medicaid Redesign Team's Brooklyn Work Group identified excess inpatient bed capacity prior to DSRIP. Both reports recommended closing and merging facilities. Most recently the Medicaid Redesign report identified three central and east Brooklyn hospitals that should be consolidated into a single system and encouraged the integration of 2 other hospitals located in central Brooklyn into an integrated care delivery system. We expect that as we increase access to and utilization of outpatient and community-based services and otherwise transform the care delivery system, there will be fewer inpatient beds needed in Brooklyn. A preliminary analysis we conducted of the impact of eliminating all avoidable Medicaid hospitalizations and readmissions within Brooklyn suggested that approximately 104 beds could be eliminated. CCB will develop a bed rationalization plan as part of its IDS project, working with hospital partners and stakeholders to determine the best approach while balancing the need for inpatient services. CCB has already had initial discussions with partner hospitals about repurposing existing inpatient space.

If DSRIP goals are achieved, skilled nursing facilities will also have excess capacity. Similar to inpatient hospitals, CCB will bring together skilled nursing facilities to identify ways to re-deploy space and resources.

*Gaps 2:
Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services, such as hours of operation and transportation, which are contributing to the identified needs of the community.

The CNA cites several causes for shortages and access issues for outpatient and community-based services.

Gaps in such access can be attributed to transportation, cost and time barriers, limited hours of operation, perceived quality, and cultural competency gaps. In Brooklyn's Asian community, for example, cost of care was the largest reason cited for limited access to services, but language barriers, reliance on traditional sources of care (such as Chinese medicine), lack of appropriately trained Asian providers, and perceived quality problems were all cited as drivers of care gaps. More generally, 65% of Brooklyn residents represent minority groups, and approximately one in four people in Brooklyn report speaking English less than "very well," and nearly half speak a language other than English at home. Among respondents using ERs, 17% reported they did so due to lack of insurance, and 13% because the doctor's office or clinic was closed. In a survey of nearly 130 Brooklyn clinics that serve Medicaid and uninsured patients, the CNA found only 40% have weekend operating hours and 55% have some evening hours.

While over 90% of survey respondents identified accessible transportation as "available" or "very available," focus group participants noted that access to transportation services is unreliable and "a nightmare" and that in some communities, basic transportation infrastructure is limited or inaccessible to the disabled. The CNA also noted there is no directory or inventory of transportation services.

For behavioral health populations, stigma against the condition and seeking treatment at a behavioral health services provider location was repeatedly cited as barriers to care. Respondents also noted that these services are fragmented, with mental health and substance abuse services operating in separate silos, and behavioral health services being separated from medical services.

Other regulatory and reimbursement barriers also result in service gaps. The CNA found low salaries for increasingly valued services, such as care coordination, making hiring qualified candidates difficult. Lack of trust, engagement, and time for care coordination on the part of medical providers was also notable.

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*Gaps 3:

Identify the strategy and plan to sufficiently address the identified gaps in order to meet the needs of the community. For example, please identify the approach to developing new or expanding current resources or alternatively to repurposing existing resources (e.g. bed reduction) to meet the needs of the community.

CCB's has a well-designed strategy to address gaps. As set forth in our IDS project, we deploy a new model of care that integrates physical, behavioral and social needs into a coordinated care plan and creates a team-based approach to care management. We will develop and deploy a develop a Central Services Organization (CSO) that will rapidly deploy DSRIP projects across all providers, with a focus on building primary care capacity in targeted neighborhoods (such as Greenpoint, Canarsie, and East New York) and targeting mental and behavioral health providers in high need areas (such as Borough Park, central Brooklyn, Bushwick, Northern Brooklyn, and Flatbush).

An important component of addressing primary care shortages will be to both increase the number of ambulatory providers and also improve PCP hours on weekends/evenings, expand or develop new models of patient-centered care, and integrate providers into larger systems.

For behavioral health, through our Behavioral Health Integration project, we will build and integrate behavioral health with primary care, and implement the IMPACT model to extend psychiatrist capacity. Project 4.a.iii will strengthen mental health/substance abuse infrastructure, the Care Transitions project will implement the Critical Time Intervention for psychiatric patients upon discharge from our hospitals, and the Health Home At Risk project will link non-Health Home eligible behavioral health patients (such as those with depression) to Health Home services.

As previously mentioned CCB will use a collaborative process to rationalize/repurpose excess bed capacity in our hospitals and nursing homes. Relying initially on input from CCB hospitals and nursing homes and then through collaborative sessions with our PPS partners, we will develop a bed rationalization plan that takes into consideration the best approach to repurposing existing resources.

✅ Section 3.7 - Stakeholder & Community Engagement:

Description:

It is critically important that the PPS develop its strategy through collaboration and discussions to collect input from the community the PPS seeks to serve.

*Community 1:

Describe, in detail, the stakeholder and community engagement process undertaken in developing the CNA (public engagement strategy/sessions, use of focus groups, social media, website, and consumer interviews).

In developing the Brooklyn CNA, NYAM undertook a detailed stakeholder and community engagement process to collect primary data to identify residents' perceptions of: the impact of community and environmental conditions on health promotion and disease prevention; primary health concerns and health needs; available health-related programming and services and service gaps; access, use and perceptions of health-related programming and services; and opportunities for improving health promotion and health care needs. The process included collecting key informant interviews, focus groups and resident surveys. In addition, CCB conducted multiple stakeholder and partner meetings on the CNA, described in Section 3.1.

In addition to the 24 focus groups described below, NYAM conducted 28 key informant interview sessions with 35 total individuals. Brooklyn PPSs' selected the key informants, whose expertise included population-specific knowledge of particular immigrant groups, older adults, children and adolescents as well as issue-specific knowledge of substance abuse, supportive housing, care coordination, corrections, and homelessness. Interviews, which lasted between 45 and 120+ minutes, asked informants about their perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities to benefit the local population.

NYAM also surveyed Brooklyn residents ages 18 and older, who were recruited by local organizations, including CBOs, senior centers, and social service and health providers, and through street outreach to engage a diverse and representative sample of community members. The approximately 681 surveys were completed by residents from across all of Brooklyn's neighborhoods with varying socio-demographic characteristics, including 44.3% Black/African American, 31.8% Latino, 13.7% Asian, 53.7% foreign born, 26.3% limited English proficiency, 82.4% living below the poverty line, 53.4% enrolled in Medicaid and 13.0% uninsured. To ensure cultural competency,

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surveys were translated into 10 languages: Arabic, Bangla, Chinese (simplified and traditional), Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish.

*Community 2:
Describe the number and types of focus groups that have been conducted.

As one part of the stakeholder engagement strategy, 24 semi-structured focus groups, each lasting approximately 90 minutes, were conducted to inform the CNA's development. The majority of focus groups were comprised of community members, including residents from low income neighborhoods and residents with unique health and service needs, including individuals with behavioral health issues, older adults, LGBTQ, immigrants and individuals with limited English proficiency. Local organizations, community based organizations (CBOs), senior centers, social service providers, tenant associations, and health providers assisted with recruiting focus group participants. Community interest in focus groups was high, with some groups including up to 30 individuals.

In addition to resident-driven focus groups, a number of focus groups were conducted with community leaders and providers, including behavioral health providers, care coordinators, and physicians. The Brooklyn PPSs assisted with recruiting these participants to ensure that key stakeholders were included.

*Community 3:
Summarize the key findings, insights, and conclusions that were identified through the stakeholder and community engagement process.

The predominant theme that emerged from the Brooklyn stakeholder and community engagement process was "disparity," with residents pointing to differences between neighborhoods, distribution of resources, and opportunity for certain communities. Stakeholders highlighted barriers to health and health care driven by poverty, including long work hours and lack of after-hours care options, unstable housing, unsafe neighborhoods, and the need to ration spending. These health barriers are pronounced for some sub-populations, including people with disabilities, LGBTQ, homeless, and the justice involved population.

Nevertheless, Brooklyn community members and stakeholders expressed interest in partnering with health care providers and hospitals to promote good health and reduce hospitalizations. To this end, residents identified the following solutions to contribute to improved health outcomes, including: increased ease of access for medical visits; improved provider sensitivity; availability of supportive services to help manage medical conditions and high-risk populations; and health education focused on disease prevention and management, insurance options, and mental health issues.

In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.

[Maimonides Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	AHRC	Dedicated to enhancing the lives of individuals with intellectual and developmental disabilities and their families	Individuals with developmental disabilities have complex needs and it is critical to ensure that their health and social needs are met to reduce preventable admissions
2	Arab American Family Support Center	Provides social services to help Arab-American immigrants better integrate into their communities through the provision of culturally, linguistically, and religiously sensitive social services	Arab residents are concentrated in key communities, such as Sunset Park and Borough Park, that are served by CCB. CCB will work with community groups to provide effective and culturally competent care to address the primary identified health needs of these residents, such as diabetes, mental illness, and smoking
3	Arthur Ashe Institute for Urban Health	Provides after-school programming, outreach initiatives, research, and advocacy to help address	There are significant health disparities across Brooklyn and it is

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[Maimonides Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		health conditions that affect minorities	important that CCB works with community-based organizations to ensure the health needs of all groups are equally addressed
4	Brooklyn District Public Health Office	Work to promote health equity and reduce health disparities by informing public policy, conducting research, and implementing community-based programs	The NYC DOHMH and its affiliated entities are an important asset for CCB for the breadth of knowledge, data, and resources they offer
5	Brooklyn Perinatal Network	Enable at-risk residents to access resources needed to maintain health, reduce infant death, and improve maternal and child health status	BPN's longstanding history of serving low-income families and children can help improve health care provided to families, particularly around perinatal care
6	Brownsville Multiservice Family Health Center	Provides and promotes integrative and high quality health care and social services to enable every individual and family in the communities we serve to achieve total health and wellness	In order to form a true integrated delivery system, CCB will work collaboratively with community providers to address the full spectrum of patient health and social needs
7	CAMBA	Serving more than 35,000 individuals and families, CAMBA provides economic development, education and youth development, family support services, HIV/AIDS services, housing services and development, and legal services	CAMBA is deeply rooted in communities served by CCB and will be a valuable partner in improving the accessibility of health and social services to vulnerable populations
8	Callen Lorde	Medical facility for the lesbian, gay, bisexual, and transgender community as well as people living with HIV/AIDS	It is the mission of CCB to provide culturally competent care and work with community resources to understand the unique health needs of the LGBT community
9	Caribbean Women's Health Association	Provides programming that aims to improve the wellbeing of individuals, strengthen families and empower communities through comprehensive, integrated, culturally appropriate and coordinated "one-stop" service	Caribbean residents in Brooklyn are faced with poverty, prejudice, and other social barriers to health. CCB is dedicated to reducing these barriers across communities to improve access to care and health status
10	Center for Independence of the Disabled, New York	Ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to the social, economic, cultural and civic life of the community	CCB seeks to provide culturally competent and equitable care to all populations, including the disabled
11	Charles B. Wang Community Health Center	Ensure that all members of our community—regardless of ability to pay—are provided with quality, comprehensive and culturally effective primary healthcare	In order to form a true integrated delivery system, CCB will work collaboratively with community providers to address the full spectrum of patient health and social needs
12	Children's Aid Society	Helps children in poverty to succeed and thrive by providing comprehensive supports to children and their families in targeted high-needs New York City neighborhoods	Foster care and preventive care agencies have unique insight on the most vulnerable populations and can help improve care delivery to these populations
13	Coalition for Asian American Families and Children	Aims to improve the health and well-being of Asian Pacific American children and families in New York City	Nearly 11% of Brooklyn residents are Asian and common health concerns include diabetes and smoking, while cultural and language barriers often prevent residents from accessing appropriate care. CCB will work with community organizations to ensure the unique needs of these residents are addressed

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[Maimonides Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
14	Commission on the Public Health System	Committed to ensuring that the voices of medically underserved communities, especially their need for safety net health care providers, are heard	CCB recognizes its influential role in transforming health care to better serve the community during and beyond DSRIP years, and will work with consumer advocacy organizations to analyze the impact of hospital transformation on patients
15	Comunilife	Provides supported transitional and permanent housing for homeless adults struggling with HIV/AIDS, serious mental and behavioral health issues, and other chronic medical conditions	The homeless population is often disconnected from primary care and includes frequent users of ED services, representing an opportunity to improve preventable ED visits
16	Community Service Society	Provides support services, research, and policy analysis that helps lower-income families get back on their feet	Community-based organizations with well-developed networks will help promote open communication between CCB and residents
17	Corporation for Supportive Housing	Provides solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities	Poor housing conditions can exacerbate the medical conditions of patients, as well as generate significant stress. CCB will work with community groups to address the housing needs of residents
18	Crown Heights Community Mediation Center	Works to make the neighborhood safer and healthier for all through youth development and anti-violence programs	In certain neighborhoods, residents report that violence serves as a barrier to accessing care and engaging in healthy behaviors, such as exercise. CCB is dedicated to addressing these social determinants of health
19	Haitian American United for Progress	Helps low-income families and individuals to live healthy and productive lives	Caribbean residents in Brooklyn are faced with poverty, prejudice, and other social barriers to health. CCB is dedicated to reducing these barriers across communities to improve access to care and health status
20	Jewish American Serving the Aging	Sustain and enrich the lives of the aging in the New York metropolitan area so that they can remain in the community with dignity and autonomy	CCB will work with community groups to address the needs of elders who often have multiple chronic conditions and complex health needs that may require long-term extended care
21	Make the Road	Builds the power of Latino and working class communities to achieve dignity and justice through organizing, policy innovation, transformative education, and survival services	Community-based organizations with well-developed networks will help promote open communication between CCB and residents
22	NADAP	Operates employment, assessment, case management and Health Home care coordination programs in New York City and Nassau County	Unemployment, lack of insurance, and poor care coordination exacerbate physical and behavioral health conditions, and CCB looks to work with community groups to address these community needs
23	New York Immigration Coalition	Works to achieve a fairer and more just society that values the contributions of immigrants and extends opportunity to all	Language and culture represent significant barriers to accessing health care and CCB seeks to address these barriers for immigrants
24	New York Lawyers for the Public Interest	Advances equality and civil rights, with a focus on health justice, disability rights and environmental justice	CCB seeks to provide culturally competent and equitable care to all populations

