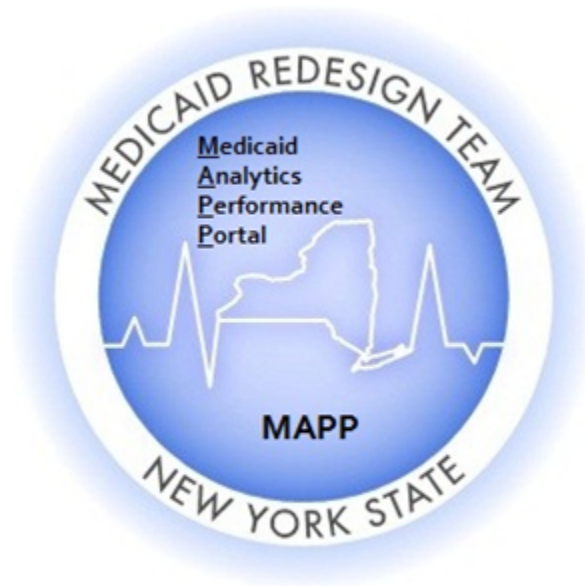


New York State Department Of Health Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Advocate Community Partners (AW Medical)



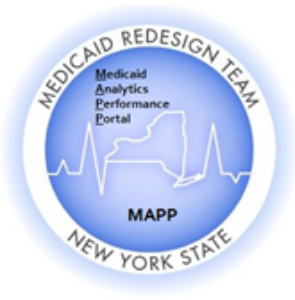
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This application is divided into 11 sections: Sections 1-3 and 5-11 of the application deal with the structural and administrative aspects of the PPS. These sections together are worth 30% of the Total PPS Application score. The table below gives you 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: **25_SEC000_DSRIP PPS Lead Financial Stability Tool AW Medical.pdf**

Description of File

File Uploaded By: ms593812
File Uploaded On: 12/22/2014 04:33 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: rt374083
Last Updated On: 12/22/2014 04:53 PM

Certified By: rt374083	Unlocked By:
Certified On: 12/22/2014 04:55 PM	Unlocked On:
Lead Representative: Ramon M Tallaj	



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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:

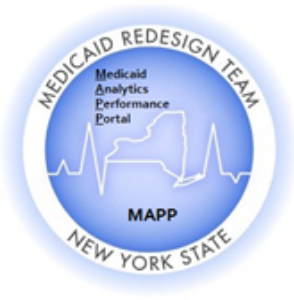
This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

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	Create an Integrated Delivery System, begin DY1, ongoing through Q4DY5	<p>The creation of a streamlined, clinically integrated delivery system (IDS) is essential to keeping patients healthy and better serving our community. The IDS will produce the following benefits:</p> <ul style="list-style-type: none"> • Engage ACP's diverse, community-based primary care physicians, specialists, and service providers with infrastructure and DSRIP programs • Advance the "Triple Aim" of better care for individuals, better health for the population, and lower costs • Reduce avoidable inpatient hospitalizations, readmissions, and emergency department visits by 25% • Provide the information technology needed to link providers and support coordinated care delivery across the IDS • Support the adoption of evidence-based clinical protocols as well as the measurement and management of continuous quality improvement and clinical outcomes • Develop the organizational infrastructure, through a strong program management office, to support population health management capabilities
2	All Primary Care Practitioners Achieve PCMH 2014 Level 3 by Q4DY3	<p>The Patient-Centered Medical Home (PCMH) model of care will transform primary care to better serve the community of Medicaid recipients. The PCMH model is critical to the improvement of cost-effective, efficient, patient-centered care for adults and children, including access to behavioral and oral health across the PPS. The benefits of PCMH practice transformation include, but are not limited to:</p> <ul style="list-style-type: none"> • Higher quality and improved outcomes at lower costs • Better care experience focusing on the whole patient, including the involvement of family and friends • Better care through the use of evidence-based medicine and clinical decision-support tools • Use of EHR to support patient care, performance measurement, patient education, and communication • Enhanced access to care such as open scheduling, expanded hours and new communication options • A shift to value-based payments to support physicians who provide better care • Transform to team-based care to deliver patient care more effectively
3	Focus on care management and disease prevention	Building on the PCMH approach, ACP can have its greatest impact in



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#	Goal	Reason For Goal
	by Q4DY1	<p>decreasing fragmented care, improving access to care and reducing chronic disease by ensuring care is coordinated across the continuum, especially for patients with complex conditions or at risk of becoming complex. Through this focus, ACP will:</p> <ul style="list-style-type: none"> • Build on PCMH use of care plans, particularly for complex patients • Provide early intervention care management to patients on a declining trajectory • Develop centralized care management and care coordination functions that get patients to appropriate level of care when they need it • Ensure better discharge planning and transitions of care following hospitalization • Focus on increasing screenings, improving access to care, identifying mental and behavioral health issues earlier, and moving from episodic to whole person care
4	Adopt evidence-based protocols by Q4DY1	<p>Across the health care industry there is room for improvement in provider's adoption of and adherence to evidence-based guidelines. Our PPS committed to implementing and hardwiring protocols and guidelines for enhanced clinical outcomes. Through our efforts, we will:</p> <ul style="list-style-type: none"> • Adopt evidence-based, EMR integrated protocols for CVD, asthma, and diabetes to identify risk factors and focus on prevention and management of chronic diseases • Ensure that high-risk patients are appropriately monitored and treated through an integrated, multidisciplinary care team approach • Educate patients on lifestyle modification and self-management as key elements of their treatment • Ensure that care that is delivered in accordance with protocol • Improve use of clinical decision-support tools
5	Expand innovative health IT platform by Q4DY3	<p>Sharing clinical data is critical to improving quality and safety of patient care and decreasing avoidable or duplicative services. Our PPS will share data both within and beyond our network. Our efforts will:</p> <ul style="list-style-type: none"> • Increase use of information technology (IT) to support patient care, performance measurement, patient education, and enhanced provider to provider communication • Enhance technologies for data analytics, disease management and population health • Ensure two-way connectivity of clinical information, number of sites/providers connected to HIE, and Meaningful Use • Apply rapid cycle evaluation of partner performance on a monthly basis in order to identify best practices and assist low-performers in improvement • Ensure data security
6	Lower costs of care while preserving Medicaid safety net system by Q4DY5	<p>Historically, providers have not been accountable for managing costs of care, and have been paid fee-for-service. We aim to shift providers to value-based payments that reward the efficient and effective use of healthcare resources. During this shift to value-based payments, we will:</p> <ul style="list-style-type: none"> • Monitor the health of financially fragile providers to ensure access to care • Reduce avoidable hospitalizations, readmissions, and emergency department visits by 25%, consistent with DSRIP program goals • Dynamically assess the supply of providers to be sure it meets patient demand for services within the PPS • Coordinate care within the network to ensure complete understanding of patient healthcare needs and efficient use of services to meet those needs
7	Enhance patient satisfaction and outcomes by Q4DY4	<p>When managing care, it is imperative that patient outcomes, including quality as well as patient satisfaction, are maintained or enhanced. Our PPS will:</p> <ul style="list-style-type: none"> • Evaluate CAHPS performance



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#	Goal	Reason For Goal
		<ul style="list-style-type: none"> • Monitor patient feedback, complaints, and appeals • Through cultural competency efforts, improve patient knowledge and experience of the healthcare system • Overcome barriers to care, through efforts to link with community resources
8	Improve community health status, ongoing through Q4DY5	<p>Social determinants of health, including but not limited to social, environmental, cultural and educational factors, have a measurable impact on population health. Therefore, improving community health status requires coordination, collaboration, and an ongoing effort to address these issues. ACP and our partners will:</p> <ul style="list-style-type: none"> • Monitor health education and compliance • Improve prevention and health literacy and reduce health disparities • Address social and workforce issues which affect community health status • Effectively draw on the expertise of partner CBOs to further strengthen cultural competence and engage patients • Build population health capabilities, with a focus on tobacco use cessation and chronic condition prevention and screenings
9	Ensure workforce stability during system transformation, DY2 through Q4DY 5	<p>Population health initiatives are successful by decreasing utilization of high cost services, such as hospital use, while increasing use of lower costs services and settings. It is inevitable that efforts such as these have the potential to destabilize the workforce if not managed with care. Our PPS is unwavering in our commitment to:</p> <ul style="list-style-type: none"> • Mitigate job loss through skill enhancement, retraining and redeployment efforts • Offer opportunities created through expansion of certain services (e.g., care management) to displaced workers • Invest in training to assist workforce in supporting new models of care delivery
10	Secure financial sustainability during and after DSRIP program period, ongoing through Q4DY5	<p>Building on the IDS infrastructure and population health programs, ACP will be able to pursue financial arrangements with value-based payments, so ACP providers can continue to:</p> <ul style="list-style-type: none"> • Further pursue relationships with managed care organizations that reward value-based care to secure long term sustainable funding for ACP's initiatives • Monitor the financial impact of DSRIP on ACP's financially fragile safety net providers • Assist safety net providers in the transition to value-based payments through DSRIP revenue loss funds

***Formulation:**

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

Advocate Community Partners (ACP) is a collaboration of diverse providers working with one of the state's largest and most respected hospital systems, North Shore-Long Island Jewish Health System, Inc. (NSLIJ). ACP physicians are in the neighborhoods we serve, and able to engage patients effectively in improving their health through culturally sensitive care supported. ACP exists as a not-for-profit Delegated Governance Model incorporating physician and hospital constituents. We maintain a physician-led Board supplemented by representation from NSLIJ and participation from other community-based safety-net hospitals to produce delivery system reform. A Steering Committee and PMO are the central control points for the work of committees. ACP's Board, professional staff, committee structure and PAC seek to achieve measurable improvements in culturally competent care and address healthcare disparities. ACP governance will oversee implementation of projects through collaboration with providers across the broad continuum of care—encompassing behavioral health and community social services organizations.

***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.



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The vision for ACP in five years, is the transformation from a large collection of healthcare providers, practicing largely in siloes, to a clinically integrated, efficient and effective care system. Advanced health IT will support our community-based physicians to connect even more closely with their patients to achieve DSRIP's "triple aim" of better care for individuals, better health for the population and lower costs.

ACP will foster disease prevention; improve clinical system integration and care transitions using evidence-based clinical protocols; demonstrate increased availability, access and use of primary care services to reduce cost, improve quality and enhance outcomes, using initiatives such as expanding PCMH capacity; integrate physical and behavioral health by building enhanced communication and collaboration between physical and behavioral health providers to reach better outcomes. ACP providers will expand value-based payment and direct payment approaches, which will increase effectiveness, efficiency and sustainability.

***Regulatory Relief:**

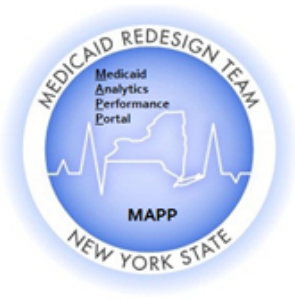
Is the PPS applying for regulatory relief as part of this application? Yes

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	Prohibited Business Practices: 10 NYCRR 34-1.3, 10 NYCRR 34-2.3, 10 NYCRR 34-2.4	<p>Projects:</p> <ul style="list-style-type: none"> • 2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management • 2aiii-health home at-risk intervention program for patients with one progressive chronic disease who are likely to evolve a second chronic condition • 2biii- emergency department (ED) care triage for the at-risk population • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions <p>Project Components:</p> <ul style="list-style-type: none"> • 2ai-ACP has an expansive integrated network of providers who will work as team to care for patients, improving overall health outcomes by monitoring and follow up. To ensure that each patient's care is managed in a comprehensive and efficient manner, it is imperative for providers to refer patients to partners within the PPS, all of whom share the common goal of meeting project metrics. • 2aiii-Primary care physicians (PCPs) will take a lead role in patient care by creating a plan to address issues related to chronic disease. This will entail referrals to appropriate providers within the PPS for clinical/testing services, to ensure that the patient's condition is monitored in a timely manner.



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#	Regulatory Relief(RR)	RR Response
		<ul style="list-style-type: none"> • 2biii-Care managers (CMs) will be placed in EDs to introduce the crucial component of long term care management/coordination at the first point of service. To meet the DSRIP goal of reducing hospital readmissions, CMs/providers will work in conjunction to refer the patient to the appropriate partners within the PPS for follow up care. • 2biv-ACP will require that every ED or hospital patient has a pre-discharge planning/transitional care visit which will include referrals to providers within the PPS who will ensure that the patient is stable/compliant post-admission. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, providers may be deterred from referring within the IDS, for the fear of engaging in prohibited business practices. Although care management requires that a provider take a lead role in a patient's care, such provider must work with a team, whom he/she can refer to, to ensure comprehensive care and monitoring of a patient's condition. Failure to grant such a waiver will adversely impact the success of the Projects. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of applying for an accountable care organization (ACO) certificate of authority; however, this option is not viable at this time due to the specific requirements for ACO formation, which do not align with the PPS in its current form. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although these regulations are relevant to patient safety in that they assure that patients are not referred for medically unnecessary care, waiver will not pose risk to patient safety. ACP will have protocols/processes in place to ensure that care plans and associated referrals are made only for medically necessary care/services to improve overall health outcomes.
2	Revenue Sharing: 10 NYCRR 600.9(c)	<p>Project:</p> <ul style="list-style-type: none"> • 2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management <p>Project Components:</p> <ul style="list-style-type: none"> • 2ai-ACP will create an IDS comprised of hundreds of providers working in conjunction to provide comprehensive patient care. Success or lack thereof will affect the PPS and the DSRIP program as a whole, hence, as contemplated by the DSRIP Program, partners within the PPS share in funds flow as an incentive to meet project metrics and the overall goals of the DSRIP program. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, the PPS may not be permitted to share in DSRIP funds received by the hospitals to the extent that such funds are viewed as the total gross income or net revenue of a medical facility. Integration, as a core component of the DSRIP program, may not be achieved if funds do not flow throughout the PPS, including from hospitals to other providers within the PPS, who must work as a team to achieve success in the DSRIP program. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered alternatives, however, no such alternatives support the funds flow arrangement that has been selected by the PPS. Further each partner within the PPS cannot seek approval from the DOH, due to the various sizes and capabilities of the partners within this diverse PPS. <p>Patient Safety Risk:</p>

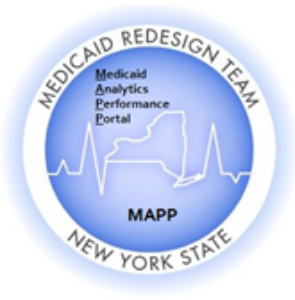


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		<ul style="list-style-type: none"> • Waiver of this regulation will not risk patient safety as this regulation pertains to appropriating hospital income/revenue to a facility over which the DOH has granted approval. ACP's funds flow methodology will ensure proper disbursement of monies from the State.
3	Ownership and Management-Active Parent: 10 NYCRR 405.1(c)	<p>Project:</p> <ul style="list-style-type: none"> • 2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management <p>Project Components:</p> <ul style="list-style-type: none"> • 2ai-ACP will form an IDS with an organizational structure comprised of committed leadership, clear governance and communication channels. ACP's leadership, in consultation with advisory and functional committees, will be largely responsible for decision-making that will ensure that the PPS meets project metrics and the overall goals of the DSRIP program. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • While it is not contemplated for the PPS to become co-operator of any hospitals, it is possible that some of the centralized collaborations within the PPS might be viewed as involving the PPS in one or more of the functions set forth in this regulation, and therefore, a waiver is being sought to avoid this unintended result. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered alternatives but there is no option that will ensure that ACP's governing body, which is largely representative of its associated partners, has the decision-making authority within the PPS that is necessary to create policies and take action in the best interest of the PPS. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of this regulation will not risk patient safety as this regulation pertains to relegating hospital decision-making authority to a PHHPC approved entity to ensure proper compliance and oversight. Each of the Article 28 entities will continue to have an approved Operator.
4	Management Contracts: 10 NYCRR 600.9(d), 10 NYCRR 405.3(f)	<p>Project:</p> <p>2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management</p> <p>Project Components:</p> <ul style="list-style-type: none"> • 2ai-ACP will form an IDS with an organizational structure comprised of committed leadership, clear governance and communication channels. To facilitate the achievement of clinical and operational objectives, it is imperative for ACP to contract with third party vendors. Contracting for crucial PPS centralized administrative services, such as information technology, will ensure that the PPS functions uniformly and partners can focus on providing the best clinical care to meet project metrics and the overall goals of the DSRIP program. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, there might be ambiguity concerning whether management contract approval might be required, and/or each PPS partner might have the onus of utilizing its own resources to perform PPS-related administrative services. Many partners have joined an IDS that can arrange such services through a governing body so that they may focus on the provision of quality clinical care. The requirements and burden of management contract oversight by the State will deter integration of providers and will ultimately compromise project implementation. <p>Alternatives:</p>

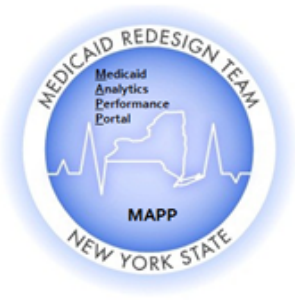


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#	Regulatory Relief(RR)	RR Response
		<ul style="list-style-type: none"> • ACP considered the alternative of having each partner arrange for and seek approval for its own management services contracts; however, this option presents an administrative burden contrary to the intent and timeframe of the DSRIP program. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of these regulations will not risk patient safety because the purpose of such regulations is to provide facilities with guidelines for the arrangement of management services. ACP's governing body will ensure that there is proper consultation and consideration prior to entering into a contract with a third party vendor.
5	<p>10NYCRR 415.3(d)(1),10NYCRR 751.9(n),10NYCRR 763.2(a)(10),10NYCRR 766.1(a)(11),10NYCRR 794.1(a)(10)</p>	<p>Projects:</p> <ul style="list-style-type: none"> • 2ai-creation of an integrated delivery system (IDS) that is focused on evidence-based medicine and population health management • 2aiii-health home at-risk intervention program for patients with one progressive chronic disease who are likely to evolve a second chronic condition • 3bi-evidence based strategies for disease management in high risk/affected populations (adult only/cardiovascular health) • 3ci-evidence based strategies for disease management in high risk/affected populations (adults only/diabetes care) • 3diii-evidence based medicine strategies for asthma management <p>Project Components:</p> <ul style="list-style-type: none"> • 2ai-ACP will create an IDS comprised of providers who understand the importance of and actively utilize platforms for interconnectivity such as electronic health records (EHR) systems and health information exchanges (HIEs) such as the RHIO/SHIN-NY. • 2aiii-The PPS will coordinate care on both a clinical and community level to address the global needs of a patient to improve overall health outcomes. It is imperative that providers have the ability to share patient health information (PHI) with entities such as community based organizations (CBOs) and social services. • 3bi-ACP will require interconnectivity between health professionals as well providers in community based and ambulatory care settings. PHI sharing is vital to ensure that all aspects of a patient's cardiovascular health are addressed and monitored, such as compliance with the Million Hearts Campaign recommendations. • 3ci-ACP will require interconnectivity between care coordination teams that will consist of a variety of providers including physicians, diabetes educators, behavioral health providers, and community health workers. PHI sharing is vital to ensure that diabetic patients are successful in self-management. • 3diii-ACP will require interconnectivity between PCPs, specialists, and community based organizations to ensure that asthma management is regionally coordinated. PHI sharing is vital to monitor the affected population. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, providers will be required to obtain consent from patient at every point of care in which PHI sharing is required. This will cause inefficiency and interruption in care, as affected populations will be inundated with consent forms. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of an opt-out approach to consent in which the patients are informed of their option opt out of PHI sharing within the



