



**Department
of Health**

DSRIP Independent Assessor

Mid-Point Assessment Report

Community Care of Brooklyn PPS

Appendix PPS Narratives

November 2016

www.health.ny.gov

Prepared by the DSRIP
Independent Assessor



DSRIP Mid-Point Assessment - Organizational Narratives

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

PPS Name: Maimonides Medical Center

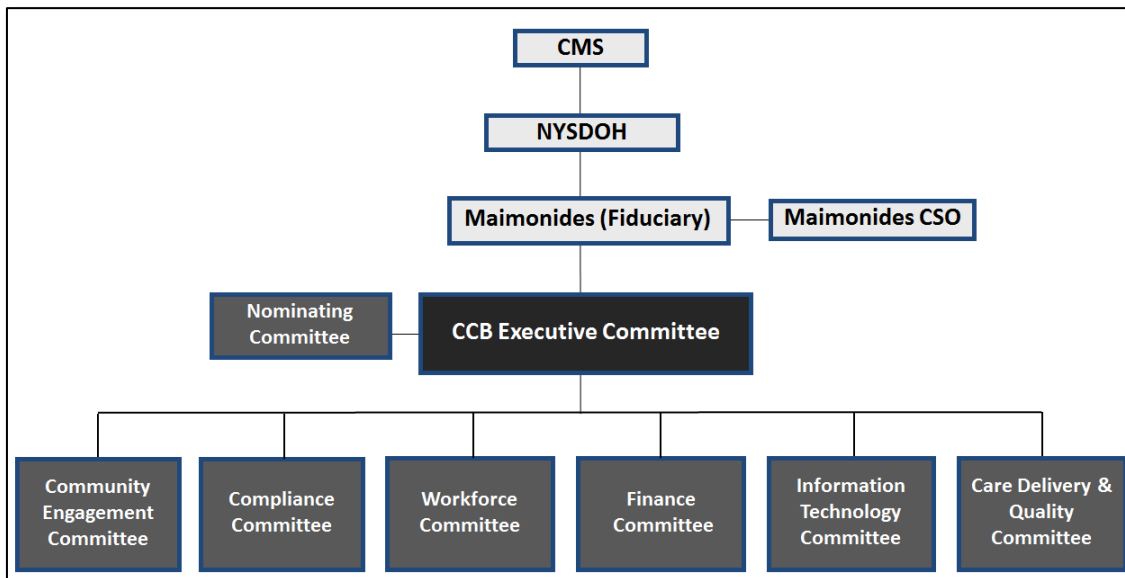
Highlights and successes of the efforts:

Governance

The Maimonides PPS, known as Community Care of Brooklyn (CCB), has developed a strong, consensus-based governance structure, including participation by a broad range of stakeholders from health care provider organizations, social service providers, and community-based organizations. Management support services are provided to CCB by the Central Services Organization (CSO) of Maimonides Medical Center (MMC). Individuals serving on CCB governance committees do so as fiduciaries of CCB, rather than as representatives of their organizations. As described below and shown in [Figure 1](#), six committees report to the Executive Committee, which serves as the CCB's board:

- Care Delivery & Quality Committee: Responsible for reviewing and assessing evidence-based clinical and care management processes and protocols, overseeing the development of project requirements to be addressed by CCB Participant organizations, and overseeing the development of practitioner communication/education plan.
- Community Engagement Committee: Responsible for advising on the engagement of the Brooklyn community in the transformation of the healthcare delivery system, with a focus on efforts to address health disparities and gaps in care, and to enhance cultural competency and health literacy across the CCB network.
- Compliance Committee: Responsible for providing guidance regarding DSRIP-related compliance issues, overseeing development of education and training to address DSRIP-related compliance, and serves as a forum for review of emerging compliance topics, risks, and best practices.
- Finance Committee: Responsible for making recommendations regarding CCB's budgets and funds distribution, overseeing network contracting processes, and serving as the forum for discussion of sustainability strategies for the CCB network.
- IT Committee: Responsible for advising on PPS IT strategy and execution, and for promoting the adoption and appropriate use of IT systems among all participants.
- Workforce Committee: Responsible for elaboration and oversight of the workforce development and training strategy for the CCB.

Figure 1



Network Development, Engagement, and Implementation

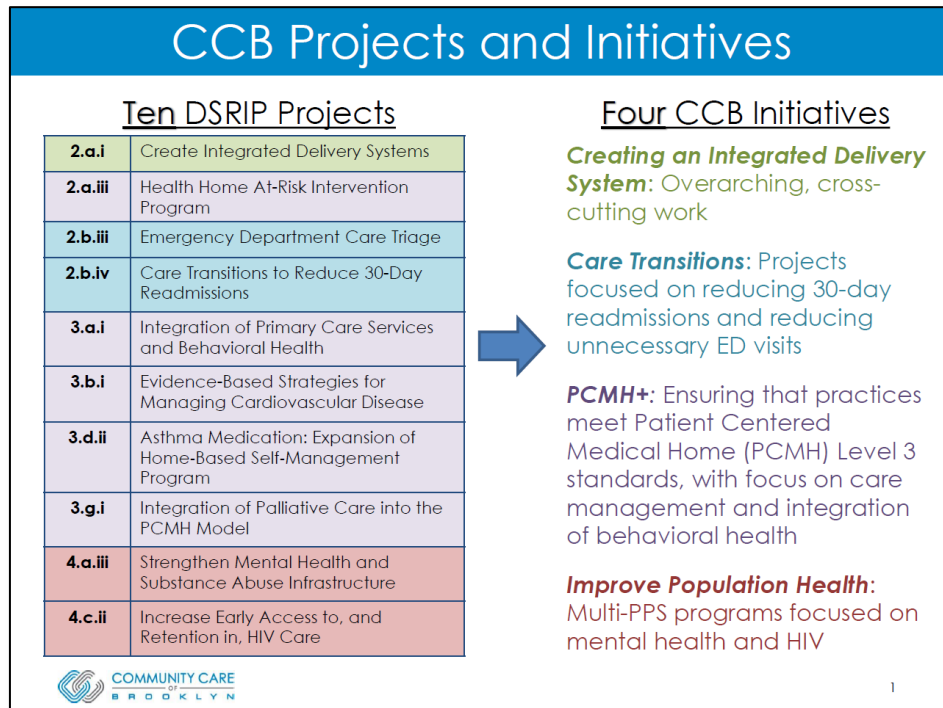
The CCB network is legally bound by executed Master Services Agreements (MSAs) between partner organizations (“Participants”) and MMC as the PPS fiduciary. The MSA, developed through a collaborative process among CCB Participants, was distributed to the CCB network in June 2015, and in September 2015, CCB launched an online Participant Survey. Responses to the Survey provide visibility into CCB Participants' capacity, areas of special focus, and suggest where each might best engage in and benefit from participation in CCB's DSRIP initiatives. As of August 1, 2016, a total of 528 organizations are now covered by signed MSAs and 260 organizations have completed the Participant Survey.