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[Maimonides Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
25	NYC Department of Homeless Services	Prevents homelessness when possible and provides short-term, emergency shelter for individuals and families who have no other housing options available	CCB will work with community groups to better address the health and social needs of homeless residents and families
26	NYCDOH/Rikers Island	Provides for the care, custody, and control of persons accused of crimes or convicted and sentenced to one year or less of jail time	The justice-involved population has unique physical and behavioral health care needs, and enhanced support is needed transition these individuals back into the community
27	Ridgewood Bushwick Senior Citizens Council	Implement new and effective strategies to improve the community and provide the necessary resources to local residents so they may improve their present living conditions and work toward long-term self-sufficiency	Several CCB projects seek to provide appropriate education and activating interventions to encourage patients to self-manage their own health
28	Services & Advocacy for GLBT Elders (SAGE)	Dedicated to improving the lives of lesbian, gay, bisexual and transgender (LGBT) older adults	It is the mission of CCB to provide culturally competent care and work with community resources to understand the unique needs of sub-groups, such as LGBT older adults

☑ Section 3.8 - Summary of CNA Findings:

Description:

In the chart below, please complete the summary of community needs identified, summarizing at a high level the unique needs of the community. Each need will be designated with a unique community need identification number, which will be used when defining the needs served by DSRIP projects.

*Community Needs:

Needs below should be ordered by priority, and should reflect the needs that the PPS is intending to address through the DSRIP program and projects. Each of the needs outlined below should be appropriately referenced in the DSRIP project section of the application to reinforce the rationale for project selection.

You will use this table to complete the Projects section of the application. You may not complete the Projects Section (Section 4) until this table is completed, and any changes to this table will require updates to the Projects Section.

[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for delivery system integration across the spectrum of care through IDS project	High rates of avoidable admissions, readmissions, and ED visits, as described below, are indicative of the need to better integrate care across the spectrum of providers. In addition, as described below, Brooklyn faces primary care shortages and access challenges that this project aims to address. By leveraging existing assets and investing in technology and system re-design, the PPS will seek to transform health care in our service area from fragmented, episodic, high-cost care to integrated, accessible, value-based care under project 2.a.i.	NYAM Primary Data Findings, September 2014 Potentially Preventable ER Visits, NYU Furman Center, 2013 NYS OMH, 2012; NYS DOH amended 2012 PPRs

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[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			Maimonides Analysis of ED Visits by ESI Severity, 2013
2	Need to reduce high numbers of preventable readmissions	In 2012, there were 8,878 potentially preventable readmissions in Brooklyn, and 2,870 were at CCB hospitals. Behavioral health issues are a driver of readmissions. 2,573 of Brooklyn readmissions were for patients with behavioral health diagnoses. On average, about 22% of those admitted with behavioral health issues had a readmission. CCB analysis of data from four CCB hospitals showed that cardiovascular conditions including heart failure, Septicemia and other infections, renal failure, pneumonia, and COPD have among the highest volumes of readmissions. Schizophrenia was also a top diagnosis for one hospital. Addressing these rates is a goal of all of CCB projects, especially the Care Transitions project 2.b.iv.	NYS OMH, 2012; NYS DOH amended 2012 PPRs Partnership for Patients Hospital-Specific Readmission Reports for Maimonides, Wyckoff, and Kingsbrook Hospitals, 2013
3	Need to reduce preventable Emergency Department (ED) visits by linking patients to primary care	The proportion of ED visits that are potentially preventable is high: 74.5% for Brooklyn as a whole and ranging from 64.6% - 80.4% among zip codes in the borough. In 2013, there were over 347,000 potentially preventable visits to the ED in Brooklyn. In addition, Community (and provider) perceptions make the emergency department a rational choice for "one stop shopping" (e.g. long PCP wait times, need for multiple visits). According to our largest PPS hospital's analysis, roughly 15% of Medicaid patients, many with mental/behavioral health issues, account for 40% of ED visits, and 3% of Medicaid patients had over 6 ED visits each, accounting for over 15% of all visits. This shows the need for resources (as will be emphasized under CCB's ED Triage project 2.b.iii) to connect patients to primary care sites, improve patient education and health literacy, and better manage non-emergent patients who present to the ED.	Primary Data Collection, Brooklyn Community Needs Assessment, Appendix D, October 2014 Potentially Preventable ER Visits, NYU Furman Center, 2013 B-HIP Report, August, 2012. Maimonides Analysis of ED Visits by ESI Severity, 2013
4	Need to improve access to primary care through CCB's IDS project to support all projects	In total, about 23% of Brooklyn residents reported that in some point in the last 12 months they needed health services but did not get them. In Brooklyn, about 25% of survey respondents (not just Medicaid) reported that primary care medicine was "not very available" or "not available at all." 13% of respondents said they used the ED because "the doctor's office or clinic was not open." 11.8% of respondents said they "couldn't get an appointment soon or at the right time."	NYAM Primary Data Findings, September 2014 Potentially Preventable ER Visits, NYU Furman Center, 2013 NYS OMH, 2012; NYS DOH amended 2012

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[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		As a result, Brooklyn has high rates of readmissions and avoidable inpatient care, as noted above. Through our IDS project 2.a.i, and supporting all of our projects, CCB will expand primary care access and improve primary care quality, focusing on key target neighborhoods.	PPRs
5	Need for community-based care management services to help high need patients access care	Several barriers prevent patients from accessing timely outpatient care, such as language and cultural differences, as well as inconvenient practice hours and long wait times for appointments. Enhanced care coordination and patient navigation can help close gaps in access, language, and patient activation. Very high need populations, including the chronically homeless, those with severe alcohol dependence and/or serious mental illness, victims and survivors of domestic violence, individuals coming out of jails and prisons, and individuals with particular disabilities are in need of, but have been unable to access, targeted and intensive care management services. Specific interventions pursued will include linking patients to care management through the Health Home At Risk project 2.a.iii, post-discharge connections to a PCMH, appointment scheduling and reminders, and warm hand-offs to specialists and community resources through the Care Transitions project 2.b.iv.	NYAM Primary Data Findings, September 2014 NYAM Health Care Resources Detailed Table, October 2014 PQI Data Suite, NYS DOH, 2012 Community Resource Maps, GNYHA Health Information Tool for Empowerment (HITE), 2014 Community Demographics, US Census American Community Survey, 2008-2012
6	Need to better address patients' behavioral health needs through integrated care	Depression, anxiety, and substance abuse are common self-reported health issues, and nearly 1 in 3 residents who utilize behavioral health services are also hospitalized. In 2012, of the almost 220,000 Medicaid beneficiaries in Brooklyn with a behavioral health-related service utilization throughout the calendar year, nearly one in three (31.2%) had an inpatient admission during the year (for any reason). Coney Island, Williamsburg/Bushwick, Greenpoint, and Borough Park are hot spots for serious mental illness, with 12%, 9.6%, 8.5% and 7.3% of residents, respectively, reporting severe psychological distress. The Brooklyn average is 6.1%, and the NYC average is 5.5%. More than half of adult behavioral health clients ages 18 – 64 had at least one co-morbid chronic condition, and almost 90% of behavioral health clients over age 65 had a co-morbid chronic condition.	NYAM Primary Data Findings, Sept. 2014 Psychological Distress Rate, NYC DOHMH Community Health Survey, 2012 BH-Related Utilization, Inpatient Admissions, NYS DOH, 2012 NYS OMH, Patient Characteristic Survey, 2013 NYS Health Workforce Planning Data Guide 2013, Center for Health Workforce Studies

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[Maimonides Medical Center] Summary of CNA Findings

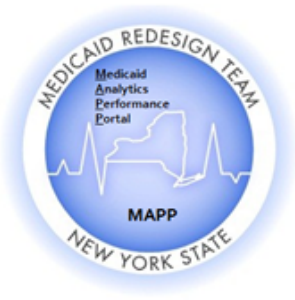| Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		And CCB recognizes there is a severe shortage of psychiatrists in Brooklyn—the borough has only 536 general psychiatrists, a rate of 21.1 per 100,000 (the NYC rate is 49 per 100,000). Through our behavioral health project 3.a.i, we will integrate care to improve the accessibility and utilization of behavioral health services among vulnerable populations, and implement the IMPACT model, which would help extend psychiatrist capacity.	
7	Need to address high rates of cardiovascular mortality, PQIs, and other indicators	Heart disease is the leading cause of mortality among the white, black, and Hispanic populations. The age-adjusted mortality rate for heart diseases was 195.4/100,000. It is the second leading cause of premature death in Brooklyn, with an age-adjusted death rate of 201/100,000, surpassing the City (184/100,000) and State (180/100,000). In 2012, there were 3,694 potentially preventable hospitalizations for circulatory conditions (PQI S02 Circulatory Composite), accounting for 23.3 % of all such admissions in the State. In 2012, there were also 862 potentially preventable hospitalizations for hypertension (PQI 07). Several neighborhoods, including Coney Island-Sheepshead Bay and Borough Park, have been disproportionately affected by CVD, with relatively high utilization rates. CCB's strategy to improve CVD management and successfully implement project 3.b.i will focus on helping primary care practices attain 2014 PCMH Level 3 recognition and implementing robust CVD management, including addressing lifestyle changes, medication adherence, health literacy, and patient confidence and efficacy in self-management. Care coordination teams will include PCPs, care managers, peer educators, and CHWs, all of whom will be trained to work with the patient in a culturally competent manner.	NYAM Primary Data Findings, September 2014 Potentially Preventable Admissions (PQI) Data on PQI 07 and PQI S02 Circulatory Composite, New York State Department of Health, 2012 Cardiovascular-Related Service Utilization, New York State Department of Health, 2012
8	Need for evidence-based strategies to promote self-management of asthma in the home-setting	Various environmental and social factors contribute to the prevalence of asthma in communities served by the PPS. High rates of serious housing violations overlap with high numbers of preventable respiratory PQI hospitalizations, particularly in the areas of Bedford-Stuyvesant, Crown Heights, Williamsburg-Bushwick, Flatbush and East Flatbush, among others. Community members in certain areas consider the prevalence of asthma to be "huge" and largely attribute it to indoor and outdoor environmental conditions. Smoking is common, especially in Chinese and Arab communities, resulting in high	NYAM Primary Data Findings, September 2014 Asthma-Related Utilization, NYS DOH 2012 PQI Asthma (S03, 05, 15), NYS DOH, 2012 Asthma Resources, GNYHA HITE, 2014

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[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		rates of asthma, lung cancer, and other respiratory problems. There is a high rate of asthma-related service utilization in Brooklyn, particularly in the Williamsburg/Bushwick, Sunset Park, and Downtown neighborhoods (among others), and a higher asthma ED visit rate in Brooklyn, compared to both NYC and NYS. There is also a high number of PQI respiratory composite hospitalizations located in North/Central Brooklyn, particularly in areas such as Bushwick and Crown Heights. These areas also have the highest concentration of potentially preventable hospitalizations for older adults for asthma/COPD. Our Asthma project 3.d.ii will include services such as a home-based visiting program, and will be implemented to help patients better manage asthma exacerbation factors in their daily lives in order to reduce avoidable service use and improve health outcomes.	Serious Housing Violations Rate, NYU Furman Center, 2013
9	Need to improve the access to, and retention in, HIV care through HIV project	HIV is the 9th leading cause of death in Brooklyn and among the top health concerns of residents, indicating the need for various community-based approaches to improve the accessibility of HIV services and patient engagement in care. To address the HIV project 4.c.ii , CCB, along with six other PPSs in NYC, engaged in joint planning to address major gaps in access to, and retention in, HIV care. Together, we have identified common sector projects (1,2,3,4,5,7,9), and have developed a common list of interventions to address those sectors. Interventions range from increasing HIV testing and viral suppression, to social marketing/educational campaigns and linkage to services for individuals in need.	NYAM Primary Data Findings, Sept. 2014 Bureau of HIV/AIDS Epidemiology data, reported by NYS Prevention Agenda 2013-2017 PLWHA, HIV Rate, Racial/Ethnic Differences, New Diagnoses, NYC DOHMH HIV/AIDS Surveillance Data 2011 HIV-Related Utilization, NYS DOH, 2012 HIV Resources, GNYHA HITE, 2014
10	Need to improve mental health and substance abuse infrastructure through MHSA project	Nearly one-third of respondents reported that pediatric and adolescent services were "not very available" or "not available at all." Primary data suggest that there are particular high need populations, including those with serious alcohol dependence and/or mental illness, who would benefit from more targeted and intensive services to ensure that a wide range of needs are addressed and systemic barriers are ameliorated. Medicaid beneficiaries with alcohol/drug use related service utilization are located in many of the same	NYAM Primary Data Findings, September 2014