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#	Regulatory Relief(RR)	RR Response
		<p>PPS and are given a reasonable period of time to in which to decide. The State, however, has not opined on the permissibility of this option.</p> <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of these regulations will not risk patient safety as the regulations pertain to giving patients the choice to make an informed decision regarding disclosure of PHI. This right can still be preserved through utilization of a thorough opt-out consent form.
6	Transfer and Affiliation Agreements: 10 NYCRR 400.9	<p>Project:</p> <ul style="list-style-type: none"> • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions <p>Project Components:</p> <ul style="list-style-type: none"> • 2biv-Every ED or hospital patient will be required to have a pre-discharge planning and transitional care visit. Visits will be coordinated with partners within the PPS, who have attested to participation with ACP and share in the common goals, as set forth by ACP and the DSRIP program. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, partners within the PPS will be required to execute separate transfer and/or affiliation agreement with approved facilities. This would impede the functionality of the PPS, which has participation agreements in place with PPS partners, representing virtually all facets of healthcare delivery/care. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of requiring each partner to effectuate its own transfer and/or affiliation agreements, but has concluded that such a requirement is duplicative, burdensome, and contrary to the goals of the DSRIP program. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety, waiver of the regulation will not pose a risk patient safety as the agreements which ACP already has in place with its PPS partners ensure that each provider will be compliant and commit to meeting the goals of DSRIP.
7	General Hospital Discharges: 10 NYCRR 405.9(f)(7)	<p>Projects:</p> <ul style="list-style-type: none"> • 2biii- emergency department (ED) care triage for the at-risk population • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions <p>Project Components:</p> <ul style="list-style-type: none"> • 2biii-Care managers (CMs) will be placed in EDs to introduce the crucial component of long-term care management/coordination at the first point of emergency care. To meet the DSRIP goal of reducing hospital readmissions, CMs and providers will work in conjunction to refer and transfer the patient to the appropriate partners within the PPS for follow-up care. • 2biv-ACP will require that every ED or hospital patient has a pre-discharge planning/transitional care visit which will include referrals/visits to providers who will ensure that the patient is stable/compliant post-admission. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, "source of payment" may be construed as applying to DSRIP funds flow and could deter a hospital from transferring a patient to a more appropriate care setting. To ensure the success of the PPS and reduce avoidable hospital readmissions, it is imperative for hospitals and

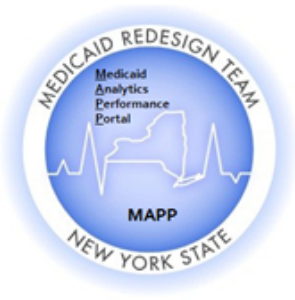


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#	Regulatory Relief(RR)	RR Response
		<p>EDs to have the ability to direct patients to facilities more suited for providing preventative services in a geographically-convenient location.</p> <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered alternatives but determined that such alternatives will serve as an impediment to meeting project metrics and the goals of the DSRIP program. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of this regulation will not risk patient safety as the regulation pertains to preventing medical facilities from transferring patients for financial reasons, post-stabilization. ACP will have protocols/processes in place to ensure that patients are transferred to medically appropriate locations that can best address their healthcare needs.
8	<p>OMH-Prior Approval Review for Quality and Appropriateness: 14 NYCRR 551.8</p>	<p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities, where availability and provision of behavioral health services are crucial to address the immediate and long-term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden to meet the application requirements for a Comprehensive PAR review. The State will likely be delayed in granting approval, as it will receive numerous applications for review from other PPSs. Such a delay will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet in effect. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety, ACP intends to comply with all requirements related to quality of care. The PPS is seeking an expedited process so that it may implement 3ai in an expeditious manner to meet the metrics for Year 1.
9	<p>OMH-Certification for Clinical Treatment Programs (outpatient): 14 NYCRR 599.5</p>	<p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long-term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions.

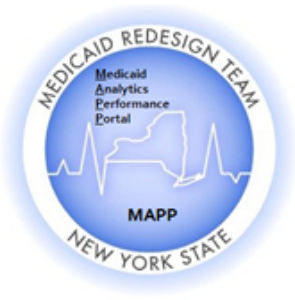


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#	Regulatory Relief(RR)	RR Response
		<p>Reasons for Waiver:</p> <ul style="list-style-type: none"> Without such a waiver, urgent care facilities will have the burden to apply for an operating certificate. Although DSRIP is a 5-year program, the operating certificate may only be effective for up to three years; such a limitation will impose an additional burden on the facility to apply for renewal taking focus away from provision of clinical care. Further, the State will likely be delayed in issuance, as it will receive numerous applications from other PPSs. Such a delay will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet in effect. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> Although this regulation pertains to patient safety, ACP does not intend to evade the requirements related to quality of care. The PPS is seeking an expedited process so that it may implement 3ai in an expeditious manner to meet the metrics for Year 1.
10	14 NYCRR 599.9, 14 NYCRR 599.10, 14 NYCRR 599.11, 14 NYCRR 599.12(a)	<p>Project: 3ai-integration of primary care and behavioral health services</p> <p>Project Components:</p> <ul style="list-style-type: none"> 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long-term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> Without such a waiver, urgent care facilities will have the burden to meet the staffing, treatment planning, case record, and premises requirements promulgated under both OMH, and to some extent, DOH regulations. Such duplicative requirements will likely be burdensome and deter such facilities from engaging in integrated care, adversely affecting the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet in effect. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> Although these regulations pertain to patient safety, ACP does not intend to evade the requirements related to quality of care. The PPS is seeking a consolidated process so that it may implement 3ai in an expeditious, non-duplicative manner to meet the metrics for Year 1.
11	Operations of Outpatient Programs: 14 NYCRR 587.5, 14 NYCRR 85.4, 14 NYCRR 573.1	<p>Project: 3ai-integration of primary care and behavioral health services</p> <p>Project Components:</p>



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		<ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden to apply for an operating certificate. Although DSRIP is a 5-year program, the operating certificate is valid only for a shorter period; such a limitation will impose an additional burden on the facility to apply for renewal. Further, the State will likely be delayed in issuance as it will receive numerous applications from other PPSs. Such a delay will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet in effect. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety, ACP does not intend to evade the requirements related to quality of care. The PPS is seeking an expedited process so that it may implement 3ai in an expeditious manner to meet the metrics for Year 1.
12	DOH-Issuance of Operating Certificates: 10 NYCRR 401.1	<p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden to apply for an operating certificate because these facilities will serve urban populations within the four counties covered by the PPS, and it is probable that such facilities will provide medical services comprising more than five percent of their total annual visits. The State will likely be delayed in issuance as it will receive numerous applications for review from other PPSs. Such a delay will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet

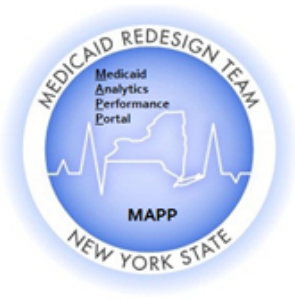


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#	Regulatory Relief(RR)	RR Response
		<p>in effect.</p> <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety, ACP does not intend to evade the requirements related to quality of care. The PPS is seeking an expedited process so that it may implement 3ai in an expeditious manner to meet the metrics for Year 1.
13	<p>Registration of Shared Facilities: 10 NYCRR 83.5, 10 NYCRR 83.10</p>	<p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden of registering with the DOH at least twice during the 5 year DSRIP program. Further, the facility will be responsible for meeting the required report and audit provisions in addition to similar requirements likely in ACP's compliance policies and procedures. Such duplicative administrative burden will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered alternatives, but options available are contrary to the intent of the PPS and overall DSRIP program goals. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of these regulations will not risk patient safety as the regulations pertain to ensure that the general public is clear as to the facilities shared and the care provided therein. ACP will have policies and procedures in place to dispel public confusion regarding the shared facility while proving quality integrated care.
14	<p>Home Visits: 10 NYCRR 401.2(b)</p>	<p>Project:</p> <ul style="list-style-type: none"> • 2aiii-health home at-risk intervention program for patients with one progressive chronic disease who are likely to evolve a second chronic condition • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions <p>Project Components:</p> <ul style="list-style-type: none"> • 2aiii-The PPS will coordinate care on both a clinical and community level to address the global needs of patients to improve overall health outcomes. Patients who are not able to travel to facilities, due to either health or transportation issues, need the provision of necessary care at home. Home care ensures that patients of low mobility are still monitored and treated for chronic conditions. • 2biv-ACP will require that every ED or hospital patient has a pre-discharge planning/transitional care visit which will include referrals to providers who will ensure that the patient is stable/compliant, post-admission. A patient's post-admission condition may limit his/her ability to travel to a facility to

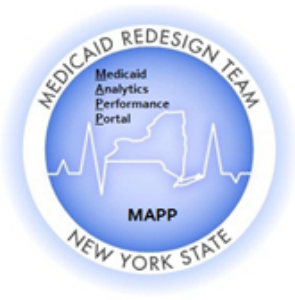


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#	Regulatory Relief(RR)	RR Response
		<p>receive appropriate follow up care; home visits are a viable and necessary alternative to ensuring that the patient is compliant and monitored.</p> <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, providers within the PPS will be limited to provision of care in facilities that have obtained operating certificates. Further, providers will be unable to provide care through home visits as the operating certificates issued to partners throughout the PPS are likely for more traditional facilities. It is neither possible nor practical for providers to obtain operating certificate for the homes they intend to visit to administer care. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of eliminating the option of home visits from transitional and long term care plans but determined many patients attributed to the PPS would be left with limited options to receive care, resulting in poor health outcomes and an increase in avoidable hospital readmissions. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety in that the DOH limits the provision of care to facilities that have received prior approval, waiver will not adversely impact patient safety as ACP will have in place protocols/processes to ensure that PPS partners provide the same quality of care in a home setting as they would in a traditional setting.
15	DOH-Issuance of Operating Certificates: 10 NYCRR 401.1	<p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden to apply for an operating certificate because these facilities will serve urban populations within the four counties covered by the PPS, and it is probable that such facilities will provide medical services comprising more than five percent of their total annual visits. The State will likely be delayed in issuance as it will receive numerous applications for review from other PPSs. Such a delay will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of providing such care through the Primary Care Host Model as provided in the New York State Proposed Rule regarding integration of outpatient services. This option, however, is not yet in effect. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety, ACP does not intend to evade the requirements related to quality of care. The PPS is seeking an expedited process so that it may implement 3ai in an expeditious manner to

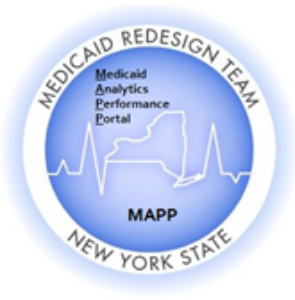


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#	Regulatory Relief(RR)	RR Response
16	Registration of Shared Facilities: 10 NYCRR 83.5, 10 NYCRR 83.10	<p>meet the metrics for Year 1.</p> <p>Project:</p> <ul style="list-style-type: none"> • 3ai-integration of primary care and behavioral health services <p>Project Components:</p> <ul style="list-style-type: none"> • 3ai-Behavioral health services must be integrated in alternative settings to increase accessibility and promote comprehensive care. ACP proposes to establish one or more urgent care facilities where availability and provision of behavioral health services are crucial to address the immediate and long term needs of patients. Incorporating an OMH licensed outpatient program into such a facility will ensure that patients with multiple needs are addressed in an integrated setting, potentially preventing avoidable hospital admissions and readmissions. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, urgent care facilities will have the burden of registering with the DOH at least twice during the 5 year DSRIP program. Further, the facility will be responsible for meeting the required report and audit provisions in addition to similar requirements likely in ACP's compliance policies and procedures. Such duplicative administrative burden will deter providers from participating in integrated care and adversely affect the meeting of Project metrics. <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered alternatives, but options available are contrary to the intent of the PPS and overall DSRIP program goals. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Waiver of these regulations will not risk patient safety as the regulations pertain to ensure that the general public is clear as to the facilities shared and the care provided therein. ACP will have policies and procedures in place to dispel public confusion regarding the shared facility while proving quality integrated care.
17	Home Visits: 10 NYCRR 401.2(b)	<p>Project:</p> <ul style="list-style-type: none"> • 2aiii-health home at-risk intervention program for patients with one progressive chronic disease who are likely to evolve a second chronic condition • 2biv-care transitions intervention model to reduce 30 day readmissions for chronic health conditions <p>Project Components:</p> <ul style="list-style-type: none"> • 2aiii-The PPS will coordinate care on both a clinical and community level to address the global needs of patients to improve overall health outcomes. Patients who are not able to travel to facilities, due to either health or transportation issues, need the provision of necessary care at home. Home care ensures that patients of low mobility are still monitored and treated for chronic conditions. • 2biv-ACP will require that every ED or hospital patient has a pre-discharge planning/transitional care visit which will include referrals to providers who will ensure that the patient is stable/compliant, post-admission. A patient's post-admission condition may limit his/her ability to travel to a facility to receive appropriate follow up care; home visits are a viable and necessary alternative to ensuring that the patient is compliant and monitored. <p>Reasons for Waiver:</p> <ul style="list-style-type: none"> • Without such a waiver, providers within the PPS will be limited to provision of care in facilities that have obtained operating certificates. Further,



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#	Regulatory Relief(RR)	RR Response
		<p>providers will be unable to provide care through home visits as the operating certificates issued to partners throughout the PPS are likely for more traditional facilities. It is neither possible nor practical for providers to obtain operating certificate for the homes they intend to visit to administer care.</p> <p>Alternatives:</p> <ul style="list-style-type: none"> • ACP considered the alternative of eliminating the option of home visits from transitional and long term care plans but determined many patients attributed to the PPS would be left with limited options to receive care, resulting in poor health outcomes and an increase in avoidable hospital readmissions. <p>Patient Safety Risk:</p> <ul style="list-style-type: none"> • Although this regulation pertains to patient safety in that the DOH limits the provision of care to facilities that have received prior approval, waiver will not adversely impact patient safety as ACP will have in place protocols/processes to ensure that PPS partners provide the same quality of care in a home setting as they would in a traditional setting.



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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.

Advocate Community Providers, Inc. (ACP) is a not-for-profit corporation that was formed to serve as one of New York's largest PPSs. ACP filed a request for a VAP safety net exception. ACP consists of AW Medical Office, PC (AW), New York Community Preferred Partners (NYCPP), and North Shore Long Island Jewish Health System (NSLIJ). AW is a primary care medical practice which filed the LOI to become a DSRIP lead and received the DSRIP Design Grant as an emerging PPS. AW represents over 2,500 providers, including over 2,000 physicians, in connection with DSRIP. Such physicians are members of 8 IPAs and 3 Medicare ACOs. These IPAs and ACOs, in partnership with a Federally Qualified Health Center (FQHC) formed NYCPP. NSLIJ is a premier health system with 17 hospitals, 5 in this PPS's region, and a broad range of other facilities. NSLIJ is the active parent of Forest Hills Hospital, also a designated safety net provider. In addition, the PPS encompasses MediSys Health Network (the sole corporate member of Jamaica Hospital and Flushing Hospital, also designated safety net providers), St. Barnabas, Lutheran, Methodist, Mt. Sinai and Montefiore.



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Given our size, we determined to operate under a Delegated Governance model. As such, the PPS was formed as a new entity, ACP, governed by its own board, which is supplemented by a steering committee representative of all key partners and other stakeholders. This model is critical to the success of the PPS because it will enable the PPS to best meet DSRIP program objectives, give voice to all parties, and implement shared governance among ACP's very large and diverse group of providers. ACP's not-for-profit status will further its transparency and accountability. In addition, the advisory committees will enable the PPS's providers and stakeholders to collaboratively oversee the DSRIP projects and develop recommendations for ACP's Board of Directors (BOD).

ACP is a membership not-for-profit corporation with 3 members: AW; NYCPP; and NSLIJ. ACP is governed by its BOD, which is appointed by its members. The BOD will form several advisory committees to engage its partners and stakeholders in governance, including: (a) a Steering Committee, which will (i) serve as a forum for providers and stakeholder groups who are in a position to have the most impact on the PPS's success, (ii) oversee the Project Management Office (PMO), which will manage the PPS's operation, and (iii) develop recommendations to the BOD with respect to the DSRIP projects; and (b) a Project Advisory Committee (PAC), which will serve as a forum for all providers and stakeholders to provide input and develop recommendations to the BOD. The BOD will also form committees to assist it in key functional areas (e.g., Clinical, Health Information Technology (HIT), Communications, Finance, Audit and Compliance Committees). Except for the Audit Committee, which will be comprised of independent members, the composition of each functional committee will be broadly representative of providers and stakeholders. Attached is an organizational chart of the PPS.

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: **25_SEC021_ACP Organizational Structure.pdf**

Description of File

ACP Organizational Chart

File Uploaded By: ms593812

File Uploaded On: 12/22/2014 02:59 PM

***Structure 2:**

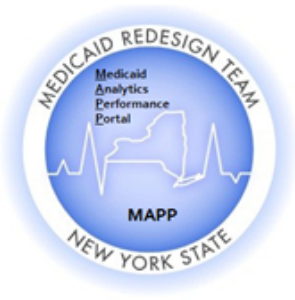
Specify how the selected governance structure and processes will ensure adequate governance and management of the DSRIP program.

ACP's governance structure ensures adequate governance and management as follows:

The Steering Committee assists the BOD to coordinate the work of committees, care teams (defined below), providers, and stakeholders. The Steering Committee will monitor PPS performance, oversee stakeholder collaboration, recommend approval of committee policies, procedures, charters and major contracts, develop a conflict of interest procedure and facilitate the achievement and management of DSRIP program along with the PMO. The Steering Committee members will be composed of representatives of the following provider and stakeholder groups:

- Union (1)
- Patient (1)
- Hospitals (2)
- Behavioral Health (2)
- Primary Care Physicians (8, 2 per county)
- FQHCs (1)
- LTCs (1)
- CBOs (1)
- HMOs (1)

Due to the large number of coalition partners, ACP developed an alternate PAC structure that presently includes 29 representatives from coalition partners and stakeholders. The PAC will advise the BOD on all PPS initiatives. The PAC's members were selected based on



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their status and geographic area, and include representatives from the following provider and stakeholder groups:

- Union (1)
- CBOs (1)
- Behavioral Health (3)
- FQHCs (2)
- Social Support (1)
- ACOs (2)
- Home Care (4)
- PCMHs (2)
- NYCPP (1)
- Diagnostic (2)
- LTCs (3)
- Hospitals (2)
- Dialysis (1)
- MCO (2)
- CHN (1)
- Other (1)

The PPS will have standing committees, each of which is led by members appointed by the BOD and composed of 4 to 10 members with associated expertise. The Clinical Committee will develop quality standards and metrics and provide adequate clinical governance at the PPS level. The HIT committee will develop technology platforms to facilitate data sharing in the PPS. The Communications Committee will develop a plan for communicating with providers and stakeholders. The Finance Committee will establish the PPS's distribution of DSRIP funds, oversee capital projects, monitor financial reports, and secure the PPS's financial sustainability. The Compliance Committee will develop and oversee a compliance program.