Requirements for participation in specific DSRIP projects are documented in one or more schedules to the MSA and are specific to the provider type, as well as to the type of payment (e.g., Implementation funds, Bonus payments, etc.) and period. The schedules are developed following approval of Clinical Operational Plans (COPs) by the Care Delivery & Quality Committee and include performance and reporting requirements as well as the available funding that will be provided to support Participants’ contributions to the achievement of DSRIP goals. CCB’s project implementation efforts ramped up significantly in DY2 Q1. To-date, 96 MSA schedules, with a total value of nearly \$17 million, have been issued to a broad set of providers, including hospitals, federally-qualified health centers (FQHCs), community-based primary care providers, care management agencies, home-based asthma care providers, and community-based organizations, among others.

CCB’s approach to addressing the goals of DSRIP is tailored to the challenges presented by the complex healthcare landscape of Brooklyn. Because Medicaid patients do not restrict themselves to receiving care from only CCB’s providers, we have not restricted our analysis to our DSRIP attributed Medicaid patients in modeling provider-specific targets and funding. While we understand that we will be evaluated on our performance against our attributed-patient panel, we want to create a consistently high level of care at each of our Participants, regardless of patient attribution. To the extent possible, we have used standardized data sets (e.g. DOH Medicaid claims data accessed through Salient Interactive Miner), as opposed to self-reported information, to create consistent performance targets and to ‘size’ funding across Participants.

As described in greater detail in the Mid-Point Assessment Project Narratives and illustrated in [Figure 2](#) below, CCB has organized its ten projects into four transformative initiatives for planning and implementation: 1) Creating an Integrated Delivery System, 2) Care Transitions, 3) Patient-Centered Medical Home Plus (PCMH+), and 4) Improving Population Health.

Figure 2



Five projects were consolidated into the PCMH+ initiative (2.a.iii Health Home At-Risk, 3.a.i Integration of Primary Care and Behavioral Health, 3.b.i Cardiovascular Disease, 3.d.ii Asthma Home-Based Management, and 3.g.i Integration of Palliative Care into PCMH) because primary care practice transformation, including PCMH recognition, is foundational to achieving these projects' goals. CCB has engaged three vendors to provide technical assistance to priority providers across the CCB network to assist them in achieving PCMH recognition (along with *true* PCMH transformation) and Meaningful Use standards. We believe that supporting comprehensive primary care transformation will provide better outcomes across the CCB network.

CCB has collaborated across PPS to align efforts in Brooklyn and across the downstate region. CCB's projects are aligned with those selected by OneCity Health PPS, and CCB continues to engage in cross-PPS workgroups/coalitions to jointly implement the Domain 4 Population health projects, and other ongoing cross-PPS collaborative efforts.

CCB's project implementation plan builds on the existing infrastructure and experience of our two participating network health homes: the Brooklyn Health Home and Coordinated Behavioral Care. Taking advantage of the health homes' combined network of care management agencies (CMAs), CCB has partnered CMAs with hospitals and FQHCs to increase health home enrollment and linkages at clinical sites. Additionally, CMAs are providing targeted care management support, in the form of part-time health coaches, to small, community-based practices that do not have the patient panels to support a full-time health coach. The web-based GSI Health Coordinator (referred to as "the Dashboard" by both its Health Home and PPS users), currently in use within both health homes, is being deployed across the CCB network for shared care coordination and care plan development. GSI Health Coordinator allows for secure messaging between providers and delivers event notifications and clinical summary documents from Healthix, our Regional Health Information Organization (RHIO).



Accountability, Compliance, and Performance

To coordinate across such a large and diverse network, CCB implemented Salesforce's customer relationship management (CRM) technology in August 2015, and is currently using the infrastructure in multiple ways, with additional uses in development. A CCB Participant Database includes all information known about Participants in the network, including information such as NPIs, addresses, affiliations, contacts, and responses to the CCB Participant Survey, which was deployed through CCB's Salesforce-supported Participant-facing Resource Portal. Salesforce supports contact center functions across phone, fax and email, and allows CCB's support team to create, assign and resolve support cases. To handle the growing number of MSAs, Business Associate Agreements (BAAs) for data sharing, and MSA schedules, CCB tracks all contracts and related Participant monthly reporting within Salesforce. CCB has just recently introduced online reporting for Participants through its Resource Portal. In the future, the Salesforce Resource Portal will be used to share Participant-specific performance information, track attendance at trainings, and share other information with the CCB network.

Importantly, CCB is leveraging the Salesforce infrastructure to implement rigorous internal controls related to contracting and compliance. Payments to Participants are contingent upon having in place 1) a fully executed MSA, 2) a fully executed BAA, 3) confirmation that the Participant was not identified in CCB's monthly verification process as an entity that is excluded from receiving Medicaid funds, and 4) a completed Participant Survey. The Salesforce infrastructure tracks and enforces these payment criteria, allows authorized staff to review and approve monthly reports, and supports electronic payments and remittance notifications, all in a controlled and efficient manner. While the MSA schedules and monthly reports (which serve as payment vouchers) include language requiring explicit attestation that the Participant is/was not an excluded provider, CCB also conducts its own compliance checks. Each month, CCB uses a web-based application, SanctionCheck, to validate Participant organizations and associated practitioners against five key databases. CCB monitors monthly updates to the National Plan and Provider Enumeration System (NPPES) database of NPIs to identify and investigate deactivated NPIs that were previously identified as belonging to Participant organizations or their employees. All potential compliance issues are recorded as cases pending investigation in our Salesforce database, which renders the Participant ineligible for payment until such cases are satisfactorily resolved.