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[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		neighborhoods with high numbers of beneficiaries utilizing behavioral health services: Williamsburg and Bushwick through Crown Heights, Brownsville, and East New York. The MHSA project 4.a.iii will promote evidence-based practices and train health professionals to better address MEB needs and better integrate substance use into MEB health promotion. CCB will implement this approach in a culturally-sensitive manner, collaborating through a City-Wide Workgroup with two other PPSs.	
11	Need to improve access to and provider education on palliative care resources	CCB palliative care clinical experts working in NYC identified PCP lack of knowledge about palliative care resources and the lack of time/expertise to discuss this subject with patients as principal causes of the low use of palliative care and hospice services. Further, according to the CNA survey, chronic pain was reported as the 4th most common self-reported health problem, at 19.1%. However, the CNA found there are only 12 facilities in Brooklyn serving Medicaid and the Uninsured that provide specialty pain management services. Twenty-three facilities offer hospice services. In 2011 NYS legislators and health officials recognized the importance of extending palliative care services to NYS residents by passing Public Health Law §2997-d, the Palliative Care Access Act. This law requires health care providers to provide information/counseling, as well as to facilitate access to palliative care to "all patients that could benefit from palliative care services." The CCB palliative care Project 3.g.i will integrate palliative care into PCP practices that have achieved PCMH certification using a care model that trains PCPs and other care team members to assess patients, educate them about palliative care support services, and create care plans that encompass pain/symptom relief and spiritual support. The project intervention will also leverage national guidelines and MOLST, and will work closely with MCOs.	Anecdotal Market Data CNA Brooklyn Resident surveys; GNYHA HITE data; Public Health Law §2997-d
12	Need to better manage diabetes in at-risk populations	CCB serves Brooklyn communities that have high utilization of diabetes services, suggesting that evidence-based strategies are needed to improve population health management and patient self-management to reduce avoidable service use. CCB will address through several of our projects, including the Health Home At Risk project 2.a.iii, which will link diabetes patients to care management	NYAM Primary Data Findings, September 2014 Diabetes-Related Utilization, NYS DOH, 2012 PQI Diabetes (S01, 01,03,

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[Maimonides Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		services and social supports, and through our Behavioral Health Integration project 3.a.i, which will help address potential drug interactions that could result in adverse outcomes for diabetes patients.	14), NYS DOH, 2012 Diabetes Resources, GNYHA HITE, 2014
13	Need to 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, eligibility for insurance, and familiarity with the US healthcare system, and identified certain neighborhoods with concentrations of minority groups. In many of these communities, smoking is a concern, and asthma, lung cancer, and other respiratory disease is more common. The CNA also found a lack of culturally and linguistically competent specialists and multi-specialty centers, particularly for behavioral and mental health. Language barriers also limit access to health information. The CNA found that 25% of residents speak English less than "very well," nearly half speak another language at home—primarily Spanish or Chinese. Among the challenges identified are: inability of providers, staff, and others to communicate in patients' native languages and concerns about quality and access among certain bilingual providers and interpretation services. This goal will be addressed under all CCB projects through our CSO, as described in Section 7.	NYAM Primary Data Findings, September 2014

File Upload: (PDF or Microsoft Office only)
Please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.

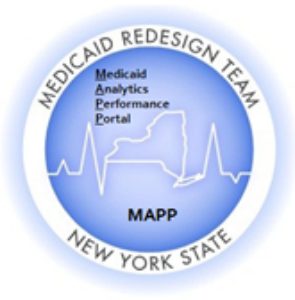| File Name	Upload Date	Description
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33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 6 of 11.pdf	12/20/2014 11:04:01 AM	Appendix A

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File Name	Upload Date	Description
33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 5 of 11.pdf	12/20/2014 11:01:58 AM	Appendix A
33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 4 of 11.pdf	12/20/2014 10:59:50 AM	Appendix A
33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 3 of 11.pdf	12/20/2014 10:57:46 AM	Appendix A
33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 2 of 11.pdf	12/20/2014 10:55:07 AM	Appendix A
33_SEC038_Appendix A - Maps of Brooklyn FINAL_part 1 of 11.pdf	12/20/2014 10:51:46 AM	Appendix A
33_SEC038_Appendix B_Detailed Tables_Health Care Resources.XLSX	12/19/2014 03:28:26 PM	Appendix B
33_SEC038_Appendix D.5 Brooklyn Survey Results.xlsx	12/18/2014 03:08:31 PM	Appendix D
33_SEC038_Appendix D.4.b Focus Group Codes.pdf	12/18/2014 03:07:36 PM	Appendix D
33_SEC038_Appendix D.4.a Key Informant Codes.pdf	12/18/2014 03:06:11 PM	Appendix D
33_SEC038_Appendix D.3 Brooklyn Key Informant List.pdf	12/18/2014 03:04:59 PM	Appendix D
33_SEC038_Appendix D.2 Organizations Collaborating on Brooklyn CNA.pdf	12/18/2014 03:03:50 PM	Appendix D
33_SEC038_Appendix D.1.c Resident Survey.pdf	12/18/2014 03:02:50 PM	Appendix D
33_SEC038_Appendix D.1.b Key Informant Interview Guide.pdf	12/18/2014 03:01:54 PM	Appendix D
33_SEC038_Appendix D.1.a Focus Group Guide.pdf	12/18/2014 03:01:06 PM	Appendix D
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33_SEC038_Appendix C_7_Brooklyn Key Informant List.pdf	12/18/2014 02:43:01 PM	Appendix C
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33_SEC038_Appendix C_3_CNA KI interview guide_final_072114.pdf	12/18/2014 02:39:47 PM	Appendix C
33_SEC038_Appendix C_2_CNA KI brief survey_final_072114.pdf	12/18/2014 02:37:48 PM	Appendix C
33_SEC038_Appendix C_1_CNA Survey_final_72214.pdf	12/18/2014 02:36:41 PM	Appendix C
33_SEC038_Appendix C_0_CNA Primary Data Collection documents described.pdf	12/18/2014 02:35:36 PM	Appendix C
33_SEC038_Appendix B_Detailed Tables_Community Based Resources.xlsx	12/18/2014 01:37:33 PM	Appendix B
33_SEC038_Appendix B_Detailed Tables_Population and Health Status.xlsx	12/18/2014 01:36:05 PM	Appendix B
33_SEC038_Appendix B_Primary Data Tables_Brooklyn_9-29-14.xlsx	12/18/2014 01:35:06 PM	Appendix B
33_SEC038_Appendix B_CNA Tables Charts and Graphs_FINAL 10.3.14.pdf	12/18/2014 01:33:15 PM	Appendix B
33_SEC038_Appendix B_CNA Detailed Tables_Population and Health Status.xlsx	12/18/2014 01:32:03 PM	Appendix B (and others) broken into multiple sections to enable upload
33_SEC038_Brooklyn_CNA_Report_FINAL 10.3.14.pdf	12/18/2014 11:51:42 AM	Main NYAM CNA Document
33_SEC038_DSRIP_CNA_BKlyn-Housing Resources.xlsx	12/18/2014 11:51:03 AM	Addendum on Brooklyn Housing Resources

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File Name	Upload Date	Description
33_SEC038_Addendum 1 Potentially Preventable Readmissions_amended October 2014.pdf	12/18/2014 11:49:57 AM	Updated PPR Report

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SECTION 4 – PPS DSRIP PROJECTS:

☑ **Section 4.0 – Projects:**

Description:

In this section, the PPS must designate the projects to be completed from the available menu of DSRIP projects.

Scoring Process:

The scoring of this section is independent from the scoring of the Structural Application Sections. This section is worth 70% of the overall Application Score, with all remaining Sections making up a total of 30%.

Please upload the Files for the selected projects.

*DSRIP Project Plan Application_Section 4.Part I (Text): (Microsoft Word only)

Currently Uploaded File: **Maimonides_Section4_Text_CCB Project Application_FINAL SUBMISSION 12 22.docx**
Description of File
CCB Final Project Application Submission
File Uploaded By: ajberman
File Uploaded On: 12/22/2014 12:30 PM

*DSRIP Project Plan Application_Section 4.Part II (Scale & Speed): (Microsoft Excel only)

Currently Uploaded File: **Maimonides_Section4_ScopeAndScale_Scale Speed_CCB 12.21 Submission.xlsx**
Description of File
CCB Draft Speed/Scale Submission; Final by 1/12
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Maimonides Medical Center (PPS ID:33)

SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

Description:

The overarching DSRIP goal of a 25% reduction in avoidable hospital use (emergency department and admissions) will result in the transformation of the existing health care system - potentially impacting thousands of employees. This system transformation will create significant new and exciting employment opportunities for appropriately prepared workers. PPS plans must identify all impacts on their workforce that are anticipated as a result of the implementation of their chosen projects.

The following subsections are included in this section:

    5.1 Detailed workforce strategy identifying all workplace implications of PPS

    5.2 Retraining Existing Staff

    5.3 Redeployment of Existing Staff

    5.4 New Hires

    5.5 Workforce Strategy Budget

    5.6 State Program Collaboration Efforts

    5.7 Stakeholder & Worker Engagement

    5.8 Domain 1 Workforce Process Measures

Scoring Process:

This section is worth 20% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

    5.1 is worth 20% of the total points available for Section 5.

    5.2 is worth 15% of the total points available for Section 5.

    5.3 is worth 15% of the total points available for Section 5.

    5.4 is worth 15% of the total points available for Section 5.

    5.5 is worth 20% of the total points available for Section 5.

    5.6 is worth 5% of the total points available for Section 5.

    5.7 is worth 10% of the total points available for Section 5.

    5.8 is not valued in points but contains information about Domain 1 milestones related to Workforce Strategy which must be read and acknowledged before continuing.

☑ Section 5.1 – Detailed Workforce Strategy Identifying All Workplace Implications of PPS:

Description:

In this section, please describe the anticipated impacts that the DSRIP program will have on the workforce and the overall strategy to minimize the negative impacts.

*Strategy 1:

In the response, please include

- Summarize how the existing workers will be impacted in terms of possible staff requiring redeployment and/or retraining, as well as potential reductions to the workforce.
- Demonstrate the PPS' understanding of the impact to the workforce by identifying and outlining the specific workforce categories of existing staff (by category: RN, Specialty, case managers, administrative, union, non-union) that will be impacted the greatest by the project, specifically citing the reasons for the anticipated impact.

A well-trained, highly engaged, and patient-focused workforce is essential to achieving CCB's DSRIP goals (see Section 1). At the same time, DSRIP implementation will significantly impact the over 50,000 professional, technical, administrative, and other individuals employed by CCB's Participants and serving Medicaid beneficiaries.

The CCB planning process has addressed three ways in which DSRIP will affect the workforce:

First, many existing employees, particularly those in primary care and behavioral health settings and those that assist in coordinating

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hospital discharges, will undergo intensive training on working as a team, care coordination, patient engagement, and cultural competency. An estimated 30% of ambulatory care and 15% of in-patient professionals will undergo training to improve skills and enable them to successfully implement CCB's 10 clinical projects.

Second, CCB's DSRIP projects will generate an estimated 1,500 new jobs within current and planned CCB locations (e.g. new primary care locations) that can be filled by existing and new employees. Most of the new positions will be for care managers, care navigators, peer services, mental health providers, and nursing professionals, who will support the patient centered medical home (PCMH), Health Homes (HHs), patients at-risk for HHs, and behavioral health sites. We also anticipate limited hiring needs within the Central Services Organization (CSO), including managerial, administrative and IT staff. Beyond DSRIP, surveyed CCB Participants identified an approximately 15% turnover rate in existing positions, consistent with industry trends, that will result in additional hiring needs. These numbers are not factored into CCB's new hire workforce model and all numbers used for workforce estimates are preliminary and subject to change.

Based on analyzing the effect of a 25% reduction in potentially preventable hospitalizations, we anticipate a reduction in 104 beds (approximately 500 positions), over the five-year demonstration period. CCB is committed to identifying any workers affected by DSRIP-related changes early-on and providing such workers with opportunities for retraining, and with training and career services provided by the 1199 Training and Education Fund (TEF) and other vendors.

CCB's third workforce challenge will be to retrain a significant number of workers and recruit new, dedicated professionals to help carry out DSRIP transformations. CCB will plan for this challenge with labor, staff representatives, and other stakeholders through our Workforce Workgroup and in collaboration with other Brooklyn PPSs.

Transformations to the delivery system will affect providers across the continuum of care, with the most significant changes affecting the following categories of staff and involving Retraining (RT), Redeployment (RD), and/or New Hires (NH):
1) Primary care physicians (PCPs) will need RT and NH as they move to PCMH Level 3 and become an integral part of many ambulatory-based projects
2) Care managers/navigators will need RT and NH due to the expansion of the PCMH and HH models, the at-risk HH project, and palliative care project
3) Peer advocates and community health workers will need RT and NH to provide a link to patients in outpatient and home settings, including in CCB's Asthma and Cardiovascular projects
4) Mental health providers will need RT and NH under the integration of primary care and behavioral health services project and through the expansion of the IMPACT model
5) Nursing staff (medical assistants, LPNs, RNs) will require RT, NH, and RD given the elimination of certain inpatient positions and increased demand for ambulatory care, and expansion of primary care, PCMH, and HH services
6) Administrative and IT staff, including data and analytics, finance, marketing, IT, and call center personnel will require NH and RT

*Strategy 2:

In the response, please include

- Please describe the PPS' approach and plan to minimize the workforce impact, including identifying training, re-deployment, recruiting plans and strategies.
- Describe any workforce shortages that exist and the impact of these shortages on the PPS' ability to achieve the goals of DSRIP and the selected DSRIP projects.