The Audit Committee will assure the BOD and the organization fulfills its responsibilities for auditing financial processes. Members will be prohibited from being an ACP employee (or immediate family member thereof) and no such member shall engage in private business with a material relationship with ACP.

The PMO will manage the administrative and clinical systems for the PPS and oversee the care teams. The administrative operations will be managed by a CEO, with the assistance of a CFO and a CIO. Clinical operations will be managed by a CMO. These officers will be accountable to the BOD for meeting DSRIP goals. To supplement the PMO, ACP will enter into an Administrative Services Agreement with NSLIJ pursuant to which NSLIJ will serve as a fiduciary to the PPS to provide funds flow in accordance with the funds flow directives established by the BOD.

A Care Team will be established with respect to the implementation of each project in each geographic sub-region of the PPS. Each Care Team will be comprised of the partners implementing the Care Team's project. Care Team will implement project goals, facilitate provider and stakeholder feedback and report progress and milestones achieved to PMO.

***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.

The BOD, in collaboration with the Steering Committee, will oversee the Clinical Committee. The Clinical Committee will develop quality standards and metrics, develop and oversee best practices, ensure accountability of partners for their performance and provide clinical governance. Provider types within the PPS that will have the most impact on quality and performance will be represented in the Clinical Committee. Members will be appointed by the BOD, which will also have authority to remove members. Among other things, the Clinical Committee's advisory functions will include the following:



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- (i) Developing standards for clinical care delivery (including structures, process, and outcomes) and overseeing the coalition partners' performance with respect to such standards (including the development of processes for the measuring and reporting on such performance);
- (ii) Developing and overseeing the implementation of best evidence based medical practices that will contribute to the clinical and financial goals established by the PPS under DSRIP;
- (iii) Developing a quality assurance and improvement process to identify the areas of care delivery that should be made the focus of improvement efforts;
- (iv) Working in conjunction with Care Teams to develop and oversee the clinical components of the projects selected so that the PPS may achieve its objectives and improve performance;
- (v) Working in conjunction with the IT Committee to establish a platform for information sharing; and
- (vi) Working in conjunction with the Finance Committee to support the achievement of the PPS's efficiency and cost-savings goals and develop pay-for-performance initiatives.

***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.

The BOD will monitor the efficacy of the organizational structure based on the performance of the PPS and feedback from providers and stakeholders. In evaluating the performance of the organizational structure, including the BOD, the Steering Committee and the PAC, the BOD will obtain feedback from committee members, stakeholders and coalition partners. This process will include annual performance surveys and reviews. The performance reviews will evaluate matters such as whether the organizational structure has effectively contributed to the achievement of the PPS's DSRIP goals, whether the governing body and committees have been effective in making decisions or recommendations, and whether the organizational structure and the processes employed by the governing body have been inclusive and participatory of coalition partners and stakeholders. Such performance reviews may indicate that a change in the governance structure is necessary to increase its effectiveness. The BOD is committed to acting upon the feedback received through such surveys and will implement policies and initiatives intended to address such feedback. In addition, the governance structure may need to evolve as the PPS evolves and begins to engage in new functions, such as value-based contracting with Medicaid managed care organizations and/or directly with New York State as, for example, a Medicaid ACO. As capital projects are developed, ACP will develop a robust capital projects management function to ensure success and accountability for capital funds.

Section 2.2 - Governing Processes:

Description:

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

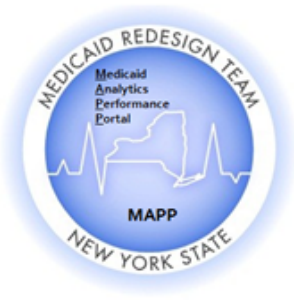
***Process 1:**

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.

Until March 31, 2016, the BOD will be composed of 8 voting directors with 1 vote each: 2 named by AW (Ramon Tallaj, MD & Emilio Villegas, MD), 4 named by NYCPP (George Liu, MD, Henry Chen, MD, Sun-Hoo Foo, MD & Juan Estevez, MD), and 2 named by NSLIJ (Jeffrey Kraut & Tom McGinn, MD). After March 31, 2016, the composition shifts so that AW and NYCPP will each name 25% of the BOD and NSLIJ will name 50%. NSLIJ will also have 2 non-voting representatives and MediSys will have 1 non-voting representative.

AW will appoint the Chair. BOD members will be responsible to promote the goals of DSRIP; monitor the success of the projects and goals; ensure that resources are used effectively; and ensure that the management team implements the organizational goals.

The Steering Committee will be comprised of the stakeholders listed on page 2, each entitled to one vote on all committee recommendations. PAC and functional committees will be comprised of members with one vote each on all committee recommendations.



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The PAC will be comprised of the stakeholders listed on page 3. Committee members will be responsible for their respective committee goals and for supporting the organizational goals.

***Process 2:**

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

Under ACP's bylaws, directors are appointed by the three members of ACP: (i) AW; (ii) NYCPP; and (iii) NSLIJ. The directors were selected based on provider types, geographic presence, community commitment, experience in healthcare and their demonstrated leadership. During the DSRIP planning phase, the BOD considered all recommendations and feedback received from the coalition partners and stakeholders. During the DSRIP implementation phase, it will consider all recommendations from the PAC, the Steering Committee and the other committees.

To select the members of the Steering Committee, the BOD first identified the types of providers and stakeholders that will be represented on the Steering Committee. In making such determination, it considered factors such as the potential to contribute to the success of the projects selected under DSRIP, attribution, geography, expertise, resources, interest level, and other such factors. In addition, ACP held informal meetings with potential partners and stakeholders, including physicians, unions and community-based organizations, to obtain feedback about the composition of the Steering Committee leadership. Based on such analysis and feedback, the BOD identified the types of positions to be included on the Steering Committee. To populate the Steering Committee, the BOD will solicit nominations for each position from the coalition partners and stakeholders. Then, the BOD will vote for each position. The nominee with the most votes for each position will be elected to that position.

To select the members of the PAC, the BOD undertook a process similar to that which it undertook with respect to the Steering Committee. It identified the types of providers and stakeholders to be represented on the PAC, with the goal of including as many provider and stakeholder types as reasonably feasible. At general meetings held in July, ACP discussed the selection of members to the PAC in order to obtain feedback from providers and stakeholders. Based on such analysis and feedback, the BOD identified the types of provider and stakeholder positions to be included on the PAC. To populate the Steering Committee, the BOD solicited nominations from the coalition partners and selected those nominees who best represented each stakeholder category and geographic area, based on experience and stakeholder affiliation.

***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.

The BOD is comprised of representatives appointed by AW, NYCPP and NSLIJ. AW represents over 2,500 provider organizations including over 2,000 physicians in connection with DSRIP. NYCPP was formed by 8 IPAs including most of the same physicians, an FQHC and 3 Medicare ACOs. NSLIJ's hospitals and other providers are represented on the BOD through the directors appointed by NSLIJ. Medisys will have a non-voting member on the BOD.

The other coalition partners and stakeholders are represented in ACP's governance through the Steering Committee and the PAC. The Steering Committee and PAC include representatives from a broad range of providers and stakeholders (see Question 2), including providers from across the continuum of care, behavioral health providers, and CBOs.

***Process 4:**

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

ACP will enter into a participation agreement with each coalition partner, which will set forth the rights and obligations of the coalition partner. The coalition partners will be represented in the governance of ACP as described above. In addition, ACP will keep the coalition partners informed of PPS developments and proactively promote their engagement.

Several entities within ACP have existing relationships with CBOs and charitable organizations. ACP will enter into a participation agreement with their organizations to solidify an ongoing relationship in serving Medicaid patients through the DSRIP program. The agreement will emphasize a commitment to expanding the host of services available to Medicaid population, including nutrition, education, and social services, to improve health outcomes and meet the objectives of the DSRIP program.



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***Process 5:**

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

During the 1st year, NSLIJ's directors will hold, in the aggregate, 25% of the BOD voting power, AW will hold 25% and NYCPP will hold 50%. MediSys's director will be a non-voting member. All decisions will be made by majority vote after taking into account recommendations and other feedback received from applicable advisory committees; provided, however, certain decisions will require a supermajority vote (80% of the voting members). Such decisions include the sale of all or substantially all of the assets, bankruptcy, liquidation, related party transactions, approval of operating and capital budgets, funds flow formulae and any changes thereto, amendment of the Bylaws or Certificate of Incorporation and matters affecting the tax exempt status of NSLIJ.

During the remainder of the DSRIP program, NSLIJ will have the right to appoint 50% of the members of the BOD, while AW and NYCPP will each have the right to appoint 25% of the members. MediSys's director will remain non-voting. All decisions of the BOD will be made upon a majority vote after taking into account recommendations and feedback from committees.

Advisory committee members will be entitled to one vote on all matters that come before the committee. The decisions of the committee, which will be in the form of recommendations to the BOD, will be made upon the affirmative vote of a majority of the committee members.

***Process 6:**

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

The BOD will consider all recommendations received from the Steering Committee and PAC. If there is a conflict among partners, stakeholders or within any committees, the BOD will make a determination after considering the facts and feedback from such partners and stakeholders. Depending on the nature of the issue, the issue may be submitted to one of the functional committees (i.e. clinical, finance, IT, audit, and compliance committees) if the issue falls within the scope of any such committee, or a special subcommittee of the Steering Committee or the PAC. If there is a conflict within the BOD, an independent third party will be selected by the Board to mediate the dispute.

***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) Meetings of the PPS's governance bodies will be open to the partners, provided that a closed executive session may be held at any meeting in the governance body's discretion with respect to matters of a confidential or proprietary nature. Meeting dates and locations will be made available to the partners in advance on ACP's website.

(b) All governance documents, including meeting materials, will be available to a partner upon request. In addition, such meeting materials (excluding confidential information) will be posted on the PPS's website.

(c) The BOD will update the PAC and the Steering Committee on the outcomes of the meetings of the BOD and its other committees.

***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.

(a) Meetings of the PPS's governance bodies will be open to the partners, provided that a closed executive session may be held at any meeting in the governance body's discretion with respect to matters of a confidential or proprietary nature. Meeting dates and locations will be made available to the partners in advance on ACP's website.

(b) All governance documents, including meeting materials, will be available to a partner upon request. In addition, such meeting materials (excluding confidential information) will be posted on the PPS's website.

(c) The BOD will update the PAC and the Steering Committee on the outcomes of the meetings of the BOD and its other committees.

Section 2.3 - Project Advisory Committee:



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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.

Since May 2014, AW and NYCPP held meetings with potential partners interested in participating in the DSRIP program. Meetings were open to any interested stakeholders and partners based on their ability to enhance the network and improve quality of care. Unions were engaged in the process and participated in such meetings.

Due to the large and unwieldy number of participants at these meetings, we determined to utilize an alternate PAC structure and presented a proposal for such structure to the providers and stakeholders at the 7/27/14 meeting. The proposal had a representative structure with an approximately 25 member PAC (which has since been enlarged to 29 members since Medisys joined). The proposal was endorsed by the participants present at the meeting.

PAC members were selected based on attributed lives, provider type, geography, expertise in population health and commitment to DSRIP objectives. PAC meetings were open to any partner. Due to AW and NYCPP's efforts to encourage the participation, PAC meetings continued to be well attended by partners, as well as the representatives formally appointed to the PAC. At PAC meetings, the projects and their alignment with the Community Needs Assessment results were reviewed and also approved. The formation of Care Teams was described and the selection of participants to the Care Teams was confirmed. The PAC meeting participants, including the hundreds of coalition partners present, were engaged in the formation of the Integrated Delivery System, and each was given an IT assessment form in preparation for integration. All present at the meetings had the opportunity to comment on the projects and their organization's participation in a Care Team as well as in the evolving organizational structure.

***Committee 2:**

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

The PAC will serve the PPS by providing advice to the BOD on the PPS as a whole and matters relating thereto. It will act as a supporting body to the BOD by obtaining feedback from coalition partners and sharing such feedback with the BOD. The PAC will also make recommendations to the BOD based on such feedback. In this way, partner and stakeholder voices are heard and counted as an important part of the governance of the PPS. Similarly, the PAC will assist the BOD in its efforts to communicate with coalition partners regarding activities of the PPS.

***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).

At PAC meetings the progress of the CNA and results were presented and input was obtained from the PAC and other partners/stakeholders which confirmed its correlation with the projects selected. The PPS organizational structure was discussed at most PAC meetings. Due to the addition of Medisys and participation of NSLIJ, the organizational structure changed from what was first presented. All such changes were presented the PAC. In connection with the CNA, ACP conducted surveys of its provider network members, including PAC members, to obtain information about health needs, health care and community resources, and initiatives most likely to contribute to improving health and achieving DSRIP goals. An online questionnaire was disseminated to 864 members and partners of the emerging PPS network.

***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.

The PAC, as supplemented by the Care Teams, include a range of healthcare and related entities, as well as local government officials and CBOs, including meal delivery, shelters, and local agencies such as NY Quits. The Care Team members are representative of every county and cultural group that the PPS serves and represent the diverse population served by the PPS. Care Teams are made up of over 550 members with a significant number from each provider type and from each county in our service area including hospitals, home health and home care agencies, OASAS, OMH and OPWDD providers, FQHCs, nursing homes, home meal delivery organizations, pharmacies, hospices, care coordinators, dialysis centers, ACOs, transportation, durable medical equipment, urgent care centers, managed care plans



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and others.

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 Compliance Officer (CO) will report to the Board. S/he will be employed by NSLIJ and have at least 8 years' experience in a healthcare organization, demonstrated leadership, and familiarity with operational, financial, quality assurance, human resource procedure and regulations.

The CO is highly placed to exercise independent judgment without fear of reprisal. S/he has direct access to all senior management, legal counsel (internal & external), and leadership of each participating provider and/or agent.

CO oversees the Compliance Program, functioning as an independent person who reviews and evaluates compliance issues within the PPS. S/he ensures the BOD, management and employees comply with the rules/regulations of regulatory agencies, that PPS policies and procedures are followed and that behavior in the organization meets standards of conduct.

***Compliance 2:**

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

The CO will implement all actions to achieve Compliance Program objectives. Duties include:

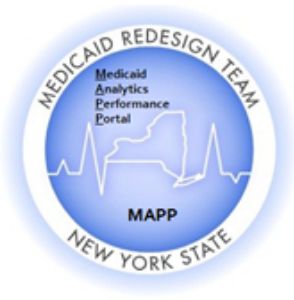
- Developing policies/protocols to prevent illegal/unethical conduct.
- Manage daily operation of Program.
- Implement a Code of Conduct.
- Continuing education.
- Collaborates with other departments (e.g., risk management, internal audit, employee services) to direct concerns to appropriate channels for investigation and resolution.
- Oversees uniform handling of alleged violations of rules, protocols, and Code of Conduct and Compliance Program- evaluating initiation of investigative procedures.
- Acts as independent reviewer- ensures compliance issues appropriately investigated/resolved.
- Monitors/coordinates compliance in other departments to know status of all activities and identify trends.
- Identifies potential vulnerabilities, implements corrective action plans, and generally guides how to avoid/deal with similar situations in future.
- Reports regularly to keep Compliance Committee and management informed of operation and progress of compliance efforts.
- Ensures proper reporting to authorized enforcement agencies.

***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.

Employees, management, staff, and persons of coalition partners currently receive compliance training under any existing compliance programs currently maintained by the coalition partners. In addition, all employees, management, staff and persons participating in ACP will receive compliance training by ACP. By the second quarter of 2015, the general compliance program will be implemented and the CO is developing/approving both the general and specific education and training programs. General training will include:

- ACP's compliance philosophy and commitment to compliance.
- Code of Conduct and compliance expectations.
- Employee obligations to adhere to laws and regulations and consequences for non-compliance.



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- Reporting standards and confidential reporting process.
- Identification of CO and overseers of compliance.

*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.

ACP will provide web-based information, accessible to all, concerning processes for filing complaints or registering concerns against ACP and its services and providers. Beneficiaries will receive written materials describing complaint processes and providers will display such information in their offices. Neither ACP nor any of its providers may retaliate against an individual for filing a complaint.

Complaints may be registered with or received by ACP through several channels of communication, including, but not limited to:

- On-line.
- Email.
- Text Messaging
- Mail.
- Facsimile.
- Complaint hotline.
- Patient representatives at partner offices.

The procedures for the complaint notification, acknowledgement of its receipt, claim investigation and taking of appropriate remedial action shall be available by the time the Compliance Plan is instituted.

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.

The Finance Committee (FC) will have, at a minimum, 10 members representing the provider/payer types and geographic areas served.

Duties include:

- Develops/implements policies/protocols for financial accountability and funds flow
- Develops annual operating and capital budgets
- Oversees capital projects
- Monitors/recommends/reports to BOD compliance with adopted budgets and strategic objectives
- Management of fund distributions
- Reviews risks management program from an insurance coverage and liability perspective to ascertain adequacy to safeguard against liability/loss
- Review FC's performance and reassess FC's Charter, with recommendations to BOD

Notwithstanding, our financial success in identifying financial trends is supported by collaboration with the other committees (IT, clinical, PAC) on ACP's major transactional procurements. Duties include:

- Review/approve major IT strategies and projects (e.g., design & implementation of enterprise-wide resource planning systems).
- Evaluate/manage contingent liabilities developed in each of DSRIP project.
- Review/approve medical service agreements, major financing transactions, leases, acquisitions, guarantees, and credit extensions.

*Organization 2:

Please provide a description of the key finance functions to be established within the PPS.



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Key finance functions of the PPS are assumed by the FC and its CFO, both whom are principally accountable for the oversight of all finance functions for ACP. Key finance functions include:

- Establishing the annual budget.
- Developing the formula for allocation of DSRIP funds.
- Overseeing capital projects, with the oversight of the Finance Committee
- Monitoring criteria and standards for distribution of funds to each of the PPS partners.
- Defining financial performance metrics that each ACP Member is expected to achieve (and corresponding penalty/bonus metrics).
- Developing an independent audit and oversight process of DSRIP fund distributions.
- Establishing procedures for receiving and treating complaints in PPS from providers regarding accounting, internal accounting controls, and audits.
- Implementing internal controls over funds flow and fund reinvestment initiatives into PPS
- Monitoring and managing financial risk, spending commitments, and tax strategies.

***Organization 3:**

Identify the planned use of internal and/or external auditors.

The Audit Committee will employ internal auditors and supplement such auditors with an external audit function. The Committee will develop procedures for engaging independent auditors and is authorized to coordinate its audits with Finance, Compliance and any other committees of ACP. Internal auditor duties include:

- Developing/approving the internal audit charter, annual audit plan and major changes therewith.
- Reviewing/auditing annual financial statements and internal controls/communications.
- Auditing management's internal controls, compliance and risk assessment practices.
- Conducting special investigations (e.g., suspected corruption, conflicts of interest, criminal activity) and whistleblower policies.

The Audit Committee will also employ independent external auditors to perform the following duties:

- Review/issue opinions on financial statements (annual or longer) to evaluate financial or compliance trends.
- Evaluate performance of our auditor's internal quality control procedures.
- Evaluate the relationship between an internal auditor and ACP.