CCB's analytics team supports program planning, clinical quality improvement and data-driven decision-making, using Medicaid claims data accessed through Salient Interactive Miner, the MAPP Dashboards, SPARCS and other data sources. CCB is creating a secure portal that will be used to collect Actively Engaged patient information from our Participants for DSRIP Quarterly Reports, which will allow us to study correlations between interventions and outcomes. Acknowledging the importance of social determinants to the health of Medicaid patients, the CSO is working to understand the impact of social determinants of health to inform patient engagement models as the DSRIP program evolves. We anticipate that these analytics will provide invaluable support for the assessment of value-based payment proposals as well. CCB has completed the necessary DOH System Security Plan (SSP) workbooks and is working to configure a secure hosting environment that will allow CCB to access and analyze identified patient rosters, Medicaid claims and other DOH-provided data sets containing protected health information (PHI), further enhancing our analytics capacity.

Workforce & Training

Another example of cross-PPS collaboration is CCB's efforts in the area of workforce planning. CCB partnered with three other downstate PPS (OneCity Health, the NYU Lutheran PPS, and Bronx Partners for Healthy Communities) and jointly engaged BDO Consulting, in partnership with the Center for Healthcare Workforce Studies, to develop a consistent, comprehensive Workforce Survey. Released in February 2016, the Workforce Survey was designed to address the state's requirements, ensure that organizations participating with more than one of the PPSs are only surveyed once, and aggregate responses at a level that will allow for data sharing and analysis. BDO also worked with



CCB and the other PPS on the development of their baseline reports on compensation and benefits, and on the development of reports on the so-called 'target workforce state,' taking into consideration both demographic and technical trends and the anticipated impact of DSRIP interventions on the likely future demand for staff in a variety of roles across the PPS as a whole.

In a continuation of Maimonides' longstanding track record of collaboration with its labor partners, the PPS has engaged 1199 Training and Upgrading Fund (TUF) to develop our PPS workforce training strategy and key aspects of the training program itself. The training strategy will be based on program needs identified by CCB's Care Delivery & Quality Committee and incorporate elements from CCB's Cultural Competency and Health Literacy Strategy as well. Trainings have been developed and deployed for health home care managers, Transitional Care Nurses, Transitional Care Managers, and Patient Navigators. An online training, "DSRIP 101", is also under development and will be deployed broadly across the CCB network. CCB has collaborated with Kingsborough Community College to develop a health coach training program. Launched in the spring of 2016, the program has enrolled approximately 40 trainees who will receive health coach certification and 4 college credits. Additionally, CCB has engaged the Institute for Family Health (IFH) to provide training and technical assistance to CCB Participants to support implementation of the IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) Model of Collaborative Care for Depression. IFH is initially targeting nine hospitals and FQHC partners for a total of more than 20 sites. Similarly, the palliative care curriculum for primary care practices has been developed by subject matter experts from the Metropolitan Jewish Health System's (MJHS) Institute for Palliative Care, with a planned series of educational webinars launching this month.

Community Engagement

As described above, the Community Engagement Committee (CEC) was established to guide the engagement of the Brooklyn community, with a specific focus on efforts to address health disparities and enhance cultural competency and health literacy. The Committee is comprised of individuals from a number of community-based organizations (CBOs) in the CCB network. During the fall of 2015, the CEC oversaw the development of CCB's Cultural Competency and Health Literacy (CCHL) Strategy, which built upon the key findings in the Brooklyn Community Needs Assessment (CNA), and provided the overall vision for CCB's community engagement efforts. Since finalization of the Strategy, the CEC has convened to develop CCB's Community Engagement Plan and the CCHL Training Plan. All three documents were informed by the CEC members' expertise in addressing health disparities, but further informed by in-depth interviews with key stakeholders. An over-arching goal of CCB's community engagement approach is to leverage existing initiatives and trainings and identify opportunities to promote dialogue around cultural competency and health literacy wherever possible.

Given the significance of cardiovascular disease in Brooklyn and the desire on the part of members of the CEC to identify specific ways in which CBOs can be engaged to address some of the public health issues upon which CCB is focused, a workgroup was formed to focus on community engagement around cardiovascular disease. This workgroup (comprised of individuals from CBOs, clinical providers and workforce partners) was charged with development of a pilot community engagement program in Central Brooklyn, particularly in zip codes 11207 and 11212, where residents suffer from higher than average rates of cardiovascular disease and where working to address the social and other factors affecting health outcomes has been identified as a potential key to the achievement of DSRIP goals. The workgroup has decided to conduct community resource mapping in the identified zip codes as a means by which to both (a) share information about health problems and community resources available to address those problems, and (b) engage youth (high school and college students) in this specific effort and in community engagement/healthcare planning going forward. CCB is partnering with the Massachusetts Institute of Technology (MIT) and Medgar Evers College of the City University of New York on this program. This work will be undertaken over the summer of 2016 and will inform the structure and process for future community engagement activities.

Funds Flow and Sustainability Planning

As described above, CCB has established consistent rules in developing and executing MSA schedules, and has begun flowing funds to numerous Participants. CCB’s plans for the use of DSRIP funds are broken into four categories of spending, with the percent of spending in each category varying by year. The relatively fragile financial status of safety net providers in Brooklyn is such that most CCB Participants are unable to invest independent of DSRIP funding in the launch of projects and initiatives that are critical to the achievement of DSRIP goals. Accordingly, CCB has to date released funding only from the budget category “Project Implementation Costs.” As the DSRIP program evolves, and as CCB is increasingly paid on the basis of performance vs. payments for reporting, the proportion of funds distributed to CCB Participants in the form of internal PPS bonus payments will also increase. See [Figure 3](#) below for more information.