CCB's DSRIP success is contingent upon effective engagement of workers. CCB's planning to date has identified several strategies to minimize negative effects.

First, many existing and new workers will need new knowledge and skills, including care coordination, interdisciplinary team-based care planning, chronic disease management, and Health Information Technology (HIT) training. During planning and into early Year 1 implementation, and guided by the Workforce Workgroup, CCB will complete a workforce study to inform our calculation of retraining and redeployment needs and assess available worker support. CCB will then implement a large scale training initiative, carried out by established vendors, including TEF and Center for Urban Community Services (CUCS). Certain trainings will lead to certifications/licensing for existing employees. CCB aims to use training opportunities as a way to enhance skills and develop career ladders for a range of union and non-union workers, including those at entry levels such as home health aides and nursing assistants, consistent with the State Workforce Investment Board's Career Pathways Workgroup 2012 report and recommendations.

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Second, as noted above, we estimate that 500 inpatient positions may be eliminated. CCB will collaborate with TEF to identify at-risk positions and analyze skills transferability, thereby creating job transition maps and career ladders within the PPS in order to ensure that these workers are connected to new employment opportunities. CCB will contract with one or more vendors including TEF to provide workers with counseling, job search assistance, and employment workshops. These efforts will be linked to and coordinated with the recruiting efforts, described below, to ensure that CCB Participant staff are connected to new employment opportunities within CCB.

Third, CCB will need to recruit to fill existing worker shortages that will be further strained by DSRIP, particularly in light of an aging demographic (30% of the population is over 60).   For example, in Brooklyn there are currently 21.1 general psychiatrists per 100,000, less than half the NYC rate of 49. In the CNA and during planning discussions, CCB has estimated the supply gap that DSRIP will create for a range of positions including psychiatrists, primary care providers, social workers, care managers/navigators, peer services, nursing professionals, and administrative and IT roles. CCB estimates it will require an estimated 1,500 new workers to address these shortages.

To fill these gaps, CCB's workforce planning is being done collaboratively with other PPSs in Brooklyn. The PPSs will jointly develop a recruitment strategy for hard-to-fill positions so that PPSs collaborate rather than compete in this space. The PPSs will coordinate and discuss developing centralized workforce support infrastructure to support job recruitment for new positions; catalogue available positions; provide staffing and placement support; maintain an inventory of position postings and recruitment materials; and provide communication and marketing services for available positions.

Fourth, CCB will also use flexible hours, job sharing and explore other tactics to recruit and retain especially hard to recruit positions as feasible within contractual agreements. The effect of recruitment challenges on DSRIP projects will be built into our projections on speed and scale.

Fifth, stakeholder and workforce engagement are vital to successful mitigation strategies. CCB has created a Workforce Workgroup consisting of health care organizations, union representatives, staff representatives, and workforce training organizations to develop a workforce strategy that integrates mitigation techniques. As delineated under its Charter, the Workgroup will develop and monitor workforce approaches in concert with key stakeholders.

*Strategy 3:

In the table below, please identify the percentage of existing employees who will require re-training, the percentage of employees that will be redeployed, and the percentage of new employees expected to be hired. A specific project may have various levels of impact on the workforce; as a result, the PPS will be expected to complete a more comprehensive assessment on the impact to the workforce on a project by project basis in the immediate future as a Domain 1 process milestone for payment.

Workforce Implication	Percent of Employees Impacted
Redeployment	1%
Retrain	27%
New Hire	3%

✅ Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

Note: If the applicant enters 0% for Retrain ('Workforce Implication' Column of 'Percentage of Employees Impacted' table in Section 5.1), this section is not mandatory. The applicant can continue without filling the required fields in this section.

Description:
Please outline the expected retraining to the workforce.

*Retraining 1:
Please outline the expected workforce retraining. Describe the process by which the identified employees and job functions will be retrained. Please indicate whether the retraining will be voluntary.

CCB defines the term "retrain" to mean improving knowledge and enhancing skills of workers. Retraining efforts will significantly overlap with training efforts for new hires. CCB will undertake the following retraining process.

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Conduct a Training Needs-Assessment: CCB will create an inventory of necessary training modules and a listing of staff that require training in those areas. CCB expects that 30% of ambulatory-based professionals and 15% of inpatient professionals will receive some form of retraining, including inpatient providers involved in care management and discharge planning who will be key to safe and effective transitions to home- and community-based care. A range of providers may require training in cultural competency, with CNA and other demographic data suggesting that borough-wide, 16.8% of persons are non-U.S. citizens and 24.3% speak English "less than well."

Develop Curricula: CCB will utilize, adapt, and/or develop training curricula for the identified models in key areas including care coordination and management, chronic and home-based disease management, patient engagement methods, cultural competency, and HIT. CCB has rich existing curricula upon which to draw, including a Care Manager training program jointly developed with TEF that has been utilized with over 400 professionals and covers such topics as cultural competency, chronic conditions and co-morbidities, and patient-centered communication. For certain trainings, CCB will contract with technical assistance providers who have experience deploying evidence-based protocols and interventions. For example, CCB intends to work with the Institute for Family Health on IMPACT model training, and with CUCS on Critical Time Intervention Training. CCB also intends to build further relationships and, as necessary, develop contractual agreements with community and four-year colleges (e.g. the CUNY schools) with programs that align with DSRIP interventions, to ensure access to educational supports and develop a sustainable pipeline of staff over the life of DSRIP and beyond.

Deploy Training Modules: CCB will then implement our training modules with the support of TEF, which has worked with Maimonides Medical Center on staff training for a Centers for Medicare & Medicaid Innovation-funded grant, and other experienced vendors. In developing the training timeline, CCB will combine trainings, to the extent possible, in order to speed deployment, take advantage of synergies in curriculum, and reduce time away from work.

Track Success and Ensure Oversight: CCB intends to track the success of trainings to measure their effectiveness in meeting SDOH required DSRIP metrics, skills enhancement and worker enhancement, as well as worker-level feedback on training utility. The Workforce Workgroup will serve as the governing authority, overseeing retraining and other workforce strategy and ensure appropriate engagement of workers in decision-making. CCB will manage vendor trainings through the CSO, which will have a Vice President of Workforce Development who will also sit on the Workforce Workgroup.

Encouraging Voluntary Retrainings: Although each Participant will retain ultimate authority regarding training decisions—subject to collective bargaining and other agreements and related worker rights—CCB will strongly encourage all Participants to offer retraining on a voluntary basis. CCB's overarching commitment is to ensuring that all existing staff have a meaningful role in the newly shaped landscape of health care delivery under DSRIP. CCB will aim to promote workers' sense of ownership, enthusiasm, and opportunities for professional growth around DSRIP; and CCB Participants will be encouraged to discuss training and retraining programs with staff by emphasizing the role of enhanced training in facilitating career ladders and professional growth.

*Retraining 2:
Describe the process and potential impact of this retraining approach, particularly in regards to any identified impact to existing employees' current wages and benefits.

Most of CCB's retrained workers will be returning to their same roles with an enhanced skill-set; accordingly, any anticipated effects on current wages and benefits are generally neutral to positive.

As staff roles and responsibilities evolve under DSRIP, CCB will work to clarify the taxonomy among titles and functions and propose adjustments, as appropriate, to salary bands for positions that reflect staff skill development, or certifications/recertification. Human resources professionals from CCB Participants will communicate changes in compensation and potential for career ladder advancements. While compensation terms are dictated by Participant budgets, policies, and the terms of collective bargaining and other agreements, CCB will encourage Participants to implement the best practice of providing incumbent workers with the time and funding to complete necessary retraining programs if they are a condition of continued employment. We anticipate that, over time, salaries paid for work in ambulatory settings may grow as DSRIP priorities are addressed.

*Retraining 3:
Articulate the ramifications to existing employees who refuse their retraining assignment.

CCB will encourage Participants to provide workers with advance notice of the potential elimination of positions, as well as time to complete retraining programs. Employees who do not accept an available position may be included in a redeployment pool, through

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which they can search for a new position that better suits their preferences.

The consequences for employees will also vary depending upon an employee's contract terms. CCB Participants will adhere to the terms of applicable collective bargaining and other agreements in place.
Generally, employees who continue to refuse redeployment will be referred to employment counseling to help link them with vacancies.

The Placement Table in this section discusses placement impacts for redeployed positions, as described in Section 5.3.

*Retraining 4:
Describe the role of labor representatives, where applicable – intra or inter-entity – in this retraining plan.

To date, labor representatives from TEF, 1199 SEIU, CIR SEIU, NYSNA, and Maimonides Medical Center have participated in workforce planning, including retraining planning. They have also actively contributed to Care Model and Program Planning and Steering Committee meetings. The Workforce Workgroup, which will begin regularly convening in early 2015, will include labor representatives, as well as members of staff in a range of roles. Workgroup members will participate in all network-wide training assessments and the development of training methodologies, timelines, and worker noticing. Labor and other staff representatives will play an integral part in the planning and implementation of the workforce strategy, including helping to frame and disseminate key messages about the changes underway and how retraining contributes to the achievement of DSRIP goals.

During CCB's most recent convening that discussed workforce, labor representatives and other Participants emphasized the importance of educating workers about DSRIP, actively engaging them, guarding against wage erosion resulting from redeployment, and generating worker ownership of and enthusiasm in the changes underway.

*Retraining 5:
In the table below, please identify those staff that will be retrained that are expected to achieve partial or full placement. Partial placement is defined as those workers that are placed in a new position with at least 75% and less than 95% of previous total compensation. Full placement is defined as those staff with at least 95% of previous total compensation.

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	55%
Partial Placement	25%

☑ Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:
Please outline expected workforce redeployments.

*Redeployment 1:
Describe the process by which the identified employees and job functions will be redeployed.

CCB defines redeployment as moving a position to another division or location within the same entity. CCB anticipates that under CCB's DSRIP projects, approximately 500 inpatient positions such as nursing personnel or medical technicians may be eliminated. This potential is consistent with the observations made by the Berger Commission and the Medicaid Redesign Team (MRT) Brooklyn Work Group, which noted before DSRIP that there is existing excess inpatient bed capacity in Brooklyn. This excess capacity will need to be rationalized through DSRIP, under CCB's IDS project and through collaboration with other PPSs and stakeholders.

CCB's redeployment process is as follows, and will be guided by the foundational principle of ensuring that any displaced workers are connected to new employment opportunities.

First, CCB will identify workers at-risk of displacement early on, and will contract with one or more vendors including TEF to provide training to these staff to ensure that they have the skills needed to participate in a DSRIP-transformed delivery system. The vendors will guide these workers through the key steps of assessment, counseling, training, and placement, drawing on past experience in the provision of training and related services to support transformation.

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Second, CCB has budgeted for a robust set of trainings and services to support its training efforts. CCB will utilize the DSRIP training funds to offer staff retraining opportunities suitable for available positions, allowing workers to up-skill and take advantage of new career ladders in the Brooklyn health workforce. Specialized retraining may be necessary for individuals interested in moving from inpatient to ambulatory care settings, to include such topics as health literacy, patient self-management skills, motivational interviewing, chronic and home-based disease management, and HIT.

Third, CCB's workforce budget includes allocations for contingency funding to assist with the development of systems to manage job placement and redeployment services across the PPS.

This redeployment process will be guided by the representatives—labor, staff, and other—on the CCB Workforce Workgroup, who will emphasize transparency and open engagement of all potentially affected staff.

*Redeployment 2:
Describe the process and potential impact of this redeployment approach, particularly in regards to any identified impact to existing employees' current wages and benefits.

Providing health workers with appropriate wages is a foundational principle of CCB's workforce strategy. CCB is cognizant that redeployments and related retrainings may affect wages, depending upon individuals' specific positions and the potential for up-skilling with CCB's robust training. For instance, historically, pay in community-based ambulatory facilities has been lower than pay for similar roles in hospitals. CCB has estimated the placement impacts for redeployed workers in the Placement Impact table in Section 5.2.

In order to better calculate the estimated effect on wages and benefits of anticipated changes, and communicate these appropriately with employees and other stakeholders, CCB will evaluate appropriate salary bands and career ladders during workforce implementation planning. CCB will keep in mind the need at minimum to maintain base wages at current levels if the workforce is to achieve DSRIP goals and bear the burden that change can impose on CCB Participants and staff.

*Redeployment 3:
Please indicate whether the redeployment will be voluntary. Articulate the ramifications to existing employees who refuse their redeployment assignment.

CCB will encourage Participants to identify workers at risk of displacement early on, and provide workers time and funding to complete necessary retraining.

Displaced staff will have the opportunity to apply for alternative positions within CCB for which they are qualified. Employees whose positions are eliminated and who do not accept a redeployment assignment may be included in a redeployment pool, through which they can search for a new position. Generally, employees who continue to refuse redeployment will be referred to employment counseling to link them with vacancies. Yet, the ramifications for employees will vary depending upon an employee's contract. CCB Participants will adhere to the terms of applicable collective bargaining and other agreements.