***Organization 4:**

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

ACP's Compliance Program (the Program), when complete, will meet all requirements of New York State Social Services Law 363-d.

The Compliance Officer (CO), appointed by the BOD, will be responsible for the Program's daily operations. S/he will report to the BOD and coordinate with other senior management. (363-d(b)) The Program will have written policies encouraging good faith participation in the Program (363-d (e)) and expectations will be embedded in a Code of Conduct. (363-d(a)) The Audit, Finance, and Compliance Committees will coordinate a system for auditing potential or actual non-compliance across the organization. (363-d(f)) Further, all management and employees will receive periodic training on Program requirements. (363-d(c)) In addition, our policies will provide that all persons associated with ACP may report compliance issues confidentially and without fear of retaliation (363-d(d),(h)) and all such persons will have several complaint methods (e.g., online, email, mail, hotline) for confidential submissions.

Section 2.6 – Oversight:

Description:

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.

ACP will provide partners with protocols and procedure manuals with milestones and metrics for implementation and minimum performance goals. ACP reporting metrics will be developed which may include PQRS codes, Flow charts, MU data pull, CDSS alert



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fulfillment, registries and others.

ACP will monitor the utilization and quality of services of network partners. The analytics team will obtain reporting metrics on a monthly basis by partner and assess adherence to protocol processes and procedures, turnaround time for patient engagement and communication gaps. The reported metrics will be measured against encounter and claims data and reported to each partner and the Project Director. The Project Director will then make recommendations to the CMO. The CMO will address the findings collaboratively with the Project Director and Clinical Committee, and will implement corrective action plans (CAPs) as needed. The results of the CAPs will be reported to the BOD as discussed below.

***Oversight 2:**

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

ACP will use monthly data to evaluate performance of partners, which data will also be shared with the partner. If a partner's performance is deficient, the applicable Project Director will report such data to the CMO, who will work with the CEO and the Clinical Committee to consider/implement a CAP. CAP results will be presented to the Steering Committee and BOD.

As part of the CAP, the CMO will provide constructive feedback to lower performing partners and will provide information regarding their performance on relevant metrics. Such partners will be given the opportunity to improve their performance for the next monthly review cycle. If the partner does not improve and meet the minimum expectations of the CAP, then the Medical Director and Clinical Committee will bring the issue to the Steering Committee for discussion and recommendations. Such recommendations will be transmitted to the BOD which will make a final determination.

***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.

The BOD will provide the lower-performing provider with a plan to improve performance over time and inform the lower-performing provider that if such provider fails to show progress, they will be recommended to DOH for removal from the PPS. The need for corrective action will be presented in writing to the partner informing the partner of dates and deadlines for the correction. The PPS will implement a systematic corrective action approach for low and borderline performing partners. The CAP will consist of identifying specific areas of deficiency and thereafter providing needed education, training and detail oriented support to the partner. Ongoing training and support will be provided to the low performer to help achieve higher performance for up to 90 days so long as improvement is noted. In addition, the partner's poor performance may make such partner ineligible for any DSRIP incentive bonus payments otherwise payable to the partner. The BOD may recommend to DOH that the partner be removed from the PPS network, if the BOD determines the evidence suggests that the partner under consideration will not be able to or is not willing to improve their performance. The PMO will determine whether such removal could affect the PPS's ability to achieve its DSRIP goals, and will collaborate with the remaining coalition partners to appropriately address any such adverse effects.

***Oversight 4:**

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

The member renewal and removal process will be informed by Medicaid beneficiaries and their advocates, subject to applicable privacy laws and DOH policy, through survey and other forms of data collected in any of the following ways:

- On-line at the ACP website.
- Email.
- Text Messaging.
- Mail.
- Facsimile.
- Complaint hotline.
- Patient representatives at offices of the providers.



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Low performers will be monitored more frequently and receive timely assessments. The BOD will take into account Medicaid beneficiary feedback when evaluating a poorly performing provider. The BOD may implement sanctions, as discussed above, which can range from withholding of DSRIP funds otherwise due to the provider to application to the DOH for provider dismissal from the PPS.

***Oversight 5:**

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

If a provider is removed from the PPS, the PMO will review the then-current DSRIP Program guidelines to determine the nature of communication that is recommended be provided to individual Medicaid beneficiaries. Subject to applicable privacy laws and DOH policy, the PMO will communicate with the applicable Medicaid beneficiaries through available and permitted channels, potentially including e-mails, letters, the ACP website, newsletters, or other approved mechanisms. Help lines and other resources will be made available to beneficiaries who need support making arrangements that may be necessary to maintain continuity of care management and other services coordinated by ACP.

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.

ACP contracted with The New York Academy of Medicine (NYAM) and Verité Healthcare Consulting (Verité) to conduct the CNA. NYAM was contracted in two boroughs with four other PPSs. As the geographic reach of ACP extended, ACP needed to contract with Verité to cover the entire PPS geography. Exclusive contracting with Verité allowed ACP to develop strategy to create a comprehensive and uniform assessment for ACP's geography.

Guidance for Conducting Community Needs Assessments from Department of Health and the DSRIP Support Team checklist informed CNA methodology including:

- Primary Data:
 - o Key informant interviews
 - NYAM: 52
 - Verité: 25
 - o Focus groups / small group discussions
 - NYAM: 45
 - Verité: 5
 - o Surveys
 - NYAM: 1281
 - Verité: 267
- Survey Topics
 - o Community health conditions
 - o Primary health concerns
 - o Programming and services available
 - o Disparities in access and use
 - o Strategies to promote health improvement

Both firms collected primary data in partnership with community based organizations (CBOs). NYAM used street outreach in target neighborhoods, for surveys. Verité collected data from community based organizations (CBOs), Medicaid recipients, community members, providers, etc. This included a provider survey with participation from providers across the continuum of care, including primary care. See Appendix F for a full methodology description. Where appropriate, primary data was supplemented with secondary data.



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NYAM released a CNA report in October, and Verité released it in November; both reports were used to guide project selection. The findings were consistent for the overlapping geographies; Verité's CNA provided data at the neighborhood level to identify hotspots.

***Overview 2:**

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

As described in the previous section, NYAM and Verité were able to collect primary data from key informant interviews, small group interviews, focus groups, and surveys all providers and partners in the PPS network. ACP combined fall 2014 CNA reports from both firms to inform project selection. The firms incorporated secondary data from the following data sets:

- Health Status
 - o New York State Community Health Indicator Reports
 - o Behavioral Risk Factor Surveillance Systems (BRFSS)
 - o Statewide Planning and Research Cooperative dataset (SPARCS)
 - o Workbooks, charts, datasets, webinars and dashboards available at the DSRIP Performance Data website
 - o New York State Department of Health, NY Prevention Agenda 2013-2017: Prevent Chronic Disease Metrics and Prevention Agenda Goals, by Borough
 - o County Health Rankings, 2014
 - o NYS Department of Health Statistics and Data, accessed in 2014
 - o NYC Department of Health and Mental Hygiene, Community Health Survey, accessed in 2014
 - o Health Information Tool for Empowerment (HITE) of the Greater New York Hospital Association (GNYHA)
- Demographics
 - o U.S. Census Bureau, American Community Survey 5 Year Estimates, 2008-2012

This data was supplemented with a literature review including existing hospital CHNAs and reports prepared by the NYCDOH and NYSDOH, NYC Department of City Planning, local community boards, and academic institutions. As the composition of the PPS evolved and new institutional partner arrangements were formalized, ACP was able to benefit from the review of CNA documents produced by hospital systems, including its partners MediSys and North Shore Long Island Jewish as well as NYC HHC and Mount Sinai. These sources were used to complement the Verité CNA report, which served as the primary data source, for project selection and decision-making.

For a full listing of data sources, please refer to the CNA listing of sources.

✔ 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	76	17
2	Ambulatory surgical centers	38	0
3	Urgent care centers	25	1
4	Health Homes	42	10



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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
5	Federally qualified health centers	373	6
6	Primary care providers including private, clinics, hospital based including residency programs	94579	866
7	Specialty medical providers including private, clinics, hospital based including residency programs	21123	1955
8	Dental providers including public and private	7810	149
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	245	33
10	Behavioral health resources (including future 1915i providers)	1386	182
11	Specialty medical programs such as eating disorders program, autism spectrum early	154	0
12	diagnosis/early intervention	40	1
13	Skilled nursing homes, assisted living facilities	237	33
14	Home care services	2353	52
15	Laboratory and radiology services including home care and community access	115	61
16	Specialty developmental disability services	868	13
17	Specialty services providers such as vision care and DME	90	8
18	Pharmacies	414	29
19	Local Health Departments	4	2
20	Managed care organizations	13	19
21	Foster Children Agencies	153	19
22	Area Health Education Centers (AHECs)	4	0

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

***Infrastructure 2:**

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

Generally, the community has a wide range of health care resources available to help meet the needs of the uninsured and/or Medicaid population, however, the following shortages exist in the PPS Network. ACP will work closely with our partners and community organizations to identify and close specific gaps.

Primary Care
CNA indicates that 24.1% of the network live in a primary care health professional shortage area (HPSA):

- Bronx – 35.7%
- Brooklyn – 32.4%
- Manhattan – 15.4%
- Queens – 15.4%

The perception of stakeholders is that there was an insufficient access to the high quality providers on a timely basis and a lack of culturally and linguistically competent providers. To modify this reality, ACP will leverage its strengths in provider composition and cultural competency. Learning collaboratives will be a mechanism to share best practices across the network. ACP will also use care coordination models and staff to extend the geographic reach of traditional providers.

Mental Health
CNA indicates that 15.4% of the network live in a mental health HPSA. In addition, the network has low ancillary providers per 100,000 population:

- Certified Social Workers: 214
- Clinical Psychologists: 45.9

All four boroughs have neighborhoods with shortages in mental health providers. For example in Queens, mental health shortages exist in the North, Northwest and Southeast regions of the borough. To modify this shortage, ACP will partner mental health and primary care to



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better meet the needs of patients. ACP will leverage existing registries to identify patients who would benefit from care coordination – especially those who live in an HPSA.

Facility Capacity

There is a facility and bed shortage in particular boroughs in the PPS:

- Hospital Beds (per 1,000 Population, Compared to U.S. Benchmark)
 - o Queens (2,250)
 - o Brooklyn (1,500)
- Nursing Home Facilities (Health and Hospitals Corporation Health Care)
 - o Brooklyn (zero)
 - o Manhattan (zero)

ACP will enhance current health information technology infrastructure to connect facilities and reduce the burden of bed shortages.

Expanded Access Centers

CNA stakeholder discussions identified a shortage of "after hour" and weekend care centers in neighborhoods with high concentrations of Medicaid members. To modify this, ACP will develop strategically located "one-stop" urgent care centers that will be staffed by high-quality and culturally competent providers including specialists. Hours of care will be compatible with patients who work long or untraditional hours.

✔ 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	236	120
2	Food banks, community gardens, farmer's markets	1053	1
3	Clothing, furniture banks	68	2
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	53	13
5	Community outreach agencies	385	5
6	Transportation services	318	2
7	Religious service organizations	300	8
8	Not for profit health and welfare agencies	149	0
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	54	12
10	Peer and Family Mental Health Advocacy Organizations	165	17
11	Self-advocacy and family support organizations and programs for individuals with disabilities	214	0
12	Youth development programs	291	5
13	Libraries with open access computers	133	0
14	Community service organizations	385	13
15	Education	2531	4



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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
16	Local public health programs	4	2
17	Local governmental social service programs	17	0
18	Community based health education programs including for health professions/students	60	0
19	Family Support and training	266	19
20	NAMI	3	0
21	Individual Employment Support Services	284	5
22	Peer Supports (Recovery Coaches)	165	0
23	Alternatives to Incarceration	43	0
24	Ryan White Programs	88	0
25	HIV Prevention/Outreach and Social Service Programs	228	1

***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.

ACP coordinated with Leadership Council members, PPS partners and community based organizations (CBOs) to modify the composition of community resources. The modification was based on the results of the CNA including community resources inventory, mapping, stakeholder surveys and interviews. According to primary data collected through the CNA, stakeholders prioritized the need to improve access to housing, food, transportation, employment, education and family and income support services.

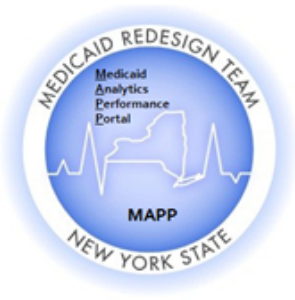
While a number of community-based providers that work on addressing these social service and educational needs are currently part of the ACP network, ACP will continue to expand the number. ACP will work on formalizing partnerships with neighborhood based organizations and municipal agencies located in or servicing identified hotspots to expand availability, access and hours of operation. ACP will draw awareness for the need to provide additional resources to these organizations by highlighting the needs in specific pockets of its service area that are disproportionately affected by these gaps. Where possible, it will also sign linkage agreements and Memorandums of Understanding to share resources to better serve communities most in need.

Key partners will be

- Local housing and community development organizations
- Food banks, community gardens and farmer's markets as well as God's Love We Deliver
- Local economic development organizations and Chambers of Commerce for employment opportunities
- Local schools and libraries
- Community-based comprehensive social service organizations
- Religious and Faith-based organizations
- Local governmental agencies such as:
 - New York City Housing Authority (NYCHA) and the Housing Preservation and Development (HPD) for greater access to affordable housing;
 - ACCESS-A-Ride for transportation services;
 - Human Resource Administration for cash benefits and income support as well as food stamps
 - NYC Department of Youth and Community Development (DYCD) for youth, youth development and family services
 - NYC Workforce Centers for employment and vocation training
- Local DOH Public Health Centers

Section 3.4 – Community Demographic:

Description:



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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:

Population Age
 Brooklyn and the Bronx had the youngest age distributions of the four boroughs, with both the highest proportions of people age 19 and under, and the lowest proportions of people age 65 and over. Queens has the highest proportion of residents between 45-64 years of age with 25.8%. Additional proportions of age demographics:

- Aged 19 and Under
 - o Bronx – 29.9%
 - o Brooklyn – 26.4%
 - o Manhattan – 17.4%
 - o Queens – 23.1%
- Aged 20 – 44 Years
 - o Bronx – 36.4%
 - o Brooklyn – 38.6%
 - o Manhattan – 45.2%
 - o Queens – 38.1%
- Aged 45 – 64 Years
 - o Bronx – 23.0%
 - o Brooklyn – 23.5%
 - o Manhattan – 23.9%
 - o Queens – 25.8%
- Aged 65 and Over
 - o Bronx – 10.5%
 - o Brooklyn – 11.5%
 - o Manhattan – 13.5%
 - o Queens – 12.9%

*Demographics 2:

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

The ACP population is very diverse. The top populations by borough include black residents in Bronx and Brooklyn, Asian residents in Queens and Hispanic residents in the Bronx. In all four boroughs, 30% or more of the population is foreign-born. Limited English speaking families in the community make up 16% of households. Percentage of total population is below (including target neighborhoods):

- Black
 - o Bronx–34%
 - Northeast Bronx, High Bridge, Morrisania
 - o Brooklyn–34%
 - Flatbush, Central Brooklyn, Canarsie
 - o Manhattan–16.1%
 - Central Harlem
 - o Queens–20%
 - Jamaica, Southeast Queens
- Hispanic
 - o Bronx–54%



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- Hunts Point, Motts Haven, Central Bronx
 - o Brooklyn–20%
- Bushwick, Williamsburg, Sunset Park
 - o Manhattan–26%
- Inwood, Washington Heights, East Harlem
 - o Queens–26%
- West Queens
 - Asian
 - o Bronx–3.6%
 - o Brooklyn–10%
- Sunset Park
 - o Manhattan–10%
- Southwest Brooklyn
 - o Lower East Side, Lower Manhattan
 - o Queens –23.5 %
- North, Northeast, Central Queens

***Demographics 3:**

Income levels:

Median household income in the four boroughs ranges from a high of \$73,362 in Manhattan to a low of \$36,084 in the Bronx, a two-fold difference. The lowest median household income of all boroughs and neighborhoods is \$21,501 in Hunts Point and Mott Haven, in the Bronx. Also in the Bronx, High Bridge and Morrisania and Central Bronx each have median household income levels just below \$25,000. In Brooklyn, the lowest median income is in two neighborhoods, Bushwick and Williamsburg, and East New York and New Lots, both slightly over \$34,000 in 2012. Manhattan exhibited the widest income disparities, with three neighborhoods over \$100,000, and lows in East Harlem (\$29,756), Central Harlem (\$37,701), and Inwood/Washington Heights (\$39,284). Queens has the second-highest median income of the boroughs (\$57,326), and the least amount of disparity by neighborhood.

***Demographics 4:**

Poverty levels:

Roughly 21% of New York City residents are living in poverty. The Bronx's poverty rate (31%) is nearly twice as high as New York State (16%) and significantly higher than the rates in the other boroughs: Brooklyn (23%); Manhattan (19%); and Queens (15%).

The borough figures mask significant poverty disparities by race and ethnicity, in each borough and citywide. The rate of Hispanics living below the poverty level is high in the Bronx (nearly 37%), Brooklyn (over 30%) and Manhattan (over 30%). Blacks and Asians have approximately equal poverty rates in the Bronx and in Brooklyn, while in Manhattan 34.6% of Blacks are in poverty compared to only 20.4% of Asians. Blacks in Queens have a lower poverty rate (13.6%) than in any other borough. White poverty rates range from 10.8% in Manhattan to nearly 24% in the Bronx, but are the lowest among racial/ethnic groups in every borough.

***Demographics 5:**

Disability levels:

There is not a consistent pattern of greater or lesser disability by race and ethnicity, except that Asians had the lowest disability rates. Residents of the Bronx between ages five and 64 years had markedly higher rates of disability than those in other boroughs, with rates as much as double those other boroughs for specific disabilities. One of the most salient disabilities for Bronx residents in this age range was cognitive difficulty, at between 5 and 5.6%. The percentage of individuals with a disability is higher among older age segments throughout the community. Among those age 65 over, between 1/4 and 1/3 of residents in each borough experienced ambulatory difficulties.

***Demographics 6:**

Education levels:



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The percentage of residents without a high school diploma is significantly higher in the Bronx (30.6%) than the other boroughs. The neighborhoods of Hunts and Mott Haven (44.6%), High Bridge and Morrisania (39.1%), and Central Bronx (38.7%) have particularly high concentrations of residents lacking a complete high school education. While Brooklyn has a considerably lower percentage of residents without a high school diploma (21.9%), the neighborhoods of Sunset Park (45.7%) and Bushwick and Williamsburg (37.2%) has some of the highest concentrations within the overall community. Educational attainment in Queens by this measure was slightly better than Brooklyn, and does not display significant disparities from neighborhood to neighborhood. While Manhattan has the lowest percentage of residents without a high school diploma, for residents of East Harlem and Inwood/Washington Heights the figure was a little over 30%.

***Demographics 7:**

Employment levels:

Unemployment rates in the community are consistently higher than the state averages in each borough except for Manhattan, where unemployment rates for Whites and Asians are lower than the state's rates. Blacks have the highest unemployment rates of all racial and ethnic groups in each borough, followed by Hispanics. Whites have the lowest rates. Manhattan and the Bronx have the highest unemployment rates for Blacks, at just over 15% and 16%, respectively. Over 14% of Hispanics living in both boroughs were unemployed. Blacks and Hispanics in Queens have lower unemployment rates than those in other boroughs. Asian unemployment is below 10% in the four boroughs. Unemployment among Whites exceeded 10% only in the Bronx.