Figure 3

Budget Category	DY 1	DY 2	DY 3	DY 4	DY 5	All Years
Project Implementation Costs	85%	75%	55%	40%	50%	60%
Revenue Loss	0%	5%	15%	20%	5%	10%
PPS Provider Bonus Payments	0%	5%	20%	30%	45%	20%
Reinvestment	15%	15%	10%	10%	0%	10%
Total	100%	100%	100%	100%	100%	100%

CCB’s sustainability planning efforts to-date have focused on in-depth engagement with vital-access hospitals, given the key role these hospitals play in implementing and achieving healthcare transformation. Substantial effort has focused on the development of NYS Vital Access Provider Assurance Program (VAPAP) transformation plans and operationalizing these plans under Value Based Payment Quality Improvement Program (VBPQIP). CCB plays a key role in facilitating, monitoring, and evaluating the hospitals participating in VBPQIP to ensure that these critical resources are in a position to engage in broader delivery system transformation efforts, including value-based payments (VBP). Engagement of other provider partners and CBOs into the VBP planning process has also begun. Working as the Sustainability Planning Workgroup, the Maimonides PPS and leadership teams at the three VBPQIP hospitals have convened to discuss VBPQIP implementation, but also initial planning related to building a clinically integrated network. The overall aims of CCB’s clinical-integration engagement is to find ways to 1) reduce cost per unit of service, and/or 2) increase the quality of services provided, and/or 3) increase the accessibility of needed services, while maintaining care in as-local-as-possible settings. Sustainability planning efforts will continue in the coming months, and we will look to engage an expanded roster of key CCB stakeholders – including network Participants, regulatory authorities and, most importantly, communities served – in the ongoing sustainability-planning process.



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

PPS Name: Maimonides Medical Center

Project: 2.a.i

Challenges the PPS has encountered in project implementation:

Brooklyn’s health care system is highly fragmented, presenting significant challenges to the development of an integrated delivery system (IDS). Many providers in this fragmented system do not have an Electronic Medical Record (EMR). Those with EMRs rely on a variety of systems with varying capabilities. Few providers have access to an electronic care management tool to manage a patient’s services, and few have achieved PCMH status.

Brooklyn’s Medicaid beneficiaries struggle with significant health disparities, complex social needs that impact health, and consequently, developing an effective IDS in Brooklyn requires coordination among a broad range of partners and specialties.

Financial uncertainty continues to be a challenge for many providers, as they struggle with resources, both capital and workforce-related, to achieve transformations within their systems and engage with other systems as part of an IDS.

Efforts to mitigate challenges identified above:

Leveraging investment and experience from the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (HEAL) and the Medicaid Health Home program, Community Care of Brooklyn (CCB) will deploy the GSI HealthCoordinator web-based care-planning tool to designate and connect members of patient care teams and document key elements of patients’ care plans, regardless of which EMRs are used by the network Participants. Subject to patient consent, Participants involved in the care of a patient will have access to a shared care plan and population-health-management platform, which includes clinical data and event notifications from the Healthix regional health information organization (RHIO), part of the Statewide Health Information Network of New York (SHIN-NY).

CCB is actively engaging practices around Patient Centered Medical Home (PCMH) standards and is deploying PCMH technical assistance to practices to assist them with the transformation necessary to achieve certification.

Recognizing the critical role of CBOs in enhancing community and patient engagement and in the development of an effective IDS, CCB is partnering with CBOs that will participate in the development of trainings that address health disparities and social determinants of health for providers and communities. CBOs are also a pivotal linkage between the community in general and healthcare providers in an IDS.



Implementation approaches that the PPS considers a best practice:

CCB considers the deployment of our web-based care planning and coordination platform essential to creating an IDS, especially considering the plethora of EMRs in use and given the logistical hurdles to adopting a single EMR across such a large PPS comprised of such a diverse network of providers (“Participants”). CCB Participants will be able to leverage the RHIO/SHIN-NY, through the GSI Health Coordinator, to facilitate data sharing and coordination of care across systems and EMRs.

CCB also considers our community engagement approach as critical to system transformation and the development of an IDS. CCB is working with CBOs to begin community engagement efforts that not only address health disparities in communities, but seek to engage CBOs and communities directly as partners in the larger IDS. CBOs act as a critical link between communities and providers, and work closely with communities to develop self-management skills and promote wellness.

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

While there are significant challenges in creating an IDS, CCB has benefited from embarking on efforts that support and promote the development of an IDS over the decade prior to DSRIP, including State support through HEAL grants to develop the Brooklyn Health Information Exchange (BHIX), which is now part of Healthix. At that time, Maimonides began working with GSI to develop the GSI Health Coordinator, which has served as the web-based care planning platform for both of CCB’s affiliated Medicaid Health Homes - the Brooklyn Health Home and Coordinated Behavioral Care (CBC), and is now central to the growth of our IDS. Additional support from a Center for Medicare and Medicaid Services Health Care Innovation Award (HCIA) in 2012 helped further develop the GSI Health Coordinator platform, tailored to our specific needs.

Further supported by the HCIA award, the overall development of the Brooklyn Health Home has been foundational to our DSRIP efforts. Maimonides recognized the importance of developing a smaller, integrated delivery system through the Brooklyn Health Home for individuals with complex, chronic conditions, and this served as the platform for creating our expansion to a larger borough-wide IDS.

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

At this time, there are no changes to the populations that were proposed to be served.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 2.a.iii

Challenges the PPS has encountered in project implementation:

Identifying patients who are eligible for the Health Home at-risk (HHAR) project has been challenging for each of CCB's network Participants. Participants may not possess a full understanding of the Health Home program and program eligibility, which impacts their ability to identify HHAR eligible patients.

There are further challenges in identifying patients within practices. These challenges include variation between ICD-9 and -10 codes and their impact on problem lists; outdated patient problem lists; and variations in documentation among providers, even within one organization. Participants without EHRs are not able to generate lists of patients to engage in this project and must rely on manual or newly developed workflows to begin identifying patients who are eligible for HHAR interventions.

Another challenge is the lack of workforce to interface with patients at the practice level. This is particularly an issue with small practices, which account for 77% of our network's primary care practices (PCPs).