*Redeployment 4:
Describe the role of labor representatives, where applicable – intra or inter-entity – in this redeployment plan.

To date, labor representatives from 1199SEIU, CIR SEIU, NYS Nurses Association, and Maimonides Medical Center have participated in workforce planning, including the discussion and early development of redeployment planning. The Workforce Workgroup will include such labor representatives, as well as representative workers themselves, in the decision-making structure. Workgroup members will participate in network-wide redeployment assessments and the development of redeployment methodologies, timelines, and worker noticing strategies. Labor and other worker representatives will play an integral part in the planning and implementation of the workforce strategy, including helping to frame and disseminate key messages about the changes underway, through redeployments and otherwise, and averting risks of downward mobility and wage erosion.

✅ Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

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Please outline expected additions to the workforce. Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

*New Hires:

Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

CCB's DSRIP projects will create demand for a number of new positions. CCB has conducted preliminary modeling to obtain directional estimates on new hiring needs, based upon CNA and other New York health workforce planning data, demographic data, and professional and clinical guidance regarding appropriate patient to provider ratios to provide cost-effective, high-quality care. In our modeling, CCB assumed that all staff whose positions are eliminated would be given the opportunity to apply for new/expanded positions and that any remaining gaps would be filled with new hires recorded in the table below.

CCB will conduct a more detailed workforce survey as part of implementation and Year 1 planning to confirm the estimated number of new positions in each of the following categories:

1) Case managers: CCB relies heavily on care managers and care navigators to coordinate care throughout the PPS, including in Health Homes (HHs), PCMHs, and in the At-Risk HH and Palliative Care projects. As CCB expects to dramatically expand service delivery to HH and HH at-risk patients through DSRIP, it will have sizeable worker growth in the two Participant HHs, PCMHs, and other outpatient care management settings.

2) Mental health providers: Mental health providers (including psychiatrists, psychologists, substance abuse counselors, certain social workers, and other specialists) will be essential to provide expanded mental health services to the population, including through co-location of primary care and behavioral health sites. As the CNA demonstrated, Brooklyn currently has a deficit of mental health providers, and CCB intends to help address this deficit through DSRIP workforce expansions.

3) Physicians and nurse practitioners: Physician and nurse practitioner hires will be necessary through the IDS project. These professionals will staff primary care and multispecialty practices, urgent care centers, EDs and mental health and substance abuse programs.

4) "Other" professionals: CCB has used the "Other" category to include nursing staff (medical assistants, LPNs, RNs), peer services (peer advocates/counselors, community health workers), Physician Assistants, and pharmacists. Ambulatory nursing staff will be an essential part of primary care expansion, PCMH Level 3 attainment, care transitions to reduce 30-day readmissions, and other projects. Peer services will be important in CCB's Asthma home-based education and cardiovascular projects, given that peers serve as an important link to patients in outpatient and home settings. CCB also anticipates a need for new pharmacists, particularly to support Care Transitions, At Risk HH, Cardiovascular, and Palliative Care projects.

5) Administrative and IT staff: There will be additional staff needed for CCB's CSO to support the transformation. DSRIP will generate new employment opportunities for administrative and financial personnel, data and analytics professionals, marketing staff, IT personnel (to support Dashboard and transition to EHRs, among other functions), and call center staff.

CCB will plan recruitment efforts in collaboration with other PPSs in Brooklyn to ensure alignment of strategies. CCB will also engage TEF's Employment Center as well other experienced vendors in staff trainings and related efforts, including recruitment and pre-screening new applicants for new positions. CCB will promote transparency in all recruitment efforts, ensuring that all interested individuals have an opportunity to become engaged in the health workforce under DSRIP and beyond.

In the table below, please itemize the anticipated new jobs that will be created and approximate numbers of new hires per category.

Position	Approximate Number of New Hires
Administrative	30
Physician	10
Mental Health Providers Case Managers	1,315
Social Workers	40
IT Staff	10
Nurse Practitioners	30
Other	65

☑ **Section 5.5 - Workforce Strategy Budget:**

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In the table below, identify the planned spending the PPS is committing to in its workforce strategy over the term of the waiver. The PPS must outline the total funding the PPS is committing to spend over the life of the waiver.

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	2,457,000	1,755,000	1,263,600	842,400	702,000	7,020,000
Redeployment	567,000	405,000	291,600	194,400	162,000	1,620,000
Recruiting	56,700	40,500	29,160	19,440	16,200	162,000
Other	680,400	486,000	349,920	233,280	194,400	1,944,000

☑ Section 5.6 – State Program Collaboration Efforts:

*Collaboration 1:
Please describe any plans to utilize existing state programs (i.e., Doctors across New York, Physician Loan Repayment, Physician Practice Support, Ambulatory Care Training, Diversity in Medicine, Support of Area Health Education Centers, Primary Care Service Corp, Health Workforce Retraining Initiative, etc.) in the implementation of the Workforce Strategy –specifically in the recruiting, retention or retraining plans.

CCB surveyed Participants to identify State-Based training and recruitment programs from which they have benefitted and that they intend to continue to utilize during the DSRIP demonstration period. Based on Participants' successful experiences to date, CCB intends to leverage and further investigate use of the State programs mentioned below.

First, mental health providers, including South Beach Psychiatric Center, have benefitted from the New York State Office of Mental Health Collaborative Documentation trainings, which train staff on enabling clinicians and clients to collaborate in documenting assessments, service planning, and ongoing client-practitioner interactions.

Participants also currently utilize and intend to further engage with the Doctors across New York program to help train and prepare physicians to care for Brooklyn's diverse population.

Third, the Health Workforce Retraining Initiative will continue to be a key resource for our Participants in training redeployed workers, including training new care managers within the Health Home and PCMH settings.

Fourth, Brooklyn- Queens-Long Island Area Health Education Center (BQLI-AHEC) has a track record of addressing health workforce issues in underserved communities and is another potential resource that Participants may utilize.

During implementation planning, as CCB completes a comprehensive workforce survey, we will review the available State-funded initiatives and identify further opportunities to utilize these programs to facilitate training and recruitment efforts. CCB recognizes that the State is an important partner in retraining efforts.

☑ Section 5.7 - Stakeholder & Worker Engagement:

Description:
Describe the stakeholder and worker engagement process; please include the following in the response below:

*Engagement 1:
Outline the steps taken to engage stakeholders in developing the workforce strategy.

To better understand and address any negative workforce effects, CCB created a Workforce Workgroup consisting of health care organizations, labor representatives from 1199SEIU and NYSNA, worker representatives, and workforce training organizations. As delineated under the Workgroup Charter, the Workgroup will lead a concerted and ongoing effort throughout planning and implementation to develop and routinely monitor workforce approaches in concert with key stakeholders. CCB's workforce planning—including discussions of training, redeployment, and recruitment needs—is being done collaboratively with other Brooklyn PPSs, in order to ensure alignment of workforce planning.

Starting in November 2014, CCB also convened key stakeholders, including union representatives and health care organizations, to begin discussions regarding DSRIP's workforce implications and key mitigation strategies. TEF will provide consultative expertise to the PPS

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with respect to labor management collaboration.

*Engagement 2:

Identify which labor groups or worker representatives, where applicable, have been consulted in the planning and development of the PPS approach.

CCB's planning and development process has involved a range of labor and worker representatives, including the following individuals:
- Selena Pitt, 1199 TEF
- Tom McIntyre, 1199
- Sandi Vito, 1199 TEF
- Laura McSpedon, Organizer, CIR SEIU
- Eliza Carboni, Area Director, NYS Nurses Association

These individuals have advised on key components of a workforce strategy, including ensuring that all existing workers have an active role in the transformation, and that CCB proactively prepares for, and mitigates against, any elimination of worker positions by ensuring that individuals are given opportunities to connect to the many new positions that DSRIP will create.

*Engagement 3:

Outline how the PPS has engaged and will continue to engage frontline workers in the planning and implementation of system change.

CCB will engage frontline workers in the planning and implementation of system change through the PAC and through the Workforce Workgroup, which will spearhead the planning and implementation of system change, with regular meetings beginning in early 2015.

More generally, CCB will use 'town hall' meetings to educate staff at all levels about DSRIP and solicit workers' feedback on planning efforts through surveys and/or focus groups, as appropriate. Like all persons affected by DSRIP, frontline workers will also be encouraged to obtain information on a CCB website with workforce information, and to provide comments, suggestions, or concerns by communicating with CCB's established governance structure.

*Engagement 4:

Describe the steps the PPS plans to implement to continue stakeholder and worker engagement and any strategies the PPS will implement to overcome the structural barriers that the PPS anticipates encountering.

CCB is committed to actively engaging stakeholders and workers in workforce strategy design and implementation. CCB has identified three potential structural barriers for remediation:
1) Cross-PPS coordination: CCB will continue to communicate and openly coordinate with other PPSs around how to recruit essential workers.
2) Robust communication with frontline workers: CCB will engage workers in planning and implementation through the PAC and Workgroup, as well as surveys and/or focus group discussions. CCB's Workgroup will also work to identify ways to improve communication.
3) Divergence of views within Workgroup: The Workgroup aims to ensure that all voices are heard in workforce strategy planning and implementation. Workgroup decision-making will operate using a consensus-based process (75% of present members), which will build support and buy-in for decisions. CCB's conflict-resolution strategy (outlined in the Governance section) will apply.

✅ Section 5.8 - Domain 1 Workforce Process Measures:

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

- Implementation plan outlining the PPS' commitment to achieving its proposed workforce strategy (Due March 1, 2015).
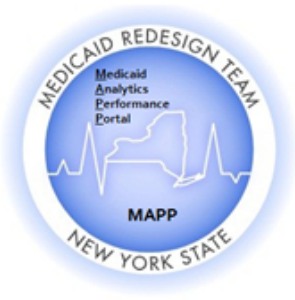
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- Periodic reports, at a minimum semi-annually and available to PPS members and the community, providing progress updates on PPS and DSRIP governance structure.
- Supporting documentation to validate and verify progress reported on the workforce strategy, such as documentation to support the hiring of training and/or recruitment vendors and the development of training materials or other documentation requested by the Independent Assessor.

☑ Please click here to acknowledge the milestones information above.

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SECTION 6 – DATA SHARING, CONFIDENTIALITY & RAPID CYCLE EVALUATION:

Section 6.0 – Data-Sharing, Confidentiality & Rapid Cycle Evaluation:

Description:

The PPS plan must include provisions for appropriate data sharing arrangements that drive toward a high performing integrated delivery system while appropriately adhering to all federal and state privacy regulations. The PPS plan must include a process for rapid cycle evaluation (RCE) and indicate how it will tie into the state's requirement to report to DOH and CMS on a rapid cycle basis.

This section is broken into the following subsections:
    6.1 Data-Sharing & Confidentiality
    6.2 Rapid-Cycle Evaluation

Scoring Process:

This section is worth 5% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
    6.1 is worth 50% of the total points available for Section 6.
    6.2 is worth 50% of the total points available for Section 6.

☑ Section 6.1 – Data-Sharing & Confidentiality:

Description:

The PPS plan must have a data-sharing & confidentiality plan that ensures compliance with all Federal and State privacy laws while also identifying opportunities within the law to develop clinical collaborations and data-sharing to improve the quality of care and care coordination. In the response below, please:

*Confidentiality 1:

Provide a description of the PPS' plan for appropriate data sharing arrangements among its partner organizations.

> CCB's plan for appropriate data sharing is to use our Central Services Organization (CSO) to, across our network, quickly provide needed trainings, monitor compliance with applicable privacy laws, and require corrective actions when necessary (as described below). Effective data sharing is an essential element of DSRIP's provider collaboration and underpins our integrated delivery system, and CCB aims to foster clinical collaboration and data sharing to the greatest extent possible while carefully adhering to important federal and state laws that protect privacy.
>
> CCB's experience with data sharing in the RHIO and Health Home contexts will guide its approach: Maimonides has played a key role in the Healthix RHIO (previously BHIX) for several years and serves on Healthix's Board. Maimonides is also a co-owner and manager of the Brooklyn Health Home, and in that capacity has managed the development of a secure platform for patient information sharing that goes beyond the RHIO.

*Confidentiality 2:

Describe how all PPS partners will act in unison to ensure data privacy and security, including upholding all HIPAA privacy provisions.

> As a condition of joining CCB, each organization will sign a data-sharing agreement requiring adherence to federal and state privacy requirements, including requirements that a) data only be used for permitted uses under HIPAA; b) data only be shared for CCB patients who have consented to such sharing; c) certain alcohol/drug abuse information is exchanged in accordance with 42 CFR Part 2; and d) data storage complies with HIPAA security standards. Through its IT Committee, CCB will establish a formal program for data sharing compliance. Through our CSO, we will also provide privacy-law trainings, monitor participant compliance, and require corrective actions when necessary (as described in Section 2). The PPS will use the existing IT platform, the Dashboard, which allows for dynamic tracking of patient consent to ensure privacy law compliance.

*Confidentiality 3:

Describe how the PPS will have/develop an ability to share relevant patient information in real-time so as to ensure that patient needs are met and care is provided efficiently and effectively while maintaining patient privacy.