***Demographics 8:**

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

Criminal Justice

The racial and ethnic composition of inmates during NYC's FY2012 was: 57% Black, 33% Hispanic, 7% White, and 1% Asian, with the remaining 2% unknown. Males made up 93% of all inmates. The age distribution of inmates was fairly even between ages 19 and 64:

- 7% were 16 to 18
- 23% were 19 to 24 years
- 28% were 25 to 34 years
- 20% were 35 and 44 years
- 22% were 45 to 64
- Less than 1% was over 65 years or of an unknown age

Note that demographic characteristics such as poverty, education and race/ethnicity and language attainment may influence health literacy, limit practical choices and community environments that are not supportive of healthy behaviors.

For a detailed analysis of Community Demographics, please refer to Section Bi of the CNA document.

File Upload (PDF or Microsoft Office only):

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

File Name	Upload Date	Description
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No records found.

✔ 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:



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For all ages, heart disease (HD), cancer, and pneumonia and influenza (pneumonia), diabetes mellitus, chronic lower respiratory disease (CLRD), and stroke were the leading causes of death in 2012 in the four counties served by ACP. For HD, CLRD, and stroke, the proportions were slightly higher for females. Non-Hispanic White had a higher proportion of deaths than Non-Hispanic Black followed by Hispanic and Asians. Kings, Bronx and Queens had higher rates for HD, pneumonia, and diabetes.

Leading causes of premature death before age 75 were cancer, HD, unintentional injury, diabetes mellitus and CLRD. For less than 65, the proportion of deaths from use of or poisoning by psychoactive substance, and HIV were higher than diabetes. Males had a higher proportion for deaths from HD, psychoactive and HIV; females had a higher proportion of deaths from cancer. The Bronx and Brooklyn ranked highest for deaths before 65 and for Black and Hispanics.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

For Medicaid beneficiaries with chronic conditions in the four counties served by ACP, the leading causes of hospitalizations in 2012 were for substance abuse and cardiovascular diseases and disorders followed by diabetes mellitus, and respiratory and mental diseases and disorders. Of those with substance abuse, 65% had an admission (average of three admissions). Over 40% of those with cardiovascular had admissions (average of two). Substance abuse also had high ED use (average of four visits). For the set of Prevention Quality Indicators (PQI) Composites, New York and the Bronx had higher than the State's observed rate of hospitalization per 100,000. These include the PQI composites for acute, all circulatory, all diabetes, all respiratory, chronic and overall. For age 18+, the age-adjusted preventable hospitalization rate was highest for the Bronx and Brooklyn. Blacks and Hispanics have the highest rates in Manhattan and Brooklyn.

***Challenges 3:**

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

The Bronx has the lowest observed Prevention Quality Indicators (PQI) hospitalization rate. Asthma in younger adults and COPD or asthma in older adults were the highest. PQIs for diabetes ranked second, especially for diabetes with long-term complications. The acute PQIs ranked third, urinary tract infection (UTI) was higher than that for bacterial pneumonia and dehydration. Manhattan ranked second worse compared to New York State (NYS) rates. However, the acute PQIs were worst for Manhattan, with not much difference between the three conditions. Asthma ranked second, with COPD or asthma in older adults worse than in younger adults. Admissions for heart failure and hypertension ranked third; diabetes ranked fourth. Brooklyn was only above NYS rate in the circulatory conditions, with heart failure being worst; hypertension and angina were only slightly above NYS rate. All ambulatory care sensitive conditions for Queens were below NYS rate.

***Challenges 4:**

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

Cardiovascular Diseases

Heart disease is the leading cause of death for both males and females in all four boroughs. APC experiences high percentages of Medicaid Beneficiaries with cardiovascular disease:

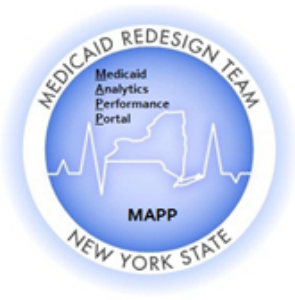
- Bronx –26.6%
- Brooklyn –31.4%
- Manhattan –32.4%
- Queens – 28.7%

Whites and Blacks had the highest mortality rates for heart diseases among all, with the rate for Blacks significantly higher than that for Whites in Manhattan. The heart disease mortality rate for Hispanics was higher in the Bronx and Brooklyn compared to the rate for all of New York.

Diabetes

Diabetes was the single most frequently mentioned health issue in key informant interviews, was among the most prominent issues raised by the majority of Medicaid member focus groups, and ranked as the highest-priority health issue on surveys. These findings are confirmed by the percentage of Medicaid Beneficiaries with diabetes:

- Bronx –11.0%



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- Brooklyn –11.2%
- Manhattan –12.1%
- Queens – 11.1%

Diabetes was among the top five leading causes of death in the Bronx, Brooklyn, and New York City overall. The Bronx had a significantly higher hospital discharge rate than the state for the "All Diabetes Composite" PQI, and for several specific diabetes PQIs, including short-term diabetes complications, and uncontrolled diabetes.

Asthma

Asthma was raised as a high priority issue in key informant interviews. This is supported by Asthma prevalence for Medicaid Beneficiaries data below:

- Bronx –8.1%
- Brooklyn –3.9%
- Manhattan –6.0%
- Queens – 4.8%

The rate for chronic pulmonary disease or asthma in older adults was 38% higher in the Bronx than for the state. Half of CNA interview participants who mentioned asthma suggested focusing on childhood asthma.

Mental Health

In key informant interviews, mental health issues were discussed in several forms, including depression and anxiety, domestic violence, schizophrenia, and other conditions and behaviors. Below is Medicaid Beneficiary data:

- Mental Health Conditions
 - o Bronx –22.7%
 - o Brooklyn –17.5%
 - o Manhattan –26.0%
 - o Queens – 14.1%
- Percentage of Mental Health Service Clients with Selected Chronic Co-Morbidities
 - o Bronx –46.1%
 - o Brooklyn –48.3%
 - o Manhattan –74.9%
 - o Queens – 51.8%

HIV

The prevalence rates of those living with HIV or AIDS in the Bronx, Brooklyn, and Manhattan were nearly twice to more than four times greater than the state average. Blacks and Hispanics had much higher HIV and AIDS prevalence rates than Whites, but nearly all racial and ethnic groups in the Bronx, Brooklyn, and Manhattan had significantly higher rates than their respective groups at the state level. Below is HIV case rate per 100,000:

- Bronx –48.6%
- Brooklyn –36.2%
- Manhattan –49.3%
- Queens – 23.4%

Sexually Transmitted Diseases (STDs)

The Bronx, Brooklyn, and Manhattan compared unfavorably to NYS for case rates of chlamydia, gonorrhea and syphilis, with rates in some cases two to three times the state average.

*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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There is an opportunity to improve maternal and child health outcomes in New York City per the data below:

- Mortality Rate per 1,000 Live Births - Infant
 - o Bronx -5.7%
 - o Brooklyn -4.4%
 - o Manhattan -3.9%
 - o Queens - 4.3%
- Percentage of Births with Adequate Prenatal Care
 - o Bronx -54.6%
 - o Brooklyn -65.0%
 - o Manhattan -69.4%
 - o Queens - 65.1%

Maternal and child health indicators overall are worse in New York City than New York State. Brooklyn and Queens have higher percentage of women in WIC who are pre-pregnancy underweight. The Bronx is worse off compared to the other boroughs and New York State in half of the maternal and child health indicators. In all boroughs except the Bronx, Blacks have much higher infant mortality rates than any other race or ethnicity.

*Challenges 6:

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

Obesity

The percentages of adults who are obese were higher in the Bronx (23.5%) and Brooklyn (21.7%) than in NYS. The percentage of children and adolescents who are obese was higher in all four boroughs than both the NYS rate.

Physical Inactivity

According to the County Health Rankings, Bronx ranked 60th out of 62 counties in NYS for diet and exercise. Nearly 1/4 of residents in Bronx, Brooklyn, and Queens reported not exercising in the past 30 days, compared Manhattan at 16.5%. In Brooklyn, Bay Ridge/Bensonhurst and Greenpoint stood out with over 30% of residents reporting no exercise in the past 30 days.

Cigarette Smoking

Adult smoking prevalence has increased over the past three years. In 2011 the percentage of adults who smoke in NYC was 14.8%. The percentage of adults who smoke cigarettes was higher in Bronx (18.1%) than the state rate (17%).

Alcohol use

Manhattan reported the highest proportion (26.2%) of binge alcohol use compared to the other boroughs and to New York City (19.6%). Three neighborhoods in Manhattan stood out with over 29% reporting binge alcohol use.

For a summary of prevalence in these areas by borough, please refer to the CNA ExExhibit 7B.

*Challenges 7:

Any other challenges:

Not applicable

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**



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hospital and nursing home beds.

Our CNA analysis suggests that bed capacity in the four boroughs is between New York State and U.S. urban bed-to-population ratios; therefore not in a significant overcapacity or deficit situation. Within the past five years, four hospitals in Queens near FHMC and JHMC have closed. Simultaneously, the population in Queens' County increased. There is no current excess bed capacity; however, if initiatives are successful in reducing utilization, future bed reductions may be necessary. Nursing home bed capacity has an oversupply in the Bronx, although daily census figures illustrates beds are filled regardless of over-capacity. There is also generally an undersupply of behavioral health beds. ACP will encourage partners in areas of oversupply of hospital and nursing home beds to reduce beds to better meet the needs of the population.

• Excess (Deficit) Hospital Beds per 1,000 Population Compared to U.S. Benchmark

o Bronx –(125)

o Brooklyn –(1,512)

o Manhattan –3,267

o Queens – (2,250)

• Inpatient Psychiatric Bed Capacity, Adults and Youth, per 100,000 Population

o City-wide –62.0

o Bronx –55.3

o Brooklyn –47.3

o Manhattan –91.9

o Queens – 48.5

• Nursing Home Weekly Bed Census: Available Capacity

o Bronx –5.8%

o Brooklyn –7.6%

o Manhattan –6.7%

o Queens – 7.7%

CNA primary research did not identify issues with over- or under- bed capacity, but rather focused on the language and cultural skills of hospital staff to service Medicaid patients and others who speak limited English and/or are recent immigrants.

Stakeholders engaged in the CNA process, identified an inadequate supply of behavioral health and substance abuse services as the highest priority issue second only to shortages in primary, specialty, inpatient, home health, and long-term care providers. Respondents made the following recommendations to address health service gaps they ranked as high priority: develop and/or partner with patient-centered medical homes as hubs of coordinated and integrated care; improvements in Medicaid coverage (e.g., expansions, covered services, and coordinated re-enrollment); and increased provider reimbursement.

ACP will review bed capacity and provider capacity with hot spots to develop a strategic plan to address gaps in capacity. ACP is using the State based HIE, in addition to health information technology (HIT) proprietary tools, to integrate across the continuum of care and address access issues. ACP will also build upon current care coordination and preventive care strengths to address primary connectivity and preventive care challenges.

***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.

Based on the primary data collected, causes of gaps are as follows:

Quality of Care

- Potentially preventable visits (PPV) rates may be driven in part by the adequacy and perceived quality of the supply of primary care resources, but also by individual resident choices and by knowledge of alternative care (or self-care) options
- Potentially preventable readmission (PPR) rates can be an indicator of quality problems in several different parts of the care delivery system, including quality of care inside the hospital, the quality of discharge instructions and follow-up to support self-care, and care



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transitions to rehabilitation, specialists and/or primary care physicians in the community

Availability

- HEDIS data points to limited supply of preventative, ambulatory services
- CAHPS Measures identify reasons related to accessibility that limit adequate care

Accessibility

- Poor reimbursements that have the effect of limiting supply for Medicaid members; managed care plan limits on the number of visits per year; and a lack of coverage of some medications
- Long scheduling wait times for appointments
- Limited evening and weekend hours
- Limited awareness of and knowledge about services
- Limited health literacy
- Lack of culturally competent and language accessible information
- Stigma against using community services

Transportation

- Limited transportation services in some areas for older individuals with general mobility or disability issues
- Limited access to healthy and affordable food, transportation, employment and family and income support services

Affordability

- There is a direct relationship to High rates of household poverty and high rates of unemployment and the uninsured
- Low levels of education
- A variety of barriers to care, including eligibility for insurance, low levels of health literacy, and limited English proficiency. These demographic indicators indicate that gaps are closely linked to socioeconomic issues.

***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.

ACP's strategy to address the identified gaps for Medicaid patients suffering from chronic conditions will have several areas of focus. The delivery of health services to these high-risk populations needs to be more integrated, with attention to dedicated care coordinators. By integrating health providers from a variety of settings ACP will reduce PQI Admissions by providing greater accessibility to community health services and also reduce PPR readmissions by ensuring that patients have the resources they need to manage their care effectively.

ACP will make changes to increase access to care for non-urgent care needs. This includes changing the operating procedures and office hours of PCPs in the network, implementing new protocols and models of care for ED frequent flyer populations and increasing the provision of culturally competent and multi-lingual health care information and interventions. ACP will continue to develop and strengthen existing linkages and partnerships with health care and community providers to create "one-stop" health care sites to address patients basic and chronic health needs.

ACP will address these gaps by continuing to integrate available health resources outside of the health provider's office or ED. Specific to cardiovascular disease management and prevention current resources that can be used to meet this aim include:

- Using the FQHCs and Health Homes already in the PPS and developing patient-centered medical homes and address lifestyle factors affecting cardiovascular disease.
- ACP will utilize community assets that specialize in preventing known cardiovascular disease risk factors including smoking and tobacco use by partnering with the NYC DOHMH and its District Public Health offices
- Food banks and food access organizations such as Gods Love We Deliver can be a partner resource for a healthy diet. A number of other local community-based organizations can serve as on-the-ground partners.



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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).

ACP identified appropriate organizations to provide insight on the community health needs while working in collaboration with partners, including the PAC, project care teams and input from the NYAM and Verité reports. To identify community based organizations, ACP considered elements to ensure the participation of a broad cross-section of stakeholders:

- CBOs that had not previously worked with ACP
- CNA findings (gaps, demographics)

We generated a list of CBOs based on first-hand knowledge, external review, and consultations with service providers, including CBOs. The list of CBOs identified was cross referenced with the elements listed above to ensure a match between needs and organizations. The ultimate group of CBOs included CBC, which is a large group of behavioral and mental health physicians.

ACP then reached out directly to these organizations, most of which are familiar with DSRIP, and engaged them in CNA primary data collection strategy and analysis. These organizations assisted with recruitment of survey, interview, and focus group respondents to ensure representation of diverse populations. These organizations also assisted in the recruitment of focus group participants, facilitated the groups and administer surveys, served as key informants, and identified others that should be approached for primary data collection.

Members of the ACP team and Steering Committee provided briefings to numerous elected officials on DSRIP implementation and the status of the ACP projects. ACP worked with various federations of social service providers to access a range of stakeholders and providers indigenous to the PPS service areas with interest to collaborate. The following organizations will continue to be collaborated: Federation of Protestant and Welfare Agencies; Hispanic Federation; Asian American Federation; Black Agency Executives; New York Immigration Coalition; and Catholic Charities.

All of the stakeholder and CBO engagement provided rich information because most were familiar and eager to contribute to DSRIP design. The feedback and findings were ultimately included in DSRIP planning and selection for projects.

***Community 2:**

Describe the number and types of focus groups that have been conducted.

Community surveys were translated and small group discussions/focus groups were conducted in the primary languages spoken in the respective communities as follows:

- 77 key informant interviews
- 45 focus groups with Medicaid patients and the uninsured
- 5 small group discussions with Medicaid recipients and low-income community members
- 1,281 general community member surveys
- 267 PPS provider surveys

In addition, ACP created a variety of vehicles for ongoing community and stakeholder engagement for the life of the DSRIP project. These include a project website, targeted e-mails, and community presentations. CNA findings are now available for general consumption and ACP will initiate a broad dissemination strategy in accordance with its Communication Plan. In accordance with this plan, meetings will be held in local Community Boards, individual sites and umbrella groups, and federations of CBOs and FBOs, offices of elected officials, and hospitals, as well as in numerous other sites to reach the diversity of stakeholders in ACP's target communities.

***Community 3:**

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



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From the stakeholder and community engagement process, eight priority health and health service challenges were identified:

1. Cardiovascular Disease
2. Diabetes
3. Asthma
4. Mental and behavioral health and access to care
5. Sexually transmitted diseases including HIV/AIDS
6. Delivery system coordination, integration and navigation
7. Health literacy and knowledge of the health care system
8. Language and cultural barriers to care

These findings were identified through different survey types and cannot be quantifiably compared however, they are important to the CNA.

Mental health was identified as a significant and highly prevalent health need, and an area with under-resourced, disconnected prevention and treatment services.

Stakeholders also provided insight into the need for integration. The ability of and degree to which service providers share information about patients' health conditions and treatments, coordinate care, and integrate services has significant implications for health care costs, quality, and outcomes.

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.

[Advocate Community Partners (AW Medical)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Elected Officials	Policymakers at the Federal, State and local levels of government. Represent broad constituencies in target communities for the DSRIP projects selected by the PPS.	As policymakers, these individuals have concerns over and above the outcomes of the policies they establish. These individuals not only have the trust of the community and a wide range of stakeholder contacts, they also evaluate reform activities and policies aimed to improve health outcomes. Furthermore, these individuals are highly vested in communicating with constituents about policy changes and obtaining input for implementation and subsequent reforms.
2	Federation of Protestant and Welfare Agencies (FPWA)	A network of 200 member agencies and churches throughout the five boroughs that serve more than 1.5 million New Yorkers of all ages and ethnicities.	FPWA is one of the city's premier social service support organizations with a wide reach among health and human service providers and recipients. These stakeholders have a unique provider perspective and are able to engage and facilitate the participation of direct users and provide input from the bottom-up.
3	Hispanic Federation	A network of Latino non-profits (providing a broad range of services from poverty relief, housing, food security to youth development) that serves more than 2 million in the Northeast area.	Expansive access to the Latino community in the five boroughs. Network agencies work in the fields of health and human services. These stakeholders have a unique provider perspective and are able to engage an important demographic group of



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[Advocate Community Partners (AW Medical)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			the PPS
4	Asian American Federation	A pan-Asian nonprofit organization representing a network of community service agencies in the Northeast. Many of these organizations provide immigration assistance, poverty relief and family supports.	Expansive access to the Asian community throughout the City of New York. Network agencies work in the fields of health and human services. These stakeholders are able to engage an important demographic group
5	Black Agency Executives	A membership organization comprised of executives of major human service agencies in NYC established to support the needs of Black leaders in human service (poverty-relief, youth development, etc.) professions.	Expansive access to the Black community throughout the City of New York. Membership organizations work in the fields of health and human services. These stakeholders have a unique provider perspective and are able to engage and facilitate the participation of direct users and provide input from the bottom-up.
6	New York Immigration Coalition	A membership organization comprised of 200 immigrant serving organization in New York City. Many of these organizations provide immigration assistance and related advocacy but also provide poverty relief and family supports.	Expansive access to the often hard-to-reach immigrant community. Membership organizations are of and from the communities they serve and are dedicated to expanding and ensuring access to health and human services to the immigrant population in the City of New York.
7	Catholic Charities	A network of 9 Catholic Charities Agencies including 300 neighborhood and community sites that provides over 350,000 individuals annually with a variety of social supports.	Expansive access to a wide range of individuals throughout the five boroughs and can gain direct users input
8	Coordinated Behavioral Care (CBC)	CBC and its Health Home serve over 18,000 individuals in the five boroughs. Its IPA serves over 25,000 unduplicated Medicaid recipients in the five boroughs. Its network is comprised of 49 experienced and well-regarded Behavioral Health (BH) providers.	CBC has great expertise and a specialized service network that focuses on NYC Medicaid recipients who have BH disorders, either a serious mental illness (SMI), serious substance use disorder (SUD) or both. This was especially important to ACP, since 82% of NYS preventable readmissions (\$665 million) are people with a BH diagnoses.
9	Unions such as the New York State Nurse Association and SEIU 1199	The New York State Nurses Association is a union of 37,000 frontline nurses in New York—it is the City's largest union and professional association for registered nurses. SEIU 1199 in New York City organizes the city's voluntary, not-for profit hospitals and their primarily female, African-American and Latino workers. 1199 has 200,000 members and serves 1,138 facilities in NYC.	Both unions are key leaders in the health care industry in New York that provided valuable input in the formation of the PPS's workforce strategy. Representatives of these organizations also serve on the ACP PAC and project teams.
10	IPAs	Independent Physician Associations such as: Balance IPA; Breukelen Community IPA; Chinese American IPA; Corinthian Medical IPA; Eastern Chinese American Physician IPA; Excelsior Medical IPA; Korean American Physician IPA; and Queens County IPA.	The membership of the IPAs includes physicians and specialists from diverse backgrounds including Asians, Hispanic/Latinos, and African-Americans, as well as other physicians throughout NYC. Each member brings on-the-ground



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[Advocate Community Partners (AW Medical)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			knowledge of key communities and often performs the role of "cultural bridge" to the larger healthcare system. These IPAs have amassed an impressive record of positive outcomes in the delivery of healthcare. They are experienced in the management of risk-based managed care programs, including programs for Medicaid members and Dual-eligible patients.