Efforts to mitigate challenges identified above:

CCB has been educating network Participants on Health Home and HHAR, which has improved Participant recognition of differences in eligibility for these two populations. CCB is providing assistance in connecting patients at Participant practices with Health Home services for eligible individuals. CCB has also paired Participant Health Home care management agencies with practices to enroll Health Home eligible patients during clinic visits, and to help identify HHAR eligible patients. Additionally, CCB has identified care management agencies to partner Health Coaches with smaller primary care practices that do not have the volume of patients to support a full time Health Coach.

CCB is supporting practices by providing guidance on relevant ICD codes, and has engaged with clinical leadership at practices around documentation and problem list reconciliation. CCB has also provided short-term workflow solutions to support practices without EHRs to identify HHAR eligible patients until long-term solutions are implemented.

CCB has developed and launched training for health coaches who will work with HHAR-eligible patients. CCB has also developed and launched training for care teams in motivational interviewing techniques for patient engagement.



Implementation approaches that the PPS considers a best practice:

CCB's Health Coach training is a best practice in supporting practice-based care management for HHAR-eligible patients. Motivational interviewing training for care teams is also a best practice.

Creating direct linkages between providers and Health Home care management agencies to facilitate Health Home enrollment across the CCB network is also a best practice.

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

CCB has partnered with the City University of New York (CUNY) Kingsborough to create a curriculum for health coach training for qualified medical assistants (MAs) and patient care technicians (PCTs), not only to support the HHAR project and PCMHs in general, but also as an opportunity for career development. Individuals who complete the curriculum will receive college credits.

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

At this time, there are no changes to the populations that were proposed to be served.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 2.b.iii

Challenges the PPS has encountered in project implementation:

Access to timely primary care services is a challenge for Community Care of Brooklyn (CCB) network participants. While some patients targeted in this project do not have an established relationship with a primary care provider (PCP), others who have a PCP cannot access care in a timely manner when they need it. Therefore, connecting patients with PCPs is only part of the challenge, as Patient Navigators in CCB network EDs are identifying challenges around getting timely appointments for more urgent issues.

A related challenge will be changing patient behavior even as we work to increase access to and availability of primary care services. A significant driver of low acuity ED visits is the lack of timely access to services after hours, including lab and radiology services.

Another challenge is that EDs do not prioritize low acuity visits, and thus do not allocate any internal resources to addressing issues in this population. Where low acuity visits intersect with high utilization, more attention is paid to such individuals. However, low acuity paired with low utilization is not considered a priority for EDs, and there are challenges in getting EDs to focus on such patients.

Efforts to mitigate challenges identified above:

CCB is working with PCPs to achieve PCMH Level 3 designation, a key component of which is offering same-day appointments and open access scheduling. CCB is also working with select primary care practices to extend hours on nights and weekends through a variety of mechanisms including recruitment of new PCPs. Certain CCB Participants have also received Capital Restructuring Financing Program awards to expand capacity via new primary care and urgent care sites.

CCB is working with network EDs to prioritize high utilizers who present with low acuity to EDs, many of whom may qualify for Health Home services, by embedding Health Home care management agencies in hospitals. These on-site Health Home coordinators facilitate Health Home enrollment and engagement with the goal of improving connections to community-based services and reducing ED use. CCB will continue to work with and provide training to EDs around low-acuity visits that are not associated with high utilization, with a goal of establishing or strengthening PCP relationships.

Implementation approaches that the PPS considers a best practice:



CCB considers the use of the GSI HealthCoordinator system a best practice that can facilitate coordination between the ED, community providers, and other support services. On-site Health Home care management agencies at hospitals, focusing on enrolling and engaging Health Home-eligible patients when they present to EDs and hospitals, is also an emerging best practice.

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

CCB is working with its network Participants to analyze performance metrics related to improved patient outcomes that are critical to all PPS's success with DSRIP efforts. Some quality metrics are not "assigned" to the ED Triage project specifically, but EDs would represent a good opportunity to engage patients who may be having adverse outcomes that will drive these performance metrics. Examples include asthma- and behavioral health-related performance metrics. CCB is also focusing efforts on addressing individuals identified as super utilizers, and participated in the first NYS DSRIP MAX series to develop workflows to manage this population at Interfaith Medical Center. CCB plans to use the MAX project as a pilot for larger network implementation.

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

While the ED Triage project focuses on low-acuity visits and improving primary care access, in-depth, local, community-needs assessments have helped focus each network ED on the populations and needs that are specific to their community. For example, the needs assessment completed as part of CCB's participation in the MAX series highlighted that super utilizers often presented for low-acuity visits and that lack of connection to primary care was frequently not the key driver of such ED visits. While CCB's initial plans for the ED Triage project focused largely on identifying low-acuity patients and connecting them to PCP appointments, there is growing recognition that each ED has unique super-utilizing populations with a range of behavioral health and social issues that drive their ED visits. Reducing preventable ED visits will require strategies that address these local issues.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 2.b.iv

Challenges the PPS has encountered in project implementation:

There are barriers to effective communication and coordination between hospitals and community providers that often complicate patients' transitions. Coordination challenges are often the underlying cause of unnecessary readmissions. Additionally, there are challenges to effectively linking patients with appropriate community-based resources, clinical services and social services, post-discharge.

There are challenges within hospitals around coordinating their own internal resources to focus on following patients at risk for readmission through the 30-day care transitions period. Hospitals have limited, if any, resources devoted to such post-acute care follow up, and incorporating new resources brings challenges of internal coordination with existing resources. Additionally, hospitals have limited awareness of Health Homes and limited mechanisms for engaging patients with Health Home services.

These issues highlight the importance of coordinating new and existing resources in order to improve the efficiency and effectiveness of engaging patients around their care transitions when they are at risk for readmission.

Efforts to mitigate challenges identified above:

CCB will deploy our web-based care collaboration system, GSI HealthCoordinator, to help address the fragmented nature of communication and coordination efforts during care transitions from hospitals. Through GSI HealthCoordinator, providers in the hospital can communicate securely with care managers, community-based organizations (CBO), PCPs and other members of Patients' care teams. CCB is also pairing Health Home care management agencies with hospitals, to facilitate enrollment and engagement with Health Home services for eligible patients when they are hospitalized. CCB has developed close working relationships with many community-based social service agencies and will build on this base to connect patients with available programs and resources.

