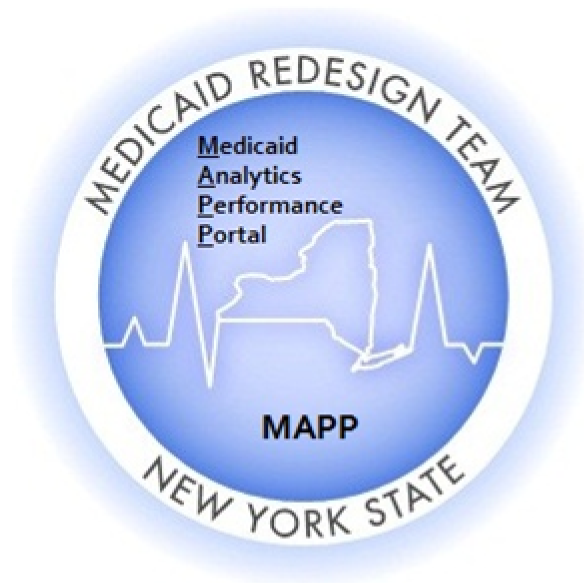
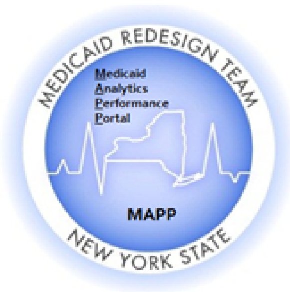
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



New York City Health and Hospitals-led PPS



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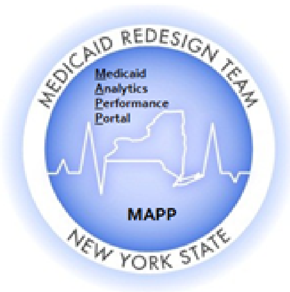

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New York City Health and Hospitals-led PPS (PPS ID:52)

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: **52_SEC000_PPS Financial Stability Test.pdf**

Description of File

PPS Financial Stability Test

File Uploaded By: jaredaug
File Uploaded On: 12/18/2014 08:19 PM

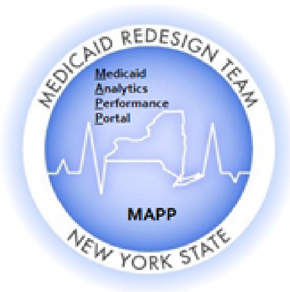
You can use the links above or in the navigation bar to navigate within the application. Section 4 **will not be unlocked** until the Community Needs Assessment in Section 3 is completed.

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: jaredaug
Last Updated On: 12/22/2014 11:39 AM

Certified By:	wilsonr2	Unlocked By:	
Certified On:	12/22/2014 02:09 PM	Unlocked On:	
Lead Representative: Ross Wilson			



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:

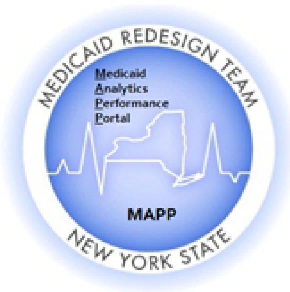
This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

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 a patient- and family-centered integrated delivery system in New York City	The lack of integrated approaches to address the healthcare needs of our communities and the many social determinants of health adversely impacts the health status of New Yorkers. The CNA demonstrates a lack of access to primary and behavioral healthcare, and a lack of coordination among healthcare organizations, providers, and community-based organizations. Additionally, the CNA underscores the challenges faced by providers in ensuring appropriate care to over 1.5 million residents who are disengaged from the delivery system or are uninsured. To address these gaps, we propose to develop an integrated delivery system capable of providing patient- and family-centered care across the continuum, including essential social services. We will enter into formal contractual arrangements with a range of community-based providers and organizations, and we expect these arrangements to evolve over time into a more consolidated and integrated delivery system driven by value-based payment models.
2	Decrease potentially avoidable emergency room visits	Potentially preventable visits to the emergency department (PPV-ED) per 100 Medicaid beneficiaries are 38 in the Bronx, 29 in Brooklyn, 42 in Manhattan, and 27 in Queens. Twenty-one UHF neighborhoods that encompass 61% of our PPS's Medicaid population will be targeted for patient engagement as their observed/risk-adjusted expected ("O/E") ratios of PPV are above 1.0 (indicating a gap in care). Through our PPS's analyses, an estimated 41% of patients who visited the ED were found to not have their own primary care provider (PCP). Several of the top 10 diagnoses of patients presenting to EDs could often be treated instead by a PCP. To address these gaps, the PPS has developed an approach to ED care management which will strengthen patient relationships with PCPs, triage their conditions, and provide navigation support for patients with non-emergent illnesses, and facilitate care coordination for patients treated and released from the ED.
3	Decrease potentially preventable readmissions	Potentially preventable readmissions (PPRs) are frequently caused by poor care coordination or ineffective transitions of care. PPS analyses show an opportunity to reduce PPR rates since risk-adjusted O/E PPR ratios reach 1.04 in Brooklyn, 1.13 in the Bronx, 1.17 in Manhattan, and 0.79 in Queens.