✔ 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.

[Advocate Community Partners (AW Medical)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	High discharge rates for Cardiovascular diseases	Risk-adjusted rates for hospital discharges for angina without procedure were higher in the Bronx, Brooklyn, and Queens than the New York State rate. Discharge rates for heart failure and the overall Prevention Quality Indicator (PQI) "All Circulatory Composite" were higher in the Bronx and Brooklyn than for the state. The discharge rate for hypertension was 50 percent higher in the Bronx than the state.	Verité CNA Report (Exhibit 49)
2	High Mortality for Cardiovascular Diseases	Overall mortality rates for diseases of the heart were higher than the New York State rate for the Bronx, Brooklyn, and Queens.	Verité CNA Report (Appendix 5 - Exhibit 5D)
3	Heart Disease & Hypertension as leading cause of death	Heart disease was the number one leading cause of death for both males and females in all four boroughs and New York City as a whole. It was also the leading cause of premature death for males and the second leading cause for females in the Bronx. It was the second leading cause of premature death for both males and females in Brooklyn, Manhattan, and Queens.	Verité CNA Report (Exhibit 90 and Exhibit 91)



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[Advocate Community Partners (AW Medical)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
4	Need for additional cardiovascular care	Survey respondents ranked cardiovascular diseases second highest-priority health issues.	Verité CNA Report (p. 140)
5	High Diabetes PQIs for several boroughs	The Bronx had a significantly higher hospital discharge rate than the state for the "All Diabetes Composite" PQI, and for several specific diabetes PQIs, including short-term diabetes complications, lower-extremity amputation among patients with diabetes, and uncontrolled diabetes. The Bronx had diabetes hospitalization and short term complication rates greater than 75 percent worse than the New York State average. Brooklyn's rate was higher than the state for diabetes long term complications and for uncontrolled diabetes.	Verité CNA Report (Exhibit 49)
6	High Diabetes hospitalization rates	The Bronx and Brooklyn had sharply elevated rates of diabetes hospitalization (and mortality), with figures between 38 and 123 percent higher than the state average.	Verité CNA Report (Exhibit 105 and Appendix 5 - Exhibit 5D)
7	Need for additional diabetes care	Diabetes was the single most frequently mentioned health issue in key informant interviews, and was among the most prominent issues raised by the majority of Medicaid member focus groups. Diabetes was seen as a critical health issue in all four boroughs of the community.	Verité CNA Report (p. 131)
8	High hospitalization rate for asthma	According to New York State Department of Health (NYSDOH), the Bronx, Brooklyn, and Manhattan all had rates of hospitalization for asthma overall and for youth up to age 17 worse than the state. Rates in the Bronx were approximately three times the state averages. Asthma hospitalization rates among youth were highest in every borough for Blacks and Hispanics.	Verité CNA Report (Exhibit 101)
9	High asthma PQI rates	The PQI discharge rate for asthma in younger adults was above the state average in the Bronx and Manhattan. The "All Respiratory Composite" discharge rate was 42 percent higher in the Bronx than for the state. The rate for chronic obstructive pulmonary disease or asthma in older adults was 38 percent higher in the Bronx than for the state.	Verité CNA Report (Appendix 4 - Exhibit 4A)
10	High ED visit rates for asthma	Hospital emergency department visit rates for asthma were higher in all four boroughs than the NYS PA 2017 target, and higher in the Bronx, Brooklyn, and Manhattan than for New York State. The Bronx exhibited rates more than three times the state averages, for all ages and for those aged 0-4 years.	Verité CNA Report (Appendix 7 - Exhibit 7B)
11	Need to additional asthma care	Asthma was raised as a high priority issue as frequently as diabetes and cardiovascular diseases in key informant interviews. Asthma also was mentioned as a top issue in the majority of the Medicaid member focus groups. In the provider survey, pulmonary and respiratory diseases were the fourth-ranked health issue by both physician and non-physician respondents.	Verité CNA Report (p. 132 & 140)



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[Advocate Community Partners (AW Medical)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
12	High prevalence of depression	According to the Medicaid managed care program Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, nearly 19 percent of New York City respondents reported being depressed, and 11.6 percent reported having "emotional problems or mental illness."	Verité CNA Report (p. 116)
13	High utilization levels for hospital psychiatric services	The inpatient psychiatric average daily census per 100,000 population for adults was higher than the New York State average in all four boroughs, with the Bronx and Manhattan approximately 40 percent higher than the state.	Verité CNA Report (Exhibit 20)
14	Lack of access to mental health services	Concerns about the availability, accessibility, and level of funding for mental health services were in the top one-third of health service challenges raised by interview participants. Key informants shared limitations in provider supply, reimbursement, available medications, and limits on the number of managed care visits for mental and behavioral health services.	Verité CNA Report (p. 135)
15	Lack of coordination between mental health and primary care services	Mental health services also were believed by many interview participants to be poorly connected to physical health care providers and provider institutions, making continuity of care and maintenance of outcomes difficult.	Verité CNA Report (p. 135)
16	Inadequate supply of behavioral health providers	The supply of behavioral health services was perceived as the biggest gap in available health care, behavioral health, and social services.	Verité CNA Report (pp. 140, 143, 144)
17	Lack of mental health advocacy	Mental health advocacy and education was ranked by survey respondents as the top community-based "resource" that can assist in addressing identified health priorities. And, when asked to rank a number of proposed initiatives and actions that would have the greatest impact on improving care and reducing avoidable hospital admissions, respondents placed "expansion of mental and behavioral health services" fourth, behind "integration of primary care and behavioral health services."	Verité CNA Report (p. 146)
18	Lack of care coordination between providers	Problems with care coordination, management, and navigation were among the top three system-related issues cited in key informant interviews with providers of physical health, mental health, and social services. Issues included: incomplete referrals, inconsistent inter-provider communication, a lack of provider knowledge of services available outside their specialty, and failure to receive reports from other providers.	Verité CNA Report (p. 134)
19	High PPV rates	The rates of Potentially Preventable Emergency Room Visits (PPVs) when Medicaid was the payer were substantially (26% to 74%) greater in each borough compared to the average for all payers, including private insurance, Medicare, and self-pay.	Verité CNA Report (Exhibit 44)
20	High levels of tobacco use	The percentage of adults who smoke cigarettes was higher in the Bronx and Brooklyn than the state rate	Verité CNA Report (Exhibit 114 and p.122)



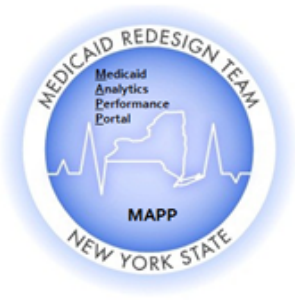
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[Advocate Community Partners (AW Medical)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		and the NYS PA 2017 target.	
21	High prevalence of obesity in adults and children	The percentages of adults who are obese were higher in the Bronx and Brooklyn than in New York State, and compared to the New York State Prevention Agenda 2017 (NYS PA) target. The percentage of children and adolescents who are obese was higher in all four boroughs than both the New York State and the NYS PA 2017 target.	Verité CNA Report (Appendix 5 - Exhibit 5C and Appendix 7 – Exhibit 7B)
22	High prevalence of binge alcohol use	In the NYC DOHMH Community Health Survey, self-reported binge alcohol use was between 10 and 75 percent worse than the New York City average in all neighborhoods of Manhattan except for the Upper West Side and Washington Heights/Inwood.	Verité CNA Report (Appendix 5 – Exhibit 5B)
23	High chlamydia incidence rates	The chlamydia incidence rate in all four boroughs compared unfavorably to New York State, except among females in Queens. Rates in the Bronx were more than 75 percent worse than the state average, while rates for different age groups among males and females in Brooklyn and Manhattan were typically between 10 and 75 percent worse than the state rates.	Verité CNA Report (Exhibit 107)
24	High case rates for gonorrhea and syphilis	The Bronx, Brooklyn, and Manhattan compared unfavorably to New York State for case rates of gonorrhea and syphilis, with rates in some cases two to three times the state average.	Verité CNA Report (Exhibit 107)
25	High HIV/AIDS case rate	HIV and AIDS case rates were extremely high in the Bronx, Brooklyn, and Manhattan in 2012. The prevalence rates of those living with HIV or AIDS in the Bronx, Brooklyn, and Manhattan were nearly twice to more than four times greater than the state average.	Verité CNA Report (Exhibit 106)
26	Large immigrant population with different health needs	The community is composed of a high percentage of people who were born in countries other than the United States. Particularly for more recent immigrants, unfamiliarity with the organization of health care and related services has the potential to create barriers to care. Fifty percent of Queens residents were foreign born, according to the U.S. Census Bureau. That figure ranges from 30 to 40 percent for the other boroughs, with significant differences among neighborhoods. Flatbush in Brooklyn was 50 percent foreign born, for instance, while the Greenpoint community was only 26 percent foreign born.	Verité CNA Report (Exhibit 64)
27	Large number of Limited English speaking households	Across the four boroughs, 16 percent of households are "limited English speaking," meaning that no one age 14 or over speaks only English or speaks English "very well." The figure is lowest for Manhattan (10.4%) and highest in Queens (19.1%), but there is significant neighborhood-level variation:	Verité CNA Report (Exhibit 66)
28	Need to more culturally competent services	Medicaid members reported greater difficulty with language, cultural competency, and health system	Verité CNA Report (p. 133)



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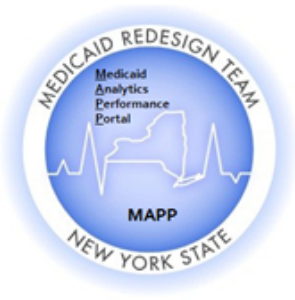
[Advocate Community Partners (AW Medical)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		navigation when seeking hospital emergency department, diagnostic or inpatient care.	
29	Low levels of health literacy	When asked to rate the relative priority of "contributing factors to health," survey respondents chose "awareness/knowledge about available health services" and "health literacy" as their top two choices. Both physician and non-physician respondents rated both among their top selections.	Verité CNA Report (p. 141)
30	Low levels of educational attainment	Considering educational attainment as one proxy for health literacy and knowledge of the health system, the percentage of residents without a high school degree or equivalent is highest in the Bronx (30.6%) and lowest in Manhattan (15.1%). As with other social and demographic indicators, there is significant neighborhood-level variation. Neighborhoods with the highest percentages of residents with no high school degree are:	Verité CNA Report (Exhibit 74)

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
25_SEC038_Brooklyn_CNA_Report_FINAL.doc	12/22/2014 04:42:54 PM	CNA Completed by NYAM
25_SEC038_Bronx CNA Report_Final.docx	12/22/2014 04:41:32 PM	CNA Completed by NYAM
25_SEC038_ACP CNA report 12-15-14-FINAL (Verite).pdf	12/22/2014 04:40:22 PM	CNA Completed by Verite



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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:	AW Med_Section4_Text_20141222_ACP_DSRIP Project Plan Application _ Section 4 Part I(text)_FINAL.docx
Description of File	<input type="text"/>
File Uploaded By:	ms593812
File Uploaded On:	12/22/2014 04:13 PM

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

Currently Uploaded File:	AW Med_Section4_ScopeAndScale_20141222_ACP DSRIP Project Plan Application _Section 4_Scale_and_Speed_FINAL.xlsx
Description of File	<input type="text"/>
File Uploaded By:	ms593812
File Uploaded On:	12/22/2014 04:15 PM



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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.

The goals of the DSRIP project and that of ACP is to improve quality of care, the health of the patient and reduce costs through the development and implementation of a comprehensive system which will require a workforce with new skillsets. Healthcare workforce is expected to be impacted as the delivery system focuses on moving services from the hospital ED and inpatient setting to community based providers. Based on a survey of our partners, ACP expects only slight reductions to the workforce in the first several years of the DSRIP program and only moderate reductions thereafter.

The PPS project implementation plan will engage about 45,000 employees across the PPS network, of which approximately 21,000 will be



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directly involved in DSRIP project development. About 9,000 employees are expected to participate in training, retraining and/or redeployment. These include staff across PPS partners with 1800 new staff members preferentially recruited from the current workforce.

ACP believes that the greatest impact on the workforce will be felt in years three, four and five of DSRIP as healthcare reform increasingly takes hold and the program focuses more on outcomes. Therefore, during the first two years of the program, ACP will assess the anticipated needs for later in the program, and establish a plan for how to best address these needs. In the interim, ACP will focus on workers who require more extensive training in order for them to qualify for the new positions we expect will become available in the last three years of the DSRIP program. Developing opportunities for the workforce to participate in more extensive training programs early on is an important mechanism for reducing the potential negative impact of DSRIP on the workforce in the later years of the program and having a smooth transition.

ACP understands that new positions for which employees are being trained may not be equivalent to positions that they may lose through reductions in the workforce. ACP will work to redeploy as many employees as possible. ACP's workforce strategy will leverage both current and emerging roles across its partners, while building new career pathways, skill enhancement and redeployment strategies that will maximize opportunity minimize negative impact on workers and fill talent gaps.

ACP is committed to addressing gaps through expanded opportunities for retraining and redeployment of current workers before providing opportunities to new candidates. ACP will work directly with the 1199SEIU Training and Employment Funds (TEF) organization. ACP will contract with TEF as our workforce training partner to identify at-risk workers and retrain them for new and emerging positions. ACP will work with other PPS organizations within our service area in order to mitigate any negative impacts of DSRIP on the workforce in the four Boroughs we cover.

Successful implementation of DSRIP projects will drive reductions in the use of the emergency rooms and inpatient services, therefore ACP anticipates that the following positions may be impacted:

- Downsizing in union workers such as Hospital Nurses, Certified Nurse Assistants, Hospital support staff including ED Triage nurses, registrars, clerical workers, security, interpreters and maintenance workers
- Increase in workers such as primary care and specialist office staff, care managers and care coordinators, patient advocates, population health management professionals, IT support staff and others

There is likely to be a significant opportunity for training and retraining as workers assume new roles including functions within the developing Integrated Delivery System.

Where staff reductions are inevitable, the combined effects of retraining, redeployment and natural attrition will meet our strategy to avoid layoffs.

***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.

PPS' Approach to Minimize Workforce Impact:

ACP's high level approach and strategy to minimize the negative impact to the workforce includes the following:

- Creating over 1800 new jobs and filling these positions preferentially with displaced staff from within the PPS'.
- Partner with 1199SEIU Training and Employment Funds (TEF) lead workforce development provider and use their expertise to identify at risk workers and retrain for new and emerging positions, provide training to incumbent workers who need additional skills to perform existing jobs to meet DSRIP requirements, and to develop and provide training for new occupations.
- Assessment, training, and redeployment across PPS' in the four boroughs represents an important element of ACP's strategy to minimize the negative impacts on the workforce. As PPS' pool their knowledge, expertise and resources, ACP's opportunity to minimize



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the negative impacts of DSRIP on the workforce are improved. TEF will play a similar role with other PPS', and therefore will provide opportunities for synergy, cost effectiveness, and functional integration on overall strategic goals and objectives.

- Change management is essential to the success of our workforce strategy. ACP will work closely with TEF to facilitate the necessary cultural and systemic change, to reduce the potential negative impact to the workforce.

Workforce Shortages that Exist and the Impact of These Shortages:

Several areas of shortage have been identified as below without which ACP cannot achieve the DSRIP goals, therefore ACP will hire professionals to address the following identified areas of resource shortage:

- Certified Depression Care managers, and Diabetic and Asthma educators, that are needed for quality disease management and patient care throughout several projects.
- General Case managers. Project success revolves around effectiveness of managing patients in the outpatient/PCP setting.
- Care Coordinators. The success of the DSRIP projects is highly dependent on patients being able to receive needed services and remaining connected to healthcare services which they often don't get for lack of good care coordination with appointments, transportation, specialty and community services.
- Social workers and Patient Advocates. Patients often don't receive and don't know how to request necessary social services because they are disconnected and lost in the system. Social workers and patient advocates can fill this gap and ensure that patients get connected to social services, government programs and have access to community based organizations. They also provide population education and patient incentives. ACP will hire Social workers and Patient Advocates.

ACP's success in projects implementation depends on filling these positions and presents opportunities for current members of the workforce to upgrade skills, gain new credentials and play new roles in the healthcare system of tomorrow. The ACP workforce strategy includes hiring new personnel to staff shortages and mitigate dislocations through redeployment and retraining. These strategic workforce efforts will provide job growth, improve quality of care and patient experience and create healthier communities.

***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	10%
Retrain	10%
New Hire	5%

✔ 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.



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As part of the retraining process, ACP will contract with TEF to deliver high quality training. Training will be conducted by expert clinical staff, experienced educators in adult learning theory, and organizational development experts. Training opportunities will be vast and include upgrading skills, filling in knowledge gaps, obtaining certification as required and/or working towards college/academic credits.

A wide range of mediums will be utilized for training which includes the use of media and technology, as well as classroom-based training modalities and in-service training. TEF uses CUNY wherever possible to deliver training programs that offer college credit or where high quality workforce and certificate programs meet industry needs.