NYS Confidentiality – High

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CCB will make the Healthix RHIO the central platform for sharing patient information. Providers that have already developed EHR systems will be encouraged to connect to the RHIO as soon as they are able, so that information can be exchanged in real-time during the early stages of DSRIP. For providers that do have EHRs but are unable to connect to the RHIO in Years 1 and 2, CCB will make sure that traditional, one-to-one exchanges are in place for projects that rely on the exchange of information; for example, connections will be established between providers sharing space. Providers that do not have EHRs (and those that have EHRs but are unable to connect to the RHIO) will be given access to RHIO data through our Dashboard portal—in accordance with privacy laws—so that they can understand the health needs of their patients. The Dashboard will be critical for information exchange, and CCB will extend it to all Participants, including clinical, social and community based organizations. Additionally, through Project 2.a.i, CCB will support PCPs and other safety net providers in meeting PCMH Level 3 criteria by the end of DY3, thereby enhancing connectivity. In addition, CCB will work with Medicaid MCOs to obtain claims data to supplement clinical data.

CCB's CSO will provide guidance and assistance to Participants to foster this real-time exchange of information. The CSO will identify protocols and guidance to include specific data elements (e.g. age, disease-specific data points, PCP assignment) which are required to be shared by each Participant to support DSRIP projects. The CSO will also provide assistance to Participants in selecting EHR vendors to ensure that industry and federal standards related to these specific data elements and interoperability are met. CCB will also provide trainings to Participants on how to use the RHIO and how to use both clinical and claims data to improve patient care, as necessary.

☑ Section 6.2 – Rapid-Cycle Evaluation:

Description:

As part of the DSRIP Project Plan submission requirements, the PPS must include in its plan an approach to rapid cycle evaluation (RCE). RCE informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to be overseen and managed.

Please provide a description of the PPS' plan for the required rapid cycle evaluation, interpretation and recommendations. In the response, please:

*RCE 1:

Identify the department within the PPS organizational structure that will be accountable for reporting results and making recommendations on actions requiring further investigation into PPS performance. Describe the organizational relationship of this department to the PPS' governing team.

Successfully monitoring and improving performance is foundational to establishing value-based contracting. The Quality Division of the CSO will be responsible for reporting results against DSRIP targets. Results will be shared with the Care Delivery and Quality Committee, a group of clinical experts and champions that will review performance on a project, Participant, Hub, PPS, and population level and recommend changes to protocols, procedures, workflows, and actions requiring further investigation into PPS performance.

The Committee will elevate recommendations to the Executive Committee. Upon Executive Committee determination, the CSO will disseminate new/revised protocols, modify operational procedures or workflows, contact non-performing Participants, or update PPS systems, for implementation by Participants. CCB Participants will have authority to act immediately on improvements and to correct protocols that may cause harm, without waiting for Committee review and approval, so long as the Executive Committee is notified in writing of the intention to do so, along with a justification.

*RCE 2:

Outline how the PPS intends to use collected patient data to:
- Evaluate performance of PPS partners and providers
- Conduct quality assessment and improvement activities, and
- Conduct population-based activities to improve the health of the targeted population.

To evaluate performance, assess quality, and identify improvement opportunities, CSO staff will incorporate insights from evidence and leading practices into care protocols consistent with DSRIP objectives, review performance data, and monitor/report on progress to CCB, Participants, and stakeholders. CCB will use our CSO's robust data analytics and evaluation infrastructure to conduct weekly review of updated patient-level data and DSRIP metrics (Domain 2 and 3) from the CCB Dashboard, EMRs, claims, surveys or reporting data, and will use this data to identify patients for targeted outreach and management for health improvement activities. Population Health metrics

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will be measured monthly.

The Care Delivery and Quality Committee will develop recommendations for protocol improvements and conduct oversight of individual providers to ensure effectiveness, and will review data for population trends suggesting additional protocols, interventions or other needed quality improvements.

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*RCE 3:

Describe the oversight of the interpretation and application of results (how will this information be shared with the governance team, the Providers and other members, as appropriate).

The CSO's Chief Medical Officer will have oversight responsibility for analytics and quality management and will ultimately be responsible for providing and interpreting CCB data for the Care Delivery and Quality Committee (a group of clinical experts and champions) and across all Participants. Leveraging this existing IT infrastructure, the CSO will generate summary key metrics reports that will be provided to all Partners on a monthly basis, and will also be reviewed at regular Care Delivery and Quality and Executive Committee meetings. Data will be benchmarked to leading practices, state and PPS targets, and other measures to provide context to the Committee. The CSO will also generate key metrics reports for individual Participants which will be shared via the Dashboard. Reports demonstrating lower than anticipated performance will go to the Director of Provider/Patient Engagement for corrective action as needed.

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*RCE 4:

Explain how the RCE will assist in facilitating the successful development of a highly integrated delivery system.

Through rapid cycle evaluation, CCB will use repeated measures over time, evaluating them at least weekly, to understand the relationship between implementation of our new models, immediate changes in outcomes, and the rate of change in outcomes. Using statistical methods and the data sources described above, we will be able to measure the results of our models and understand how to best improve outcomes, resulting in a high-functioning PPS. Importantly, our CSO will collect information on providers, their culture, and how they implement interventions to identify best practices for successful interventions. CCB will also provide regular feedback to participating providers on a host of metrics, and will undertake efforts to share best practices and, as described above, disseminate them and ensure through knowledge-sharing activities that they are promptly incorporated into CCB's implementation efforts through the CSO.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

Description:

Overall DSRIP and local PPS success hinges on all facets of the PPS achieving cultural competency and improving health literacy. Each PPS must demonstrate cultural competence by successfully engaging Medicaid members from all backgrounds and capabilities in the design and implementation of their health care delivery system transformation. The ability of the PPS to develop solutions to overcome cultural and health literacy challenges is essential in order to successfully address healthcare issues and disparities of the PPS community.

This section is broken into the following subsections:
      7.1 Approach To Achieving Cultural Competence
      7.2 Approach To Improving Health Literacy
      7.3 Domain 1 - Cultural Competency / Health Literacy Milestones

Scoring Process:

This section is worth 15% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
      7.1 is worth 50% of the total points available for Section 7.
      7.2 is worth 50% of the total points available for Section 7.
      7.3 is not valued in points but contains information about Domain 1 milestones related to these topics which must be read and acknowledged before continuing.

☑ Section 7.1 – Approach to Achieving Cultural Competence:

Description:

The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Cultural competency is critical to reducing health disparities and improving access to high-quality health care. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground.

In the response below, please address the following on cultural competence:

*Competency 1:

Describe the identified and/or known cultural competency challenges which the PPS must address to ensure success.

CCB will serve many diverse communities in Brooklyn, where more than 65% of residents represent minority groups (34.2% identify as African American, 19.8% Hispanic/Latino, and 10.6% Asian).

The CNA found that Brooklyn's multiple racial and ethnic groups each have unique needs related to culture, language, education, and economics, and many face disparities in care. The CNA identified barriers to care, particularly for immigrant populations, including linguistic challenges, eligibility for insurance, and familiarity with the US healthcare system.

Certain neighborhoods have concentrations of minority groups, including communities of Chinese in Sunset Park, Russian in Brighton Beach/Coney Island, Polish in Greenpoint and Williamsburg, Latino in Bushwick and Sunset Park, Arab, North African, and Orthodox Jewish in Sunset Park and Borough Park, and Caribbean in East Flatbush. In many of these communities, smoking is a concern, and asthma, lung cancer, and other respiratory disease is more common. Cultural beliefs also discourage residents of the Chinese community from seeking medical care outside of Chinese medicine, and language barriers limit access to health information. The CNA also noted that residents with substance abuse and behavioral health issues face stigma in many of these communities.

Finally, the CNA found a lack of culturally and linguistically competent specialists and multi-specialty centers, particularly for behavioral and mental health.

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CCB must address these challenges to be successful, especially given that many of these communities are hot-spots for utilization, inpatient admissions, chronic disease, behavioral health concerns, and other indicators that CCB aims to improve.

*Competency 2:

Describe the strategic plan and ongoing processes the PPS will implement to develop a culturally competent organization and a culturally responsive system of care. Particularly address how the PPS will engage and train frontline healthcare workers in order to improve patient outcomes by overcoming cultural competency challenges.

Our vision is to ensure a culturally responsive system of care for each of our patients. CCB's strategy for achieving this vision builds upon our experience with Health Homes, through which we have already identified care management agencies with linguistic expertise and cultural skills to meet our patients' needs. Maimonides is capable of interacting with patients in 70 different languages and reflecting a wide range of cultural values and norms. We will replicate this program across all Participants.

CCB also will contract with community-based organizations to provide culturally competent care and special programs for distinct communities. CCB is currently conducting an inventory of our partners to ensure the adequacy of our network to meet these needs.

Working with training partners, CCB will build on a strong foundation for cultural competency training already in place and require training for an estimated 27% of the total workforce in CCB impacted by DSRIP. CCB will review and, as appropriate, expand or extend existing programs, including:
- An existing nurse training module on cultural competence and hospital policies regarding access to interpreters, which could be utilized across CCB hospitals.
- An extensive Care Manager Occupational Training on ethics, cultural competency and health disparities, which emphasizes a code of respect for patients. This training will be critical for CCB's network of care managers, who are responsible for linking patients to social and medical support services in their communities.

To support and supplement training, CCB's provider engagement specialists through our CSO will implement an outreach/education program on cultural competency. CCB will also establish and report on short- and long-term goals and, through the CSO, will ensure that health literacy programs and leading cultural competency practices are integrated quickly and effectively into policies and protocols.

*Competency 3:

Describe how the PPS will contract with community based organizations to achieve and maintain cultural competence throughout the DSRIP Program.

CCB is in the process of identifying and evaluating community-based organizations to support our cultural competency strategy, with the goal of engaging CBOs serving each of the minority groups mentioned in the previous section. CCB will also ensure representation of these groups on its PAC (described in Section 2). While the CNA identified some organizations, notably physician IPAs with a focus on certain communities, it found the distribution of these and other resources varies widely across the region, perceived quality is sometimes a challenge, and many services are not widely available or accessible to the target population.

Several community-based organizations with expertise on cultural competence have been active participants in CCB's planning governance structure and will continue to be critical to our operational Governance moving forward. The Caribbean Women's Health Association of Brooklyn, Services for the Underserved, the Jewish Association of Services for the Aged, Diaspora Community Services, and others have already contributed to discussions of project interventions and special considerations for the populations they serve. CCB, through our local community hubs, will be poised to leverage the strengths of each community organization to address special issues and concerns related to cultural competence.

CCB also plans to develop and maintain a comprehensive inventory of community-based organizations to ensure patients faced with social needs and barriers that often trump medical care and management are aware of, and have access to, resources and services that address the social determinants of health. CCB care managers and navigators will have access to this inventory electronically and will connect beneficiaries to these resources to ensure their basic needs are met, allowing beneficiaries to better adhere to care plans and manage their and their families' health.

☑ **Section 7.2 – Approach to Improving Health Literacy:**

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Description:

Health literacy is "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions". Individuals must possess the skills to understand information and services and use them to make appropriate decisions about their healthcare needs and priorities. Health literacy incorporates the ability of the patient population to read, comprehend, and analyze information, weigh risks and benefits, and make decisions and take action in regards to their health care. The concept of health literacy extends to the materials, environments, and challenges specifically associated with disease prevention and health promotion.

According to Healthy People 2010, an individual is considered to be "health literate" when he or she possesses the skills to understand information and services and use them to make appropriate decisions about health.

*Literacy:

In the response below, please address the following on health literacy:

- Describe the PPS plan to improve and reinforce the health literacy of patients served.
- Indicate the initiatives that will be pursued by the PPS to promote health literacy. For example, will the PPS implement health literacy as an integral aspect of its mission, structure, and operations, has the PPS integrated health literacy into planning, evaluation measures, patient safety, and quality improvement, etc.
- Describe how the PPS will contract with community based organizations to achieve and maintain health literacy throughout the DSRIP Program.

As part of the CNA, the PPS conducted focus groups and surveys of Brooklyn residents, providers and community-based organizations to identify health literacy challenges and programs and providers that address them. The CNA found that 25% of residents speak English less than "very well" and nearly half speak another language at home—primarily Spanish or Chinese. Among the challenges identified are: inability of providers, staff, and others to communicate in patients' native languages and concerns about quality and access among certain bilingual providers and interpretation services.

To improve and reinforce our patients' health literacy, CCB has adopted common organizational values and evaluation measures placing the patient at the center of the care model and addressing a range of health literacy issues, including social determinants of health. CCB's project care models will support patients through peers, navigators, and care managers and engage patients, caretakers and families.

CCB will collect patient feedback using focus groups, interviews and questionnaires at least semi-annually, monitor health literacy efforts, and utilize our CSO and community Hubs to ensure literacy programs and patient-engagement practices are effectively integrated effectively into our protocols. The Care Delivery and Quality Committee and CSO will establish health literacy measures and targets for each DSRIP Year to assess the PPS and individual Participants' progress toward achieving health literacy for the target population.
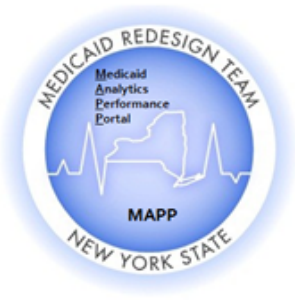
Because patient engagement is critical to realizing self-management and shared decision-making, CCB will use its existing IT infrastructure to engage and educate patients on their care. The Dashboard links patients electronically so they may communicate easily in real time with their interdisciplinary care team; patients have the ability to direct their care, view their coordinated care plan, and securely message and interact with providers.