CCB has invested in resources at each network hospital to implement the 2.b.iv project, and is working closely with each hospital to develop and refine workflows and processes that coordinate existing resources with the additional resources of Transitional Care teams, Health Home coordinators, and ED Patient Navigators.

CCB has worked to ensure provider input and buy-in through the development of care transition protocols in consultation with an actively engaged Care Delivery and Quality Committee and program planning workgroups for the 2.b.iii and 2.b.iv projects, both of which include Participants from across the CCB network.



Department of Health

Implementation approaches that the PPS considers a best practice:

CCB considers the use of the GSI HealthCoordinator a best practice that can facilitate coordination between the ED, community providers, and other support services. On-site Health Home care management agencies at hospitals, focusing on enrolling and engaging Health Home-eligible patients when they present to EDs and hospitals, is also an emerging best practice.

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

CCB has undertaken two quality improvement initiatives related to 2.b.iv: 1) a monthly Transitional Care call that includes the Transitional Care teams from each network hospital; and 2) the creation of a tool for use in reviewing the quality of 30-day care plans. Both initiatives support quality improvement processes at each hospital, and the monthly calls use the learning collaborative approach to facilitate sharing of best practices, challenges, and to think collectively about process improvements that might drive improved outcomes.

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

In-depth, local community needs assessments by each partner have helped identify specific populations that each hospital will focus their efforts around managing care transitions and reducing readmissions. While there is broad overlap in the populations at each hospital that will be served through this project, there are important, local differences in clinical populations at risk for readmission at each facility, and each hospital is developing workflows and resources to address these more-specific populations at risk.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 3.a.i

Challenges the PPS has encountered in project implementation:

Resources are a challenge for 3.a.i, especially for those practices implementing physically co-located services into either primary care or behavioral health settings. Space, physical plant issues, and availability of primary care physicians (PCPs) present challenges for CCB Participants seeking to integrate primary care into behavioral health services. Participants with experience attempting to integrate primary care into behavioral health settings have all acknowledged significant hurdles to long term sustainability of this model.

Behavioral health staff resources are a challenge because of shortages in supply of psychiatrists. A challenge specific to implementation of the Improving Mood - Promoting Access to Collaborative Treatment (IMPACT) model is identifying psychiatrists who can support the role of the collaborative care consulting psychiatrist at partner sites that do not have associated behavioral health services. Several Participants lack such resources, and thus face more significant barriers to implementation.

Stigma associated with behavioral health conditions continues to be a challenge. Provider engagement remains a challenge because of stigma, in addition to concerns about additional workloads for PCPs.

Efforts to mitigate challenges identified above:

CCB will leverage resources from the Health Homes in CCB's network to address the lack of coordinated, primary care services for individuals with serious mental illness. Health Homes have demonstrated the ability to use care managers and the GSI Dashboard to coordinate care across primary care and behavioral health settings, forming a virtual care team. CCB is promoting improved medical monitoring in behavioral health settings to assist clinics in adopting population health management strategies for the patients they serve.

As sustainability and clinical effectiveness have been demonstrated for behavioral health integration into primary care settings, CCB is promoting adoption of physical co-location of behavioral health staff and services and/or collaborative care and the IMPACT model. For Participants lacking existing internal or collaborative psychiatric resources, CCB is planning to implement telehealth services for collaborative care.

CCB has begun providing training and technical assistance on the IMPACT model and behavioral health integration. Training consultants will assist practices in adopting the IMPACT model and work to minimize burdens for providers by assisting with the creation of efficient workflows.

CCB will undertake education and outreach for both patients and providers. Patient education will focus on



increasing knowledge about mental illness and the importance of adherence to care. Resources, including peer coaches, will be used to provide education and support to patients. The adoption of IMPACT model has been shown to effectively reduce the stigma associated with behavioral health conditions.

Implementation approaches that the PPS considers a best practice:

Use of Health Home care management and the GSI Dashboard to coordinate behavioral health and primary care services for individuals with serious mental illness is a best practice that CCB will continue to promote.

IMPACT is a best practice that has demonstrated improved outcomes, reduced stigma, and aligns resources with demand more efficiently. Integrating behavioral health services into primary care settings is a best practice which, when combined with IMPACT, provides a primary care service greater ability to manage a larger range of behavioral health issues.

Critical Time Intervention (CTI) is a best practice to address behavioral health issues in a high-utilizing patient population

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

CCB has been working closely with the NYC Department of Health and Mental Hygiene (DOHMH) and has participated in several State-led initiatives, to help promote behavioral health integration efforts. CCB has led the development of a DSRIP Domain 4 project to strengthen the mental health and substance abuse infrastructure across systems. CCB is working with three other New York City PPSs to implement a city-wide project to provide technical assistance and support to public schools to promote behavioral health wellness and improved recognition of at-risk and clinically significant behaviors. The project will also strengthen connections to care in the community for children with such needs.

CCB has been invited to participate in a Health and Recovery Plans (HARP) pilot, and has been engaged in discussions with NYS Department of Health, NYS Office of Mental Health, KPMG, and health plan on implementing the pilot.

CCB has participated in KPMG-led behavioral health clinical advisory groups on Value Based Payment, the NYC Regional Planning Consortia on behavioral health and the Population Health Improvement Program Steering Committee, all with the aim of increasing understanding of behavioral health issues. CCB supports two Greater New York Hospital Association-led behavioral health learning collaboratives through participation on the Steering Committees of the Maternal Depression Screening Collaborative and the Behavioral Health Readmissions Collaborative.

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



Department of Health

At this time, there are no changes to the populations that were proposed to be served.



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

PPS Name: Maimonides Medical Center

Project: 3.b.i

Challenges the PPS has encountered in project implementation:

Identifying patients with cardiovascular disease has been challenging due to issues with outdated problem lists, coding (ICD-9 vs. ICD-10 codes), and problems with EHR reporting features. In general, the necessary information is documented in the EHRs, but it has at times been difficult for IT staff at Participant organizations to generate those data in reports/registries from the EHRs.