More specifically, ACP will utilize the following process:

1. ACP will conduct an in-depth stakeholder workforce assessment of all partners and staff and align those needs with the selected projects. This assessment will include a network-wide assessment of how current roles may be restructured to implement the projects and an assessment of the training needs of the workforce, which will form the basis for all decisions regarding training. Restructuring roles will minimize reductions to the workforce and leverage skills across sectors. Labor management consultation will create positive relationships throughout the PPS, buy-in to the system and culture change, and support process implementation at the frontline worker level.
2. Create a PPS-specific taxonomy for titles that provide care in the community. Based on past experience with emerging new models of collaborative care, this will foster ease of skill assessment and retraining needs, smooth transition into and alignment with projects, and eliminate role confusion within the network partner agencies. This strategy will also facilitate developing a regional approach to workforce development that will create sustainability beyond the 5-year DSRIP period.
3. Utilize rapid response services to provide early intervention assistance to workers facing job loss. While the PPS anticipates minimal job loss, technical professionals and paraprofessionals in acute care settings are likely to be impacted the most with the least opportunity for redeployment. The PPS will provide these rapid response services in conjunction with existing labor unions in accordance with standing collective bargaining agreements and directly with non-union workers. Rapid response case management, including career counseling, job search assistance for non-union workers, employment workshops to increase employability and support to help employees cope with job loss will also be used to minimize the negative impact on the workforce.

ACP will work with the unions on developing protocols for union displaced workers. For non-union personnel the retraining will be voluntary. Training for at-risk workers will be voluntary, however, it will be strongly encouraged. Where new credentials or skills are needed for specific incumbent job titles, the training or credential may be mandatory, such as with asthma educator certification. In some cases, Case Managers, Care Coordinators and other staff may be required to follow specific protocols and meet the standards set by the evidence based models of care. Training for staff responsible for implementing these protocols will be mandatory in order to qualify for the position.

***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.

The success of our retraining approach will be dependent on the provision of timely information. ACP will develop a communication plan to support this process. Information will be communicated in advance allowing time for retraining. Posting will also include facts about job opportunities and salary and benefits. While repurposing of staff could result in wage reduction, ACP will make every effort to provide training for repurposing at the same level and pay rate of the previous position.

Employment opportunities will be posted through a wide range of mediums such as the website, social media and internal memoranda as they become available. Opportunities for workers to interact with the PPS through this process will improve the chances of successful job match. The PPS will use the taxonomy of job titles and transition maps to inform wages and benefits to existing employees, to mitigate downward mobility and job loss.

***Retraining 3:**

Articulate the ramifications to existing employees who refuse their retraining assignment.



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ACP will establish a process and a communication strategy to inform and educate all employees regarding anticipated changes to employment status and associated required training. ACP will follow organizational protocols and collective bargaining agreements (where applicable) for informing employees of appropriate considerations.

Should an employee refuse their retraining, every effort will be made to accomplish a better job fit. Should that process continue to result in the employee's refusal, the employee will be referred to employment counseling with TEF. ACP reserves the right to dismiss employees who continue to refuse retraining.

***Retraining 4:**

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

TEF will be the principal contractor for workforce training. In addition, labor representatives will play an integral role in the PPS' PAC and governance structure. Labor representatives are on workforce sub-committees of the PPS Steering Committee. From this vantage point, labor will play a key role in the development and implementation of this retraining plan. Labor representatives will participate in network-wide assessments and change design. ACP and union representatives have already begun this work and will continue to develop staffing models and approaches throughout the implementation period.

***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	90%
Partial Placement	10%

✔ 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.

ACP's redeployment strategy will be systematic. The strategy will focus on identifying jobs that are most consistent with the employee's current level and salary, for example, Registered Nurses may be redeployed as Asthma educator, Nurse Care manager, etc. ACP's redeployment strategy will involve a coordinated approach including: identifying job description and education level of the jobs and then matching these with a partner or position within the PPS that has the same or very similar requirements, if none is found within the PPS partners, then ACP will seek to align the employee with a similar or same position within another PPS. If no appropriate job is found, then ACP will provide individual assessments counseling/case management and training. Transitional services will provide counseling to deal with the stress, fear and often denial of the dislocation, as well as preparation in resume and interviewing skills, which are critical in facilitating the placement to new institutions.

ACP's redeployment process includes the following:

- Recruiting entry level staff from acute care settings to serve as outreach staff and also offer further training to consider new roles as paraprofessionals, such as Care coordinators and Patient Advocates.
- Redeploying hospital IT staff for EMR implementation and support.
- Providing training for positions such as Nurses to become Care Managers, certified Diabetic or Asthma educators, Depression Care Managers, etc.
- Retraining LPNs, social assistants, and others for care manager jobs, Patient Advocate jobs and functions such as PCMH support.
- Providing staff with the added training needed for certification, i.e. respiratory therapists.

Entry-level workers, such as food service, transport, and housekeeping often have skills needed in new and emerging jobs, such as



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bilingual skills and knowledge of communities targeted for DSRIP projects. These workers will receive retraining opportunities for new roles such as patient advocates, outreach workers and medical assistants. In addition, nursing assistants and patient care technicians will be offered training to become LPNS, medical assistants and PCMH support 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.

ACP will make every effort to maintain the employee at a sustainable level consistent with the employee's credentials and salary. However, it is important to point out that ACP's intention is that HR will prepare a position packet for each staff member that will be offered or selected for redeployment. This packet will include a detailed comparison between the current job and the future job, including location, salary, benefits, role, responsibilities, and training requirements over time. In consultation with partners such as TEF, we are working to determine who can potentially be redeployed and what support will be provided to these staff. We are also coordinating the redeployment process across all PPS members as well as labor representatives to understand and document to what extent redeployment will impact staff compensation and benefits.

***Redeployment 3:**

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

ACP's strategy intends that all employees within the PPS who want a role will be able to have a role. Where possible, staff with the same position titles may be asked to work in a different organization, department or location. Should they choose not to accept their new position, they will enter into a redeployment pool. Staff who are in the pool will be provided access to vacancies across the PPS. Efforts will be made to match an ACP employee with an ACP vacancy, but ACP reserves the right to dismiss employees who continue to refuse redeployment.

***Redeployment 4:**

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

ACP sought partnerships early on with key labor unions. In that regard, SEIU 1199 was invited to participate in the Leadership Council of the PAC and ACPs Steering Committee in order to ensure that labor is part of all deliberations regarding the workforce and the development of the PPS over the 5 year implementation period.

Labor has come to understand the organizational principles, goals and objectives of the PPS and their participation in it. As such, we have moved towards building contractual agreements between ACP and labor union departments, such as TEF, for the provision of technical support and training services. We will engage labor representatives when their members are identified for redeployment and or reclassification based on current collective bargaining agreements. ACP will enlist their support in identifying opportunities for their membership to fill vacancies prior to recruiting on the open market.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

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.

The DSRIP program and projects will create a wide range of new jobs. The largest category of new jobs is Case Management and Coordination. Every single project ACP selected for implementation requires a case management component. Case Managers and Coordinators can be highly trained, particularly on all of the disease management projects. These functions can also be performed by Navigators for less involved interventions.

Another important category of new hires will be Communications and Marketing/Patient Advocates who perform many functions related to community engagement. The success of DSRIP will require the services of a large number of workers who perform functions such as education, outreach and community engagement. Community Health Workers are community-oriented which requires the development of



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unique skills.

Management represents another important category of new hires. The PPS will require the services of contract managers, program directors and supervisors, division heads, administrative assistants, human resources, population health management experts and a large number of similar job titles.

The strategy includes development of job descriptions based on industry job analyses and current job market research, selection criteria, sourcing applicants and a thorough on-boarding process to fully acclimate new hires to the work of the PPS.

At a unit cost of approximately \$516.75 per trainee, TEF proposes to provide training to 8,550 employees annually. TEF is ready to offer the following training:

- Care coordination fundamentals
- ICT
- Care Manager Training
- Care Navigator training
- Outreach Specialist Training
- Care Transitions Training
- Palliative Care for PCPs
- Health Literacy Training for Asthma, Behavioral Health, HIV/AIDS, cardiovascular
- PCC
- Cultural Competency Training

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	220
Physician	30
Mental Health Providers Case Managers	510
Social Workers	90
IT Staff	30
Nurse Practitioners	45
Other	880

✔ Section 5.5 - Workforce Strategy Budget:

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	7,751,250	8,526,375	8,138,813	6,976,125	6,588,563	37,981,126
Redeployment	1,744,031	1,918,434	1,831,233	1,569,628	1,482,427	8,545,753
Recruiting	145,336	159,870	152,603	130,802	123,536	712,147
Other	1,220,822	1,342,904	1,281,863	1,098,740	1,037,699	5,982,028

✔ 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



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Workforce Retraining Initiative, etc.) in the implementation of the Workforce Strategy –specifically in the recruiting, retention or retraining plans.

ACP's workforce strategy consists of conducting a full assessment of training needs (both for staff as well as for providers), providing training opportunities as per the assessment and, developing training resources to augment the resources of the PPS. The goal is to support the PPS's retraining and redeployment efforts. Once the initial assessment of training needs is completed ACP will retrain the services of a development firm to develop a comprehensive strategy to access the following State programs as well as other funding opportunities: 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, and Health Workforce Retraining Initiative.

In this manner, ACP can ensure that its workforce strategy is aligned with existing State program efforts. Working closely with TEF will be a major asset given their experience in this field. For example, since 2002, TEF has used NYS HWRI funding to offer training to more than 75,000 workers, achieving a 97% completion rate.

✔ 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.

The PPS will work with multiple stakeholders with a focus on frontline workers to enhance the quality of care, improve patient/staff satisfaction, increase operational effectiveness and performance, and increase worker voice and involvement.

ACP aims to engage its workers through the following:

- Creating a formal vehicle for frontline managers and workers to participate in the workforce strategy planning and implementation periods
- Training and Technical support provided by TEF to enhance Systemic Cultural Change amongst the entire workforce
- Building project leaders from amongst the staff that will focus on Organizational Development, Process Improvement and Leadership Development

Conversations were held with organizations like STRIVE and the Federation of Protestant and Welfare Agencies to seek their input in the development of our workforce strategy.

***Engagement 2:**

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

ACP's workforce committee is chaired by Hal Sadowy, PhD. The committee members represent primary care providers, physicians, nurse practitioners, mental health providers, hospital, ambulatory surgical centers, health homes, community health centers, and labor unions. ACP contacted 1199SEIU early in the process, considering the large number of union employees they represent and has started working with 1199SEIU leadership. Along with other members from labor, these leaders will convene ACP's partners in labor and worker representatives in order to further develop ACP's comprehensive workforce strategy and plan of action under the leadership of TEF.

***Engagement 3:**

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

Our communications strategy for front line workers is complementary to our overall stakeholder engagement and communications plan. We have created a communications plan that includes detailed messaging, engagement modalities and timelines. For staff in particular, in addition to the formal participation vehicles described above, we plan to conduct surveys, on-site visits, forums/town hall meetings, and teleconferences to encourage feedback and input.

***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.



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ACP has begun to identify workforce needs along with relevant organizational strategies and innovations it may need to develop in early 2015. ACP has begun to craft a robust stakeholder and worker engagement strategy which includes: creation of vehicles for frontline manager and worker participation, improved patient and staff satisfaction, increased operational effectiveness and performance and Leadership Development initiatives.

In addition, ACP developed a comprehensive stakeholder communications plan with messaging, and engagement timelines for a variety of different media. ACP has also been meeting to review, analyze and agree on a workforce strategy. In consultation with TEF, ACP is reviewing structural barriers to workforce modifications in accordance with its DSRIP goals, such as inability or unwillingness to retrain/redeploy due to educational requirements.

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).
- 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.

Our PPS will maximize data sharing among our partnering organizations by working with our vendor, eClinicalWorks ("eCW") to develop a Health Information Exchange (HIE) that network partners access to have a comprehensive view on patient needs, allow for effective care management and assist with navigation of the healthcare system, while maintaining regulations as required by HIPAA. eCW is the most prevalent EHR used by many providers in our region that has the capability to interface with other EHRs. This technology platform will capture information from a range of different systems, including institutional systems, registries, labs and imaging, other EHRs/HIEs, public health agencies, payers, clearinghouses, and pharmacies. Also, processes and workflows are to be established in physician offices that include appropriate retrieval of consent forms.

***Confidentiality 2:**

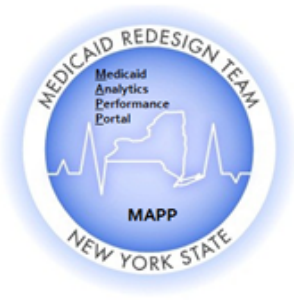
Describe how all PPS partners will act in unison to ensure data privacy and security, including upholding all HIPAA privacy provisions.

Our PPS has developed an HIT Committee that will be focused on data sharing issues such as ensuring privacy and security of data. This HIT Committee, who reports to the Board, will act in accordance with evolving views and regulations developed by the State and establish contracts with partners that will include terms and conditions that cover data sharing obligations, data-driven performance, and data usage and meet the requirements of the DSRIP program, such as care management and care coordination. They will be responsible for developing the data-centric protocols that our PPS partners must agree to, including reporting, data access and data exchange requirements. Appropriate Business Associates Agreements will be required by covered entities, as well as annual HIPAA training and attestations for all required entities.

***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.

Our PPS will work with eCW, the most prevalent EHR in use by physicians and community centers in our region, to connect providers in real time, even those using other EHRs. eCW can interface and has connectivity capabilities with other EHR systems in various settings



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that will facilitate with data exchange. With these data sharing capabilities, the PPS will have access to centralized data that will provide comprehensive patient information from across the care continuum into actionable information. This comprehensive data set will allow our PPS to stratify and target high-risk populations that require additional care, and maintain the status of patients who are identified as lower risk by providing preventable care. Real-time data will be reported, including alerts to physicians and care managers, to identify patients potentially accessing care in inappropriate settings and provide care management. Additionally, our PPS will integrate with SHIN-NY and the RHIO in order to exchange data appropriately but compliantly to further provide proper care management.

For our partners who have limited to no data-sharing capabilities, such as practices with paper medical records or stand-alone systems, our PPS will provide a variety of solutions that will assist their EHR infrastructure, including EHR build support or workarounds that use portals to capture and structure appropriate data. By offering these solutions, such as an EHR-light or portal versions, our PPS will encourage partners to connect existing IT capabilities and develop capabilities to promote data exchange.

✔ 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.

ACP has created an HIT Committee that includes both functional representatives from the executive level and stakeholder representatives from the community. This committee will work in conjunction with the PAC, and will develop materials for performance review and set policies surrounding data sharing and IT capabilities. ACP will work in conjunction with this HIT Committee and the individual Project Committees to monitor partner performance on a monthly basis and determine a course of action for low performers (other committees will provide guidance on next steps). The Clinical Committee will provide a medical economics/business intelligence function by identifying trends and red flags that highlight opportunities, as well as assess performance and deploy initiatives to improve performance. The Finance Committee will determine valuation of initiatives and ensure budget impact is appropriate. Feedback from these committees will allow us to identify opportunities and further adjust initiatives to achieve DSRIP goals efficiently and timely.

***RCE 2:**

Outline how the PPS intends to use collected patient data to:

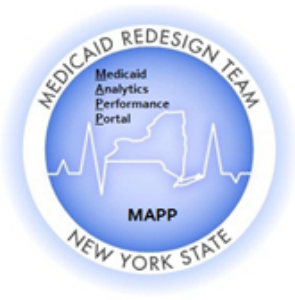
- Evaluate performance of PPS partners and providers
- Conduct quality assessment and improvement activities, and
- Conduct population-based activities to improve the health of the targeted population.

ACP will evaluate performance of the PPS partners and providers using data to create reports that assess overall health at both the patient and population level. These reports will be project-specific, target diseases and understand care gaps. Providers will be evaluated on attribution performance, attainment of project-specific goals and metrics, participation and ability to improve population health. ACP will conduct quality assessments where partner performance will be evaluated on a monthly basis. Monthly provider performance reports will be created to directionally assist providers. Performance reports will be available so that providers who are outliers can share best practices.

Lastly, ACP will use data analytics and predictive modeling tools to risk stratify the population and identify targeted patients in need of evidence based interventions.

***RCE 3:**

Describe the oversight of the interpretation and application of results (how will this information be shared with the governance team, the



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Providers and other members, as appropriate).

The HIT Committee will ensure that transparent data is packaged and delivered to the governance teams on a monthly basis. Additionally, specific reports will be delivered to corresponding committees. For example, the Finance Committee and Clinical Integration Operations Committee will review information relevant to their responsibilities. This will allow our PPS to interpret the information through dedicated, experienced teams.

Furthermore, all partners will receive written protocols and a procedure manual, with milestones and metrics for implementation and minimum performance goals, so that they are informed of expectations. Partners will have access to performance reports via a portal, so they can ensure they are meeting minimum performance goals, and so they can work towards improvement.

***RCE 4:**

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

Using all of the data processes and analytics described in this section, our PPS will synthesize timely reports that will identify high performers, with the intention of spreading best practices, and low performers, with the intention of guiding them to success, including alignment of incentives that reward performance. Agreements with payers can also facilitate focus of payments from service-based to value-based, ultimately introducing risk to areas of opportunity. We envision that, as the DSRIP timeline advances, our best practices will be communicated and implemented in a rapid fashion, contributing to building a highly functioning PPS with clinically and financially coordinated providers and an appropriately managed population.



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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.

In ACP's community, over 30% of the population is foreign-born. In some neighborhoods in Queens and Brooklyn, this rate is over 50%. Among recent arrivals, 30% to 50% have limited English proficiency. Our target population also faces high rates of poverty and unemployment along with low levels of educational attainment. The combination of socioeconomic status, limited English proficiency, diverse cultural beliefs and practices contribute to challenging social determinants of health.

Low levels of educational attainment and literacy as well as difficulty in assimilating to U.S. cultural beliefs and practices can affect all aspects of health for new immigrant populations. This is demonstrated in patients' difficulty learning about preventative measures, needed changes in behavior/practices or patients' understanding their current health conditions. It also often leads to immigrant patients seeking care in ERs for inappropriate care or serious illnesses, which would have been preventable if care had been sought earlier. In either case, this type of uninformed practice is a drain on resources and limits the effectiveness of health care professionals in these settings. Furthermore, patients often have a negative experience and feel as if the healthcare system is non-responsive and disrespectful. Thus our patient population's characteristic, wide range of cultures, low education levels, and limited English proficiency, pose significant cultural competency challenges that ACP must address to ensure success in meeting the triple aim.

*Competency 2:



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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.

ACP is in a unique position to address the aforementioned challenges by virtue of its very make-up and demonstrated ability. ACP is comprised of over 2,000 ethnically and linguistically diverse health care providers and staff, facilities, and service/support organizations. We also have hospital partners that have implemented successful cultural competency initiatives. Many of our physician and hospital-based providers were immigrants themselves and have worked hard to successfully overcome similar language and cultural barriers; this not only establishes trust and mutual respect but also contributes to the ability to successfully overcome cultural barriers to care. We can draw on the expertise of these providers to educate other healthcare providers and community-based partners, as relevant. ACP will implement a comprehensive Cultural Competency Strategic Plan via its Workforce and Public Health workgroups. It is anticipated that major projects will focus on developing a rich repository of patient education resources from our diverse partners; developing a standardized, comprehensive curricula and integrated training program that will help organizations and their staff build awareness and skills for delivering culturally responsive care.