CCB will also pursue a series of additional initiatives to promote health literacy, such as:
- Recruitment of bilingual health educators, medical interpreters, and care management staff
- Development of care plans and other patient and caregiver-facing materials at no higher than a sixth grade reading level, translated into prevalent languages
- Identification and integration of effective health literacy programs and leading patient-engagement practices into policies and protocols
- Identification and use of bilingual peer champions and "go to" resources in their communities

CCB is in the process of identifying and evaluating community-based organizations (CBOs) to support our strategy, and has already partnered with 1199 on workforce training on health literacy, and with the Arthur Ashe Institute on providing special programs to engage Brooklyn communities in their health care through familiar community settings, such as barber and beauty shops.

Several CBOs that offer linguistically appropriate services have been active participants in CCB's planning governance structure and will continue to be critical moving forward--the Caribbean Women's Health Association of Brooklyn, Services for the Underserved, the Jewish Association of Services for the Aged, Diaspora Community Services, and others have already contributed to discussions of project interventions and special considerations for the populations they serve.

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As our patients seek services to address underlying social needs (i.e., housing, access to food, employment), we will work with CBOs to introduce health care services appropriate for these clients. Wraparound services may also be introduced at transitional housing sites with the goal of preventing emergency department admissions when crises surface.

✅ **Section 7.3 - Domain 1** – **Cultural Competency/Health Literacy Milestones :**

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

- Report on the development of training programs surrounding cultural competency and health literacy; and
- Report on, and documentation to support, the development of policies and procedures which articulate requirements for care consistency and health literacy.

☑ Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

Description:

The PPS will be responsible for accepting a single payment from Medicaid tied to the organization's ability to achieve the goals of the DSRIP Project Plan. In accepting the performance payments, the PPS must establish a plan to allocate the performance payments among the participating providers in the PPS.

This section is broken into the following subsections:
   8.1 High Level Budget and Flow of Funds
   8.2 Budget Methodology
   8.3 Domain 1 - Project Budget & DSRIP Flow of Funds Milestones

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 8.1 – High Level Budget and Flow of Funds:

*Budget 1:

In the response below, please address the following on the DSRIP budget and flow of funds:

- Describe how the PPS plans on distributing DSRIP funds.
- Describe, on a high level, how the PPS plans to distribute funds among the clinical specialties, such as primary care vs. specialties; among all applicable organizations along the care continuum, such as SNFs, LTACs, Home Care, community based organizations, and other safety-net providers, including adult care facilities (ACFs), assisted living programs (ALPs), licensed home care services agencies (LHCAs), and adult day health care (ADHC) programs.
- Outline how the distribution of funds is consistent with and/or ties to the governance structure.
- Describe how the proposed approach will best allow the PPS to achieve its DSRIP goals.

All DSRIP funds will be distributed to Participants across the care continuum for project implementation and achievement of milestones and performance metrics. CCB will separate DSRIP funds in four ways:

1. The Project Implementation Fund will go to offset costs for direct project implementation costs and will be released to Maimonides, the Central Services Organization (CSO) and Participants. Participants will receive upfront payments to support hiring of staff, and payments upon completion of project milestones. Costs include coverage of fiduciary expenses and establishment of a contingency fund to cover unforeseen costs.

2. The Provider Bonus Payments Fund will be distributed to Participants to reflect participation in the successful achievement of DSRIP goals. To be eligible for Bonus Payments, Participants must reach participation and quality thresholds. Bonus Payments may be distributed in two ways: a portion to encourage ongoing participation, and a portion in connection with achievement of specific CCB project goals.

3. The Revenue Loss Fund will be distributed to certain Participants to offset a portion of net revenue lost from successful implementation of projects. Revenue Loss compensation will be provided for a limited period of time (likely 1-2 years) to assist certain Participants during a transformation period. Participants could receive payments from the Reinvestment Fund for targeted reinvestments, depending on the program or intervention.

4. The Reinvestment Fund will be used for targeted reinvestment to ensure the effectiveness of planned interventions, with funds flowing to the CSO and/or to Participants, depending on the program or intervention.

In our governance structure, the CCB Executive Committee will oversee the distribution of DSRIP funds. All participant-specific

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performance obligations, milestones, and funding amounts will be subject to the review and approval of the Executive Committee as articulated in the MSA.

Project Implementation funding distributed to Participants will be based on project-specific budgets incorporated in annual DSRIP operating plans and budgets, subject to review and approval by the Executive Committee. Provider Bonus payments and Revenue Loss compensation will be subject to review and approval by the Executive Committee. Within the Reinvestment Fund, decisions on the type, timing and level of reinvestment will be reviewed and approved by the Executive Committee.

The CCB funds distribution approach is structured to achieve our goals, because it will provide funding to build high-quality DSRIP programs while providing sizeable incentives to Participants for helping CCB achieve performance metrics. Project Implementation funding ensures the CSO receives adequate support to provide a range of central services, including accounting for and distributing DSRIP funds, while also ensuring key infrastructure can be built at Participant locations.

Incentive-based bonus payments are designed to reward both collective and individual contributions to achievement of PPS goals, with participant bonus payments linked to performance metrics and standardized across Participants by organization type.

Revenue Loss compensation balances critical short-term assistance to some Participants with enforcing accountability for long-term sustainability. Participants must document the loss associated with specific DSRIP results and provide a business plan addressing the use of funds to bridge the gap to sustainability. If available Contingency or Revenue Loss funds are not fully dispersed in any given year, the balance will be used for reinvestment or for incentives.

The Reinvestment Fund will be used for targeted reinvestment, such as adding new services or programs, or expanding initial DSRIP projects, to ensure the ongoing effectiveness of planned DSRIP interventions.

☑ Section 8.2 – Budget Methodology:

*Budget 2:
To summarize the methodology, please identify the percentage of payments the PPS intends to distribute amongst defined budget categories. Budget categories must include (but are not limited to):
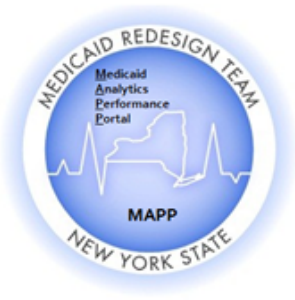
- Cost of Project Implementation: the PPS should consider all costs incurred by the PPS and its participating providers in implementing the DSRIP Project Plan.
- Revenue Loss: the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such as a reduction in bed capacity, closure of a clinic site, or other significant changes in existing business models.
- Internal PPS Provider Bonus Payments: the PPS should consider the impact of individual providers in the PPS meeting and exceeding the goal of the PPS' DSRIP Project Plan.

Please complete the following chart to illustrate the PPS' proposed approach for allocating performance payments. Please note, the percentages requested represent aggregated estimated percentages over the five-year DSRIP period; are subject to change under PPS governance procedures; and are based on the maximum funding amount.

#	Budget Category	Percentage (%)
1	Cost of Project Implementation	50%
2	Revenue Loss	15%
3	Internal PPS Provider Bonus Payments	23%
4	Reinvestment Fund	12%
	Total Percentage:	100%

☑ Section 8.3 - Domain 1 – Project Budget & DSRIP Flow of Funds Milestones:

Description:

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Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

- Quarterly or more frequent reports on the distribution of DSRIP payments by provider and project and the basis for the funding distribution to be determined by the Independent Assessor.

☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

Description:

The continuing success of the PPS' DSRIP Project Plan will require not only successful service delivery integration, but the establishment of an organizational structure that supports the PPS' DSRIP goals. One of the key components of that organizational structure is the ability to implement financial practices that will ensure the financial sustainability of the PPS as a whole. Each PPS will have the ability to establish the financial practices that best meet the needs, structure, and composition of their respective PPS. In this section of the DSRIP Project Plan the PPS must illustrate its plan for implementing a financial structure that will support the financial sustainability of the PPS throughout the five year DSRIP demonstration period and beyond.

This section is broken into the following subsections:
- 9.1 Assessment of PPS Financial Landscape
- 9.2 Path to PPS Financial Sustainability
- 9.3 Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability
- 9.4 Domain 1 - Financial Sustainability Plan Milestones

Scoring Process:

This section is worth 10% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 9.1 is worth 33.33% of the total points available for Section 9.
- 9.2 is worth 33.33% of the total points available for Section 9.
- 9.3 is worth 33.33% of the total points available for Section 9.
- 9.4 is not valued in points but contains information about Domain 1 milestones related to Financial Sustainability which must be read and acknowledged before continuing.

☑ Section 9.1 – Assessment of PPS Financial Landscape:

Description:

It is critical for the PPS to understand the overall financial health of the PPS. The PPS will need to understand the providers within the network that are financially fragile and whose financial future could be further impacted by the goals and objectives of DSRIP projects. In the narrative, please address the following:

*Assessment 1:

Describe the assessment the PPS has performed to identify the PPS partners that are currently financially challenged and are at risk for financial failure.

CCB created a survey to identify Participant organizations potentially at risk of financial failure, using NYS DOH's criteria for safety net hospitals to receive IAAF funding, and other key financial questions:

- Does the organization have at least 15 days cash and equivalents on hand? Can assets be monetized other than those vital to operations? Can resources be accessed from foundations and other affiliated entities if required to sustain operations?
- Current payer mix?
- 2012 and 2013 Current Ratio and Debt to Assets Ratio?
- Financial impact of achieving DSRIP's required metrics?
- Anticipation of major changes to current contracting or grant funding ?
- Applied for and receiving IAAF funding?

The survey was sent to all 400 CCB Participants and although most Participants are individual/small group providers, the completion rate was high. Respondents were assigned to one of three risk tiers according to survey results. The vast majority qualified as Tier 1, Not Immediately Fragile (possessing more than 15 days cash on hand without any major financial concerns). Twenty-three Participants qualified as Tier 2, Moderately Fragile (less than 15 days cash but can access assets to monetize for operations with no other major concerns reported). Five potential Participants qualified as Tier 3, Fragile (less than 15 days cash and other major concerns reported,

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including receipt of IAAF).

In addition to the financial survey, we conducted a five-year financial and utilization analysis of Brooklyn hospitals with a history of financial difficulties to further assess stability.

*Assessment 2:

Identify at a high level the expected financial impact that DSRIP projects will have on financially fragile providers and/or other providers that could be negatively impacted by the goals of DSRIP.

Successful implementation of DSRIP projects will achieve DOH's primary goal of reducing avoidable hospital use by 25% over 5 years. This will have the expected financial impact of revenue losses for some hospitals and nursing homes. DSRIP award funding is intended to assist in the transition to outpatient and community-based care over the next five years. However, if new value-based payment methodologies are not rapidly phased in, new ambulatory services will not be sustainable for all safety net providers, especially the financially fragile, who will be the most severely impacted when DSRIP funding recedes.

Expected financial impacts were also noted within our survey responses. According to these results, nine of CCB's Participant partners (hospitals, behavioral health centers and home nursing services) expect a negative financial impact from DSRIP projects. In addition to the surveys, CCB's participating hospital providers recognize that they will experience the heaviest financial impact from DSRIP projects and understand that some of the hospital Participants within the network may already be financially fragile. A separate analysis of financial and utilization metrics at Brooklyn hospitals with a history of financial difficulties confirms this. The analysis demonstrates a continual financial deterioration over the last five years with steadily declining operating margins and weakening balance sheet and liquidity ratios.

DSRIP funding alone will not save otherwise vulnerable institutions. However, via DSRIP, it will be possible to identify when critically needed providers are at risk and to help plan for the continuation of the services they provide so that the CCB PPS can still serve its mission. Our approach has the following elements:
- Early identification of financial and programmatic issues through continual monitoring. CCB plans to continue annual financial surveys in addition to the quarterly performance and financial monitoring being implemented as part of the DSRIP projects;
- Proactive work with local organizations and parent companies. CCB will continue to work with both entities to ensure the parent organization does not unknowingly diminish or withdraw services from CCB's service area and access to services can be sustained;
- Creation of a Sustainability Work Group of the Business and Operations Committee. The Work Group will work together with financially fragile Participants to develop restructuring plans or alternative pathways to providing needed services for failing institutions. The estimated financial impact will be considered in the budgeting for Revenue Loss mitigation and is discussed in Section 8 (flow of funds); and
- Commitment to using DSRIP funds to sustain needed services in the most efficient possible manner. Our use of DSRIP funds for revenue loss will be provided only upon demonstration of a negative financial impact caused by DSRIP and assurance that DSRIP funds will be used as a short term stop gap in a manner that will enhance the overall viability of the sponsoring institution. If the institution itself is not viable, that institution will need to consider merger or restructuring plans.

While DSRIP will result in lost revenue for certain institutions and services, we anticipate that other services and business lines will grow (e.g. Health Homes, home care, behavioral health services, training organizations).