Engaging care teams and patients and changing from a provider-centric directive system to a patient-centered collaborative culture requires great effort. With tight timelines and the numbers of staff and patients to engage, this issue has been particularly challenging.

Training care team members on the Stanford Chronic Care Model, motivational interviewing, stages of change, goal setting, and timely follow-up of patient generated goals is a challenge.

Patient perception of cardiovascular disease and its treatment represents a challenge. Brooklyn is one of the most diverse counties in the United States and includes patients who culturally prefer the use of herbs or other non-Allopathic/Osteopathic alternatives to treat hypertension vs. mainstream pharmacologically active medications for treating hypertension. Engaging patients around cardiovascular disease, particularly hypertension and dyslipidemia, has been challenging.

Limited staffing resources to spend time with patients to review lay-level education, develop self-management goals, and follow-up with patients has been an additional challenge.

Efforts to mitigate challenges identified above:

CCB is providing support to Participant IT staff/consultants on ICD codes and patient registries to mitigate patient-identification issues. CCB has engaged partners in meetings around the project and interventions, and we have framed the project within larger Patient Centered Medical Home efforts.

CCB is training staff on the importance of patient engagement and patient-generated self-management goals. CCB has funded, trained and launched Health Coaches into primary care Participant practices to provide additional staff resources in support of care teams.

CCB's community engagement committee has launched a community engagement effort to map resources for patients with cardiovascular disease and initiate conversations with community members around cardiovascular disease.



Implementation approaches that the PPS considers a best practice:

CCB considers the Health Coach curriculum development and training to be a best practice.

Developing training to support patient engagement and patient-generated self-management goal is another best practice.

Establishment of a community engagement committee early in program development and leveraging community partner expertise in community engagement efforts is also a best practice.

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

There is a high level of enthusiasm and participation among community engagement committee members and other partners to collaborate around strategies to enhance and strengthen community involvement and participation. The committee launched a cardiovascular disease workgroup, which led to the development of a community engagement project with an initial focus on targeting cardiovascular disease in two central Brooklyn zip codes, 11212 and 11207, through community resource mapping, key stakeholder interviews, and youth engagement.

This project is currently underway, and two key partners are the Massachusetts Institute of Technology (MIT), which is providing graduate students to supervise college and local high school students, and Medgar Evers College. The participants in this effort are working to create a Participatory Action Research (PAR) project. The PAR seeks to engage the community in partnership with academia to create a collaborative learning and quality improvement process to better understand the barriers and challenges to healthy living from a cardiovascular perspective, and to begin to identify solutions to address these barriers.

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



Department of Health

At this time, there are no changes to the populations that were proposed to be served.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 3.d.ii

Challenges the PPS has encountered in project implementation:

In-home assessments are the single, greatest challenge to the implementation of this project. In general, patients are agreeing to work with care team members, including community health workers, but there are high rates of refusals for home visits, with patients and families willing to provide information about the home environment to care team members and CHWs, but not allowing a physical home visit.

Creating a referral system that supports warm handoffs from clinical providers to home-based asthma care service providers is an additional challenge.

Participant engagement across the delivery system has been challenging given the number of Participants across CCB's network (ex: attending and rotating residents in EDs and primary care providers).

Developing the community health workforce required to support the scale of this project has been another challenge.

Efforts to mitigate challenges identified above:

CCB has identified and partnered with experienced providers of home-based asthma services in an effort to ensure that the patients and families in need of services that will reduce the need for ED visits and hospitalization can be reached.

Ongoing Participant engagement and education around the project is critical to patient engagement efforts, especially around home visits, as many patients are engaged with their providers. Improved provider buy-in will also increase the number of warm handoffs.

CCB will work to connect patient navigators in CCB's ED care triage program to home-based asthma service providers participating in this project.

CCB is collaborating with workforce development experts to develop and train community health workers (CHWs).

Implementation approaches that the PPS considers a best practice:



Department of Health

CCB is leveraging best practices of establishing collaborative and coordinated relationships across systems through the Brooklyn Health Home and the GSI Dashboard to pair hospitals/EDs with primary care providers, CHWs and asthma-based community services.

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

CCB is coordinating efforts across PPSs and with local government agencies, including NYC Department of Health and Mental Hygiene, to standardize CHW job functions and to develop training to further develop the CHW workforce and its integration into the overall health care team.

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

At this time, there are no changes to the populations that were proposed to be served.



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

PPS Name: Maimonides Medical Center

Project: 3.g.i

Challenges the PPS has encountered in project implementation:

One challenge to the implementation of this project is the lack of existing trainings in primary palliative care.

Patients have a limited understanding of the scope of palliative care, which creates challenges related to patient engagement. Patients frequently think of a palliative care as “end-of-life” care, making them reluctant to engage their providers in a broader dialogue around related issues. Cultural issues are a challenge as well, as there are important differences in how immigrant cultures engage in discussions about palliative care.

Primary care physicians (PCPs) often lack the experience and training to address palliative care issues in their practices, which creates challenges for patient engagement. Similar to behavioral health issues, PCPs often recognize that palliative care issues exist and are an opportunity to engage patients around quality of life issues, but they frequently cite lack of time and support staff to assist in engaging with their patients around these issues. PCPs also report lack of clinical and technical support from specialists.

Some EHRs do not support recording of palliative care needs and interventions, which creates challenges for providers.

Efforts to mitigate challenges identified above:

CCB has partnered with Metropolitan Jewish Health System’s (MJHS) Institute for Innovation in Palliative Care (IIPC) to develop and launch training in primary palliative care for CCB network Participant primary care providers, nurses, and social workers. The model for primary palliative care is an adaptation of the IMPACT/collaborative care model for behavioral health. Practice supports for 3.g.i include health coaches and care managers (depression care managers in IMPACT), and palliative care specialists will provide clinical backup and consultation to PCPs managing lower severity palliative care issues in the primary care practice (consulting psychiatrist in IMPACT).

MJHS’s IIPC will also develop and deliver culturally and linguistically appropriate patient-facing education that recognizes the differences in how to engage patients around these issues, especially when end-of-life issues need to be addressed. IIPC is also developing palliative care resources for PCPs, and will support practices in developing templates to support care team documentation and registry development.