ACP will continue to recruit culturally competent providers and staff, and ensure that our workforce is reflective of our communities. We will develop and hire a cadre of Community Health Workers, for frontline interaction who are trusted members of the community. We will train frontline health workers, including physicians, nurses, care coordinators and others, to further their career development and help build healthy communities and improve patient outcomes.

*Competency 3:

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

ACP is comprised of a rich and diverse network of Community-Based Organizations (CBOs) ranging from citywide umbrella organizations to ethnic focused social groups.

We plan to draw on the expertise of immigrant-specific CBOs, as well as those focused on addressing particular health disparities, to assist us in identifying opportunities to improve upon our cultural competency. For instance, where there is a need for cultural and linguistic expertise in improving our patients' outcomes, we will contract with appropriate CBOs. The CBO contractors will develop patient education materials/resources specific to our DSRIP projects for all languages and literacy levels. They will be responsible for the distribution of these materials to our patient population via media campaigns and community events. Certified CBOs will also be considered to conduct culturally and linguistically competent patient and caretaker surveys.

We plan to draw on food security organizations such as Gods Love We Deliver, and workforce development groups to serve as CBO experts in the provision of culturally competent job training and career development. We will also work with CBOs to provide worker internships and continuing education. ACP has begun to build both formal and informal arrangements with CBOs and many are represented in ACP's PAC and Steering Committee. Our Project Advisory Council is comprised of 25 CBOs from across the four boroughs and will ensure we are responding to these needs. During the implementation period, ACP will continue to identify specific hotspots and strategies that are key to strengthening the cultural competency of the PPS.

Section 7.2 – Approach to Improving Health Literacy:

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:



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- 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.

ACP is working collaboratively with community-based providers and service organizations and their staff to develop and implement a plan to improve the health literacy of patients served by our PPS. The CNA identified the range of patients' language and literacy levels and gaps (multilingual staff, equipment, simultaneous telephone translation, etc.). In response, the PPS will obtain copies of materials in additional languages that include simplified, pictorial guides to help patients understand their disease and treatment process and organize an inventory of language-specific education materials by literacy level that are available across the network. We have already enlisted the help of many of our CBO partners and PAC leadership council members to build a repository of existing health education materials. As part of the PPS' Communication Plan, we will also launch local community education campaigns through local media and community health forums and fairs.

To promote health literacy, Project Workgroups will be tasked with addressing project health literacy gaps through a work plan and timetable. ACP will also collaborate with NYCDOH on existing health education initiatives.

ACP's partners and patient advocates will continue to organize culturally competent and multi-lingual regional annual health fairs and offer health seminars at local community centers across the four NYC boroughs to improve the health literacy of the patient community.

In addition, to collecting and monitoring patient outcomes that can be linked to health literacy, ACP will conduct an annual survey to evaluate patient satisfaction on the health literacy initiatives launched during that period. ACP will adjust initiatives based on the results. ACP will also evaluate the impact of the operational and structural improvements on patient education, safety and satisfaction. This will be achieved through the careful evaluation of defined metrics and service utilization data.

To continue to improve the health literacy amongst health professionals in the PPS, ACP will encourage staff to take advantage of available training and courses such as those offered by the CDC, HHS or contracted CBO providers.

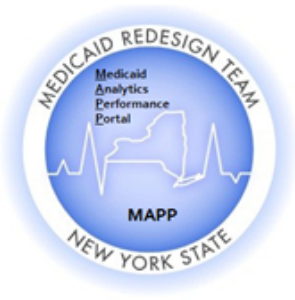
ACP's organizational principles lead the PPS' leadership and members to place a high value on health literacy. Key to improving the health literacy of our population is effectively utilizing and capitalizing on our partners' intimate knowledge of specific communities in targeted geographic areas. ACP has worked with CBOs and faith-based and religious organizations. Many of these organizations' staff and leadership mirror the communities that they serve, and may be members of these immigrant communities. This indigenous experience and wealth of insight is important to carrying out educational campaigns and programs that are successful when addressing complex health conditions with a health literacy approach.

During the implementation period, our aim is to select organizations with which ACP can take on this work, formalized through contractual arrangements with the PPS. ACP will seek to contract with CBO PPS partners; PAC members; and other CBOs, including immigrant-serving umbrella groups, local educational institutions such as CUNY, and religious groups, that are culturally aligned to the communities we serve to develop targeted health literacy interventions. These initiatives will be tailored to the needs of communities that have the lowest levels of educational attainment and health literacy. Many of these efforts will be linked to the cultural competency media and outreach initiatives but will focus on the development of visual instruments, such as infographics, using plain language materials, and providing related worker training.

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



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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.

How PPS plans to distribute DSRIP Funds (bullet 1 and 2 above):

Our fiduciary to ACP, NSLIJ, will receive all DSRIP funds and manage the distribution of those funds under the guidance of the governing board and according to defined contractual arrangements as outlined in the ACP PPS Lead Financial Stability Test dated November 10, 2014.

The ACP DSRIP Funds Distribution Plan includes six categories of funds: cost of project implementation, cost for services not covered, revenue loss, incentive payments, contingency funds, and other funds. Three of these categories have been defined by the State and are outlined in the Budget Distribution Matrix included in this section.

Bonus and incentive payments will be paid based on a methodology outlined by the Governing Board, which will be consistent with DSRIP program requirements, including the 5% limit for non-safety net providers.

Incentive payments will be given as follows:

- 22%- Primary care physicians - based on ability to manage their patients
- 5%- Specialists –based on increasing access to care and following the PPS's care guidelines
- 11%- Hospitals and other safety net providers – based on achievement of performance metrics related to overall DSRIP and project goals

Initial funding will be distributed based on project budgets, and will be dependent on a grading system. Project implementation funds will be spread across partners based on each project's budget needs.



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The Revenue Loss funds will likely be distributed only to hospitals, skilled nursing, and other facility-based providers as they are likely to experience decreases in revenue. Funds for services not covered by Medicaid account for 5% of budgeted DSRIP funds.

The governance structure; proposed approach (bullets 3 and 4):

ACP will distribute funds through individual contracts with partners, in accordance with the Funds Flow methodology developed by the Finance Committee and approved by the Governing Board. Partners will have an opportunity to provide feedback through participation in the PAC. This model will allow ACP to engage and financially reward and encourage coordination of care and achievement of DSRIP goals.

ACP's physician organizations and hospitals are accustomed to fairly distributing incentive funds through contractual relationships. Incentive payments will be made based on a methodology outlined by the Governing Board and consistent with DSRIP program requirements.

The flow of funds for all budget categories will be outlined in each contractual arrangement; NSLIJ will administer the distribution of all DSRIP funds received by ACP.

The proposed funds flow approach allows ACP to reward specific providers based on meeting DSRIP milestones, and transform care delivery with a programmatic effort and financial incentives. ACP members have significant experience with the proposed approach, and have demonstrated results implementing this type of incentive model in the past. If providers are not meeting performance standards or fulfilling project requirements, they will not receive incentive payments. Providers will receive constructive feedback if they are not meeting the basic participation requirements in the IDS. The Board may approve removal of the provider from the PPS or can provide the partner with a plan to improve performance. If a provider fails to meet the requirements outlined in the plan to improve performance, they may be removed from the PPS.

ACP is uniquely positioned to achieve these goals because it has already engaged physicians in similar efforts; many of our hospital partners have experience in successfully managing the health of a population in risk-based contracts. DSRIP funds will be used to implement IT infrastructure, enabling provider partners to overcome barriers to transforming care. Additionally, the funds will help partners transition to value-based payment models.

✔ Section 8.2 – Budget Methodology:

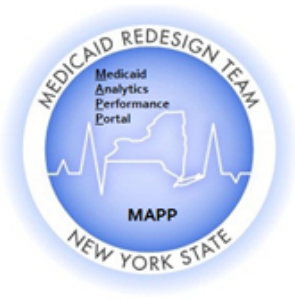
***Budget 2:**

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	30%
2	Revenue Loss	12%
3	Internal PPS Provider Bonus Payments	38%
4	Costs for Services Not Covered	5%



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#	Budget Category	Percentage (%)
5	Contingency Fund	10%
6	Other	5%
Total Percentage:		100%

Section 8.3 - Domain 1 – Project Budget & DSRIP Flow of Funds 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.

- 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.

ACP does not have any indication that any of our partners are at risk for immediate financial failure. The providers in the ACP network are primarily made up of independent physicians and community-based organizations. Most partners have been in operation for a number of years, demonstrating financial stability. In addition, if a physician's office faces financial hardships we believe our network would be able to adequately fill any gaps in care. Providers are also able to address any financial concerns with leadership during PAC meetings. However, many non-hospital partners maintain confidentiality of their financial information and were reluctant to provide it to the PPS in advance of the approval of the PPS for fear it might undermine current relationships. Once approved as a PPS, we will revisit this issue with providers to better identify those that may be financially fragile.

We have identified that behavioral health and substance abuse providers lack the financial resources needed to implement the IT infrastructure and organizational changes required by DSRIP, and risk financial failure based on the increased expectations for their role in this program. We will address their financial challenges in two ways:

- Incentive and project implementation funding, as well as technical support from the PPS, will help cover additional costs associated with the program
- Funds will be available to help behavioral health and substance abuse providers combine into larger and more stable organizations that



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can manage the complexity of new value-based payments and integrated care

***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.

The financially fragile providers expected to be negatively impacted by DSRIP goals are mostly safety net hospitals.

Our exclusive partnering safety net hospitals, Jamaica Hospital Medical Center (JHMC), Flushing Hospital Medical Center (FHMC), and Forest Hills Hospital (FHH), replicated the DSRIP algorithm for modeling avoidable hospital admissions, readmissions, and ED visits. The hospitals estimated the number of avoidable admissions, readmissions and ED visits that would be prevented if 25% of these events were prevented, meeting the DSRIP goals. Together, JHMC and FHMC would experience a decrease of approximately \$12 million dollars, a 1.5% drop in total revenue if DSRIP goals were achieved. FHH and LHH estimated that it would experience a decrease of approximately two million dollars in revenue at each hospital if 25% of avoidable admissions and ED visits were avoided.

ACP will support hospital and other partners experiencing decreased revenues through the Revenue Loss budget category (12% of total DSRIP funds). Hospitals and other partners will also be able to earn Incentive payments if performance on metrics is achieved. The distribution of funds should sufficiently support providers that might negatively be impacted by DSRIP goals.

The overall DSRIP goals of reducing avoidable hospital admissions and ED visits requires shifting care to community based settings; therefore, our PPS has projected increased revenue for lower-cost settings such as primary care physicians and behavioral health providers. Our 47 behavioral health providers, 15 substance abuse providers, and over 700 primary care physicians in the network will most likely experience increased levels of utilization and revenue as a result of DSRIP implementation.

ACP anticipates that its DSRIP projects will alter its workforce in three ways:

1. Significant expansions to workforces, offering new employment opportunities for existing and new workers;
2. Shortages in many health care professions that will require robust training and re-training efforts; and
3. Some dislocation of existing workers with significant redeployments.

Addressing these changes in workforce needs will be a top priority of the PPS.

✔ 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.

The focus of financial restructuring will be to support our partners in the shift to value-based payment arrangements. Success in these arrangements will provide revenues through the Revenue Loss budget category to allow partners to offset the impact of reduced utilization beyond the DSRIP period.

To the extent permitted by law, the PPS will coordinate efforts to shift to value-based payments across PPS partners. Some of our Partners have already made a significant commitment to this shift. For example, the physician networks that formed ACP, as well as NSLIJ and MediSys are already engaged in value-based payment arrangements and population health strategies, and are seeking to expand them.

Additionally, financial sustainability will require repurposing of existing resources, particularly retraining partners' workforces for new roles.

The Workforce redistribution and retraining plan will assist PPS partners in effectively transitioning their organizations into the integrated delivery system model that requires different resources than the current fee-for-service based health system that exists now. Ensuring the



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retraining and redeployment of the workforce will support the PPS' new clinical initiatives and more central services, such as the transformation to PCMH and improved care management services.

The PPS will continuously evaluate the adequacy of its network including the supply of hospital and skilled nursing beds. As DSRIP implementation drives down hospital and skilled nursing utilization levels, the PPS will utilize the urban U.S. bed-to-population ratio to assess the bed supply in the service area. If needed, facilities will shift inpatient beds to lower acuity beds or reduce the number of beds if needed.

*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.

ACP will support fragile safety net providers to understand and successfully implement value-based payments through IT infrastructure, clinical protocols, and targeted initiatives. The PPS will send out inquiries generally twice per year, requesting key financial indicators from partners, to safety net partners in order to evaluate financial stability. These indicators include days cash on hand, operating margin, total revenue, changes in total revenue over time, and others. Partners identified as needing financial support will receive assistance from the PPS through the Revenue Loss Budget category.

The PAC will seek feedback and guidance from PPS partners on all matters, while The Finance Committee will address any specific questions or issues raised by partners. This committee will also review results of the financial partner surveys and work with fragile and safety net providers that do not report positive financial indicators.

*Path 3:

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

After the DSRIP performance period, the PPS will focus on managed care contracts to continue to reward providers for achieving DSRIP outcomes.

ACP will sustain DSRIP outcomes through the shift to a more integrated system of care through structural integration including health information technology and PCMHs.

All providers in PPS will be trained to succeed in a managed Medicaid environment where appropriate utilization is encouraged, and performance, quality and outcomes are tracked and rewarded.

Some of our Partners have already made a significant commitment to this shift. For example, the physician networks that formed ACP, as well as NSLIJ and MediSys are already engaged in value-based payment arrangements and population health strategies.

ACP will continue to work with Medicaid health plans to enter value-based payment arrangements. Depending on each plan's ability to enter these arrangements, we will pursue shared savings and global risk arrangements.

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:

*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.

Our vision is to be a highly effective provider network that can deliver better quality care at a lower cost to Medicaid managed care organizations. Central to this capability is our ability to gather and monitor clinical data that is not available to managed care organizations. This capability is critical to delivering value as a provider network.



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With this foundation of value, we will engage Medicaid MCOs in our efforts. Medicaid MCOs are participants in ACP's PAC, giving them an opportunity to be engaged in PPS planning efforts during the DSRIP performance period. The PPS will seek progressive, value-based payment models and work with Medicaid MCOs to encourage them to implement these types of arrangements when possible. Types of models include value-based contracts that would reward providers for achieving quality goals and managing cost. Ideally these value-based arrangements would be full risk contracts where our providers are rewarded for the quality and value of care we provide to an MCO's population. The PPS will pursue opportunities to enter into these value-based arrangements with each MCO on behalf of the entire PPS network, subject to legal and regulatory constraints.

***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 is critical to the financial stability of safety net providers. Low fee-for-service payments are a major contributing factor to the fragile financial state of many safety net providers. Yet financially fragile safety net organizations are often in a unique position to improve the health of highly complex patients. Both the DSRIP program and managed care contracts can reward these organizations for achieving better outcomes and will drive partners to become more efficient.

The biggest challenge for financially fragile organizations is making the transition from fee-for-service to value-based payments. The DSRIP funds, particularly the Revenue Loss budget category, will provide funding to support that transition. Some safety net providers in the PPS have already started making this transition (e.g., MediSys and NSLIJ). Others providers would benefit from the Revenue Loss and other DSRIP funds, mainly Incentive funds, to help pay for needed resources to allow the provider to transition to value based payments.

Because of its large size, ACP is in a position to manage actuarial risk and absorb the swings in managing the care of a population. This pooling of risk allows fragile safety net providers to be rewarded for succeeding in managing care effectively, without bearing the risk of a single bad year that could be financially ruinous.

 **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 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.

ACP is uniquely skilled in population health and brings a track record of leadership and accomplishments in similar types of endeavors. These projects include participation in various risk-based managed care programs. We have developed leading CMS approved MSSP ACOs, and have participated in the creation of a NY State-certified Health Home. Additionally, we have participated in the NCQA Diabetes Recognition Program and are proactively assisting our physicians to transform to PCMHs.

In particular, MediSys has 62,000 Medicaid covered lives attributed to us under a global, capitated risk arrangement with Healthfirst; 20,000 of which are attributed to community physicians. In this arrangement, MediSys has successfully managed the cost of care and a network of providers, who are held accountable for the outcomes and cost of care for a given population. MediSys also has a population health steering committee that meets bi-monthly to review progress and barriers.

Our partner and fiduciary, NSLIJ, has significant experience in population health management and has made substantial investments in personnel and infrastructure. NSLIJ has had full risk, shared risk and shared savings contracts with Medicaid managed care and commercial payers for over 5 years. In addition, NSLIJ has started a commercial insurance company CareConnect and has a Managed Long Term Care License.

Proven Workforce Strategy Vendor (PWSV):

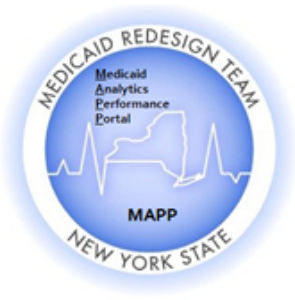
Minimizing the negative impact to the workforce to the greatest extent possible is an important DSRIP goal. If applicable, please outline whether the PPS has or intends to contract with a proven and experienced entity to help carry out the PPS' workforce strategy of retraining, redeploying, and recruiting employees. Particular importance is placed on those entities that can demonstrate experience successfully retraining and redeploying healthcare workers due to restructuring changes.

The ACP PPS will engage the 1199 SEIU League Training & Employment Funds (TEF) as a vendor for education, training, recruitment, and placement services for staff impacted through workforce transformation. TEF's tools and services are critical in promoting workforce engagement and growth.

TEF, the largest labor-management training organization in the U.S., is jointly governed by 1199 SEIU and healthcare employers. It supports 250,000 workers and over 600 employers across all healthcare sectors. Many clinical and non-clinical staff of many PPS partners have participated in TEF trainings and utilized TEF service.

With over 45 years of experience in workforce planning, training, development, placement, and consultation, TEF has a strong track record of collaborating with NYS employers, unions, and training providers to design and deliver high quality programs in an impressive breadth of subjects. For example, TEF has used NYS HWRI funding to offer training and education programs to over 76,000 workers since 2001, with a 97% completion rate. Current offerings range from occupational training for community-based workers to courses on chronic disease management, care management, and care coordination. We believe that TEF's track record speaks for itself; as a key training partner, we look forward to working collaboratively to minimize the disruptive impacts to our workforce, to the extent possible. TEF's ability to effectively utilize funds from the public and private sectors, leveraging economy of scale, a vast network of vendors, and best practices gained through its national reach is an asset to our PPS.

If this PPS has chosen to pursue the 11th Project (2.d.i. Implementation of Patient Activation Activities to Engage, Educate, and Integrate the



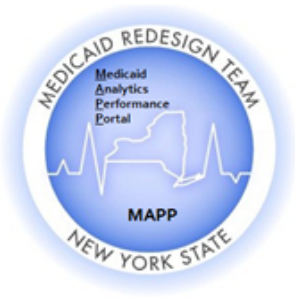
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Uninsured and Low/Non Utilizing Medicaid Populations into Community Based Care) bonus points will be awarded.



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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 Advocate Community Partners (AW Medical) that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Primary Lead Provider Name: TALLAJ RAMON MODESTO MD

Secondary Lead Provider Name:

Lead Representative:	Ramon M Tallaj
Submission Date:	12/22/2014 04:54 PM

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