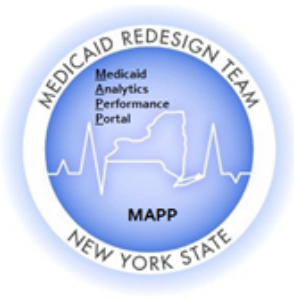### ☑ Section 9.2 – Path to PPS Financial Sustainability:

Description:

The PPS must develop a strategic plan to achieve financial sustainability, so as to ensure all Medicaid members attributed to the PPS have access to the full ranges of necessary services. In the narrative, please address the following:

*Path 1:

Describe the plan the PPS has or will develop, outlining the PPS' path to financial sustainability and citing any known financial restructuring efforts that will require completion.

DSRIP payments will be essential to the transformation of the current delivery system. CCB's funds flow methodology is designed to maximize the value of these payments to: fund programs and services that are not currently reimbursable; offset some revenue loss associated with successful implementation of DSRIP projects and interventions; and incentivize the continued adoption and utilization of

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DSRIP projects. Specifically, to sustain the delivery system changes over the next 5 years and beyond, CCB's governance organization will:
- Contract with 1199 training fund and others to build/implement work force training and related programs;
- Implement health information technology that enables providers to access shared patient information at the point of care, and follow patients over time, to produce better outcomes and lower the cost of care;
- Direct DSRIP funds to providers who can rapidly implement the clinical interventions described in Section 4;
- Demonstrate successful performance in a provider-led care model in the early years of DSRIP to encourage MCO participation and investment;
- Advance current discussions with MCOs (Healthfirst and Emblem) to design a process to move from volume to value-based payments to all beneficiaries, initially via HARP and FIDA (programs to integrate care and payments for targeted, high risk populations); and
- Establish risk-bearing and contracting structures to operationalize this shift.

Through the CSO, the Executive, and the Business Operations Committees (and the corresponding Sustainability Work Group), CCB will develop a financial sustainability plan in parallel to the Implementation Plan due March 1st. The sustainability plan will further define the 'rules' that will guide the distribution of funds and the required financial measures and expectations to be maintained, along with clinical measures. CCB does not currently anticipate additional restructuring of hospital debt.

*Path 2:

Describe how the PPS will monitor the financial sustainability of each PPS partner and ensure that those fragile safety net providers essential to achieving the PPS' DSRIP goals will achieve a path of financial sustainability.

CCB's Sustainability Work Group of the Business and Operations Committee will monitor a set of clinical, operational and financial metrics and meet regularly with the most vulnerable providers to confirm that DSRIP project funds have been properly invested and timelines met. Where indicators or activities are not in line with expectations, the CSO Provider Engagement team (responsible for engaging providers and supporting them in achieving DSRIP goals) will work with the Participant to identify and immediately address the causes. Hub-specific and PPS-wide action plans and reports will be reviewed by the Executive Committee, and CCB subcommittees and Hub Steering Committee(s) of relevance. As noted in Section 8, the Project Implementation Fund will be used to offset DSRIP project implementation costs. A portion of funds will be made available on an upfront basis for Safety Net and other providers unable to proceed otherwise, subject to specific terms and conditions, including agreement to ongoing monitoring by the CSO's Provider Engagement team.

*Path 3:

Describe how the PPS will sustain the DSRIP outcomes after the conclusion of the program.

Sustaining outcomes requires CCB Participants and MCOs to restructure traditional roles and functions. For example, CCB's DSRIP investments will create a larger and better trained care management and educator workforce embedded in primary care practices and Health Homes, bringing services directly to patients.

CCB Participants will be clinically and technologically integrated and financial sustainable, creating a network capable of performing at higher levels than today's disjointed, episodic system. Core components of contracting negotiations will include funding the CCB care management infrastructure and agreements to avoid duplication of effort with respect to care management, data sharing, network management and other functions.

Maimonides will continue conversations about transitioning to value-based purchasing with leading MCOs including HealthFirst (largest MCO; 25% market share). Maimonides has already partnered with HealthFirst on a HARP pilot. CCB will leverage these experiences and will successfully create value-based purchasing arrangements to sustain new programs and capabilities.

☑ **Section 9.3 – Strategy to Pursue and Implement Payment Transformation to Support Financial**

Sustainability:

Description:
Please describe the PPS' plan for engaging in payment reform over the course of the five year demonstration period. This narrative should include:

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*Strategy 1:

Articulate the PPS' vision for transforming to value based reimbursement methodologies and how the PPS plans to engage Medicaid managed care organizations in this process.

> Successful demonstration of CCB's care model in DSRIP Y1 and Y2 is essential to engaging MCOs in substantive discussions regarding value-based reimbursement. In Y1, CCB will formalize a Sustainability Working Group, reporting to the Business and Operations Committee, that includes leading MCOs and key Participants to guide the transition to value-based contracts. CCB will need the support of the State to assist in establishing a framework to define the relationships between MCOs and PPSs that will create the greatest value without duplicating investment. The Work Group will also serve in the capacity noted above.
>
> Maimonides has 29,000 fully capitated lives in HealthFirst (3.3% of all Medicaid MCO lives in Brooklyn). Maimonides, FEGS, and HealthFirst have also jointly developed a shared savings model for use in the HARP program. Interfaith has risk-based contracts, and other CCB Participants have varying levels of experience with managing risk. Conversations are underway with leading MCOs including HealthFirst and Emblem (combined 31% of Medicaid market share) about expanding arrangements, and a representative from HealthFirst sits on the CCB planning governance structure.
>
> CCB recognizes the need to support Participants' gradual move from volume to value-based payment under various arrangements. CCB will expand existing and create new contracting structures to implement these arrangements. Based on the success of DSRIP, CCB may also seek to engage Medicare and commercial payers regarding extending payment reform and associated clinical programs to additional populations.

*Strategy 2:

Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers

> Payment transformation will assist CCB in achieving a path of financial stability, by transitioning participant and individual provider compensation from FFS to value- and outcomes-based methodologies. The full scope of services providers will offer via DSRIP funding to their patients is not reimbursed under FFS Medicaid. The value-based payment methods CCB will seek to negotiate with MCOs will aim to reduce or eliminate providers' reliance on FFS reimbursement and afford them the flexibility to deliver the best care possible and invest savings in sustaining effective DSRIP interventions and other programs proven to improve the target population's health and reduce costs.
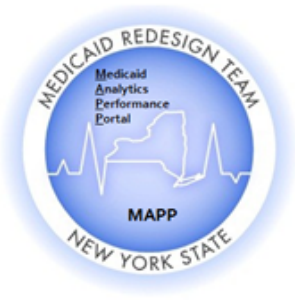>
> CCB plans to introduce member organizations to value-based arrangements at a lower level of risk by initially pursuing shared savings arrangements before gradually converting to risk-sharing arrangements over time. This will also allow CCB to evaluate member performance in value-based arrangements and will allow our internal quality and cost reporting mechanisms to ensure we are equipped to gauge performance and appropriately structure future risk-sharing agreements. Shared savings alone will not provide enough funding to support long-term sustainability of the full scope and breadth of the programs created by DSRIP. In DSRIP years 4, 5 and beyond, CCB will look to expand the level of risk and capitation assumed as our capabilities and those of our Participants increase. As Maimonides already has existing fully-capitated arrangements, they will look to expand the lives in their respective programs starting in DY 2.
>
> Payment transformation negotiations with MCOs will be framed to achieve a basic DSRIP goal: to support financially fragile safety net providers whose performance meets or exceeds quality and cost goals and whose services are critical to the well-being of PPS patients. CCB will also work with financially fragile safety net providers to optimize the use of space and human resources through repurposing and retraining with the goal of aligning patient needs to resources, thereby directing patients back to these providers for newly available services and subsequent payment.

☑ Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and

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expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

- Completion of a detailed implementation plan on the PPS' financial sustainability strategy (due March 1st, 2015); and
- Quarterly reports on and documentation to support the development and successful implementation of the financial sustainability plan.

☑ Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

Description:
The questions in this section are not a required part of the application. However, responses to these questions will be used to award bonus points which will added to the overall scoring of the application.

☑ Section 10.1 – PROVEN POPULATION HEALTH MANAGEMENT CAPABILITIES (PPHMC):

Proven Population Health Management Capabilities (PPHMC):
Population health management skill sets and capabilities will be a critical function of the PPS lead. If applicable, please outline the experience and proven population health management capabilities of the PPS Lead, particularly with the Medicaid population. Alternatively, please explain how the PPS has engaged key partners that possess proven population health management skill sets. This question is worth 3 additional bonus points to the 2.a.i project application score.

Maimonides' Department of Population Health has extensive experience with population health management by managing publicly-funded initiatives to transform the delivery system through integration, coordination and collaboration. Over the last several years, supported by $17 M in HEAL NY funds, and $14.8 M in CMMI funds, Maimonides has established a RHIO, tested new approaches to integrate behavioral health and primary care, pioneered Medicaid Health Home services, established a group of providers and an insurer to serve HARP-eligible patients, and created a pilot to migrate from fee-for-service to total cost of care.

Many Participants, including CAMBA, FEGS, Housing Works, NADAP, Village Care and VNSNY, have partnered with the Maimonides Brooklyn Health Home to conduct population health management. Care management and clinical teams work with patients/families to create/implement care plans via a web-based Dashboard. With the Dashboard, the team monitors and tracks patient health information and creates a dynamic care plan populated with comprehensive clinical/demographic data. Team members receive alerts (e.g. hospitalizations, ER visits), share information through care transitions, coordinate post-hospitalization services, and make linkages to primary and specialty care. Clinical protocols are developed through a committee structure that evaluates and selects evidence-based strategies.

Under DSRIP, CCB will embed care managers at key clinical points, such as ERs, hospitals, PCPs and community/social service settings. It will also build on Maimonides' analytics/reporting, care management teams, and IT and financial/program/network management infrastructure, embedding more care managers in key intake points and in community/social service settings and building upon this work to set advanced standards for quality in care management. CCB will also deploy the Dashboard to all partners, ensuring population health management capabilities across our network.
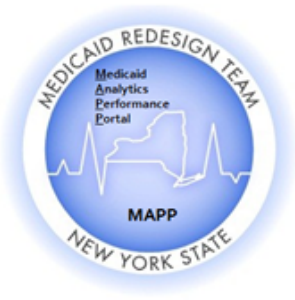
Proven Workforce Strategy Vendor (PWSV):
Minimizing the negative impact to the workforce to the greatest extent possible is an important DSRIP goal. If applicable, please outline whether the PPS has or intends to contract with a proven and experienced entity to help carry out the PPS' workforce strategy of retraining, redeploying, and recruiting employees. Particular importance is placed on those entities that can demonstrate experience successfully retraining and redeploying healthcare workers due to restructuring changes.

Building a successful integrated delivery system relies heavily on a well trained workforce to provide clinical care, care management and social services in a coordinated and effective way. CCB will leverage Maimonides' partnerships and experience working with 1199 SEIU Training and Upgrading Fund (TUF) and Center for Urban and Community Services (CUCS) to develop the comprehensive training program and workforce development strategy necessary to accomplish DSRIP goals.

We will work with longtime partners, TUF and CUCS to minimize potential adverse effects and to develop and train the workforce necessary to meet the needs of a newly integrated delivery system. One of the largest healthcare labor unions in the country, 1199 SEIU has considerable experience working to ensure that the local and national healthcare workforce is prepared to meet patients' needs. CUCS trains over 10,000 individuals annually and is widely recognized as a leader in mental health and housing trainings.

With funding through our CMMI award, we have partnered with TUF and our unionized and non-unionized partners to develop and implement an innovative training program that has helped to create and retain a well-trained workforce. Over 400 care management and
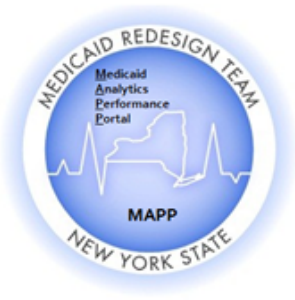
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clinical providers have completed training on a range of topics, including a program overview, our IT system, clinical management, motivational interviewing and crisis and conflicts courses. We've also partnered with CUCS to provide training on housing issues and an intensive care management program called Critical Time Intervention (CTI).

CCB can leverage this experience and partnerships and can quickly begin training for care managers, hospital workers, providers and other key personnel to support all of our selected projects. As described in Section 5, we plan to train approximately 27% of the total existing workforce within CCB that is impacted by DSRIP.

If this PPS has chosen to pursue the 11th Project (2.d.i. Implementation of Patient Activation Activities to Engage, Educate, and Integrate the Uninsured and Low/Non Utilizing Medicaid Populations into Community Based Care) bonus points will be awarded.

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SECTION 11 – ATTESTATION:

Attestation:

The Lead Representative has been the designated by the Lead PPS Primary Lead Provider (PPS Lead Entity) as the signing officiate for the DSRIP Project Plan Application. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and the Lead PPS Primary Lead Provider are responsible for the authenticity and accuracy of the material submitted in this application.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be Accepted by the NYS Department of Health. Once the attestation is complete, the application will be locked from any further editing. Do not complete this section until your entire application is complete.

If your application was locked in error and additional changes are necessary, please use the contact information on the Organizational Application Index/Home Page to request that your application be unlocked.

To electronically sign this application, please enter the required information and check the box below:

☑ *I hereby attest as the Lead Representative of this PPS Maimonides Medical Center that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.*

Primary Lead Provider Name: MAIMONIDES MEDICAL CENTER
Secondary Lead Provider Name:

Lead Representative:	David I Cohen
Submission Date:	12/22/2014 03:30 PM

Clicking the 'Certify' button completes the application. It saves all values to the database