Implementation approaches that the PPS considers a best practice:



Department of Health

CCB considers the collaboration among palliative care specialists and primary care team members to be an emerging best practice in the effort to develop a locally appropriate training curriculum and model for palliative primary care. Development of a consulting palliative care resource for PCPs is another best practice.

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

There has been a strong and positive reception among PCPs for primary palliative care training during the initial roll out. CCB recognizes that the palliative care population is relatively unengaged with Health Home care management services, despite high eligibility rates in the population. Health Home care management can provide an important layer of additional supports to patients, especially those with poor social supports, but also because of the need for improved care coordination in this population.

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

At this time, there are no changes to the populations that were proposed to be served.



DSRIP Mid-Point Assessment - Project Narratives

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

PPS Name: Maimonides Medical Center

Project: 4.a.iii

Challenges the PPS has encountered in project implementation:

There have been several challenges encountered in project implementation. The first relates to attempting to coordinate a city-wide project involving four PPSs, as fidelity to a model of care is more challenging when implementing across multiple PPSs.

A second challenge relates to the need to engage large, external stakeholders such as the Department of Education (DOE), Office of School Health (OSH), and Department of Health and Mental Hygiene (DOHMH) around implementation, with the related challenge that none of the PPSs had any experience as a PPS working with the public school system in NYC.

A third challenge involves the need to engage individual schools and staff.

Efforts to mitigate challenges identified above:

The PPSs formed a joint charter to implement one model for the project in all PPSs, helping to ensure fidelity to the model. Jewish Board of Family and Children Services (JBFCS) was chosen to lead project management efforts across PPSs to ensure consistent implementation and to apply their deep experience in working with schools.

In order to better coordinate our efforts, we have successfully engaged DOE and OSH on project implementation through a Steering Committee, along with JBFCS and the four PPSs. OSH has hired a part-time coordinator to support project implementation.

OSH has expressed concern that schools and staff will be less engaged without support around students who are having difficulty accessing care in the community. The PPSs are focusing efforts on meeting the needs of schools to access care by developing and coordinating child intake services modeled on the Urgent Evaluation Service at Maimonides Medical Center.

Implementation approaches that the PPS considers a best practice:



Department of Health

The PPSs formed a joint workgroup in order to develop a consensus-driven model and project concept document. Subject matter experts from each PPS were involved in creating the model and project concept document. This workgroup has also been important as a strategy of engagement within each PPS, and workgroup members from each PPS will play a role in local project implementation.

Another important best practice has been engaging senior leadership from multiple stakeholders, including DOE, OSH, and DOHMH to help shape the project from a high level. Finally, engaging JBFCS, who is partnering with the New York Academy of Medicine (NYAM) on project implementation, provides the PPSs with Participant partners who have extensive experience with project implementation in schools.

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

The MHSA schools-based project is being proposed in the context of other efforts to strengthen MHSA activities in schools, including THRIVE NYC, as well as two city initiatives to address community/renewal schools and high suspension schools. DOE, OSH, and DOHMH have worked with the PPSs to coordinate these efforts, so that we are able to strategically engage schools that are not implementing other city projects concurrently, so as not to overwhelm or discourage administrators.

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

One change to the population we are proposing to serve came from recognition from DOE and OSH that there are significant needs for providing MHSA-strengthening activities to elementary schools, rather than just middle and high schools. CCB and other PPS participating in this project will evaluate the potential to pilot the schools-based project in elementary schools after implementation in 100 middle and high schools in NYC.



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

PPS Name: Maimonides Medical Center

Project: 4.c.ii

Challenges the PPS has encountered in project implementation:

Coordinating a population health project across 7 PPS creates challenges to implementation. While there is great enthusiasm and commitment to collaboration among the PPS, given the number of strategies employed throughout NYC to improve HIV screening and access to care, and given the number of PPS involved, it has taken time to organize workgroups and create plans that will satisfy each PPS' project needs.

Access to data to understand the current screening, infection, and mortality rates is a challenge. Data will support identification of borough and city-wide hotspots and the appropriate deployment of resources.

Understanding the capacity of Participants within the CCB network to address this project is another challenge.

Efforts to mitigate challenges identified above:

The Citywide HIV Coalition, made up of representatives of the collaborating PPS, invested time to discuss opportunities for cross-PPS planning. Together, the Coalition created workgroups to focus on common strategies, and to help structure and align the implementation efforts. These workgroups include: 1) models of care for viral load suppression, 2) HIV screening and linkage to care, 3) PrEP implementation, 4) peer-based interventions improving service delivery of HIV care and prevention, and 4) EMR and data utilization.

CCB has established an HIV Workgroup that includes among its members individuals in a wide range of roles from a diverse group of stakeholder organizations committed to and engaged in efforts to end HIV/AIDS. CCB's HIV Workgroup serves as the forum for discussion of opportunities to increase access to and retention in HIV care that cut across the various subcommittees of the larger HIV Coalition. The CCB HIV Workgroup also allows for the identification and focused assessment of specific interventions and strategies to be deployed across CCB's large network of Participants.

Community needs assessments, MAPP Performance Dashboards, Medicaid claims data available through the Salient Interactive Miner (SIM), and NYC Department of Health and Mental Hygiene (DOHMH) HIV epidemiology data will be used to better understand what is happening across the City and in local communities.

We will use the CCB Participant Survey, CCB and citywide workgroup member expertise/insight, and Health Home resources to help us understand what resources are available locally and across NYC. CCB is



examining the potential to develop resource management tools in our web-based care collaboration system, GSI HealthCoordinator.

Implementation approaches that the PPS considers a best practice:

Engaging in collaboration across multiple PPS is an emerging best practice, as there is great potential for changes in population-based outcomes with larger, collaborative networks addressing problems together.

CCB has contracted with Housing Works to lead and implement this important population health effort for the PPS.

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

CCB is one of 7 downstate PPS collaborating on this project to align our approach, resources, and coordination with non-DSRIP programs and community resources that aim to address the same population and issues.

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

At this time, there are no changes to the populations that were proposed to be served.



**Department
of Health**