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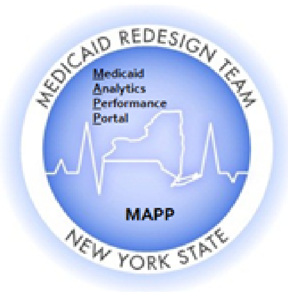
#	Goal	Reason For Goal
		Twenty-one UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for four Prevention Quality Indicator (PQI) measures: COPD or asthma; respiratory composite; chronic composite; and heart failure. Patient engagement activities will be enhanced in these neighborhoods since they constitute a significant proportion of our PPS's total population (69%). To address these gaps, our PPS will pursue a two-pronged approach to improve care transitions: (1) standardize Project Re-Engineered Discharge (RED), a proven method to improve care transitions, across all hospitals and (2) strengthen coordination across the continuum.
4	Provide greater access to primary care and enroll patients in appropriate care models	Expanding access to primary care services and enrolling patients in appropriate care models will be essential to meeting the DSRIP goals and achieve long-term sustainability. As part of our planned activities, we will link primary and behavioral healthcare services and expand our capacity to more efficiently treat larger patient populations. We intend to develop new resources and programs to meet the needs of our communities, including an enhanced care management platform to identify, stratify, and manage the care of patients and populations, and to retrain and hire a large cadre of patient navigators, care managers, and care coordinators. In addition to these programs, we will work to expand the capacity of and enrollment in our affiliated Health Homes, and to assist our community-based PCPs in attaining 2014 NCQA Level 3 patient centered medical home (PCMH) recognition and meet Stage 2 Meaningful Use standards.
5	Promote integrated primary and behavioral health services in an outpatient setting	New York's Medicaid beneficiaries with mental health (MH) and substance abuse (SA) diagnoses are high users of ED and inpatient services: 42.3% and 58.4% of MH and SA patients, respectively, had at least one ED visit and 32.3% and 65.0% had at least one admission. Readmission rates for individuals with MH diagnoses are high as well; 23.3% in NYC, and 20.9% for NYS. The CNA indicates low utilization of behavioral health (BH) resources, which CNA participants note are difficult to access. The CNA posits that low utilization may also be due to stigma associated with BH, inconvenient BH clinic operating hours and lack of awareness of available resources. To address the needs of individuals with co-morbid physical and BH needs before they reach an ED or inpatient setting, we will pursue physical co-location of BH providers at primary care sites, physical co-location of PCPs at BH sites, and expansion of IMPACT, the evidence based depression care model, across the PPS service area.
6	Form a Central Services Organization to serve as the nexus for all population health activities	To successfully implement and continuously improve DSRIP programs throughout our large and diverse PPS, significant dedicated resources and an intensive focus on improving population health will be required. Our PPS is developing a Central Services Organization (CSO), which will be supported by robust analytics and health IT infrastructure to manage a range of population health functions required for DSRIP and long-term success. As currently envisioned, it will provide an integrated platform for all DSRIP projects and initiatives. Its functions are designed to include: protocol management, care transformation, patient engagement, risk stratification, patient navigation, care coordination, IT, and other central support services (e.g., human resources, finance, communications, etc.). Subject to implementation planning, the workforce will include project managers, data analysts, PPS partner coordinators, and engagement workers, among others.
7	Actively engage the uninsured and low- and non-utilizing patients in care before they become sick	There are approximately 1.1 million uninsured and 700,000 low-and non-utilizers in our PPS. The CNA estimates that nearly 21% of all individuals live below 100% of the Federal Poverty Level, 18.6% of which are non-US citizens, 22% have less than a high school diploma, and 24.6% speak



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#	Goal	Reason For Goal
		English "less than very well". These rates exceed NYC and NYS averages and are shown to be associated with disconnectedness from the healthcare system. In order to engage these patients in care, we will implement a comprehensive patient engagement program with two-fold goals: enroll patients in coverage, where possible, and engage patients in high-quality, patient-centered care, regardless of their insurance status. Our PPS will initially focus on those with chronic illness, those with limited English proficiency (LEP), immigrants, and the undocumented, as these groups are shown to have lower insurance coverage rates and less regular contact with the healthcare system.

***Formulation:**

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

In formulating our PPS, we were guided by several core principles. First, our PPS should be organized around the needs of the patient, the family, and the community, with an emphasis on high-quality, patient-centered care that also addresses the social determinants of health. Thus, we engaged a large number of community-based organizations (CBOs) to join our PPS. Second, our PPS's ability to deliver patient-centered care depends on a well-trained workforce focused on providing seamless care across the continuum. To address this, we engaged our labor partners throughout the process, and are committed to a robust program of training and education across clinical and community-based settings. Third, our PPS will operate transparently with a strong bias toward inclusivity. Thus, our governance structure ensures that our community-based partners hold a majority of the seats on our Executive Committee, and also provides ample opportunity for local involvement and guidance. Fourth, we must become self-sustaining. Thus, we have included two managed care organizations as partners in our PPS, and expect to leverage their expertise to increase PPS adoption of value-based payment models.

***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.

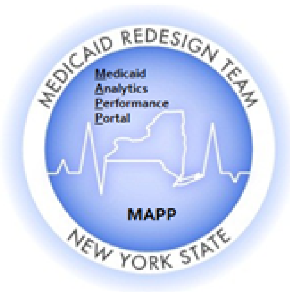
Our vision is to become a fully-functioning, integrated delivery system (IDS) of health and social service providers that spans the entire care continuum, with a focus on addressing the social determinants of health, such as housing. Linked by a Central Services Organization (CSO), we will manage the health of defined populations. Our PPS would be paid using value-based payment models for delivering high-quality care and avoiding unnecessary ED and inpatient admissions. As the only NYC PPS sponsored by a public hospital, we will develop population health programs to care for all, regardless of insurance status. DSRIP will allow us to fully engage the uninsured population, which has received much of its care on an episodic basis, by using care management programs to improve continuity and coordination. Long-term sustainability of our PPS depends critically on the adequacy of value-based payment models used to compensate the PPS for services and programs. We look forward to working with our partners and the State as we leverage our experience with risk-based payment models and work closely with our managed care organization partners to achieve sustainability post-DSRIP.

***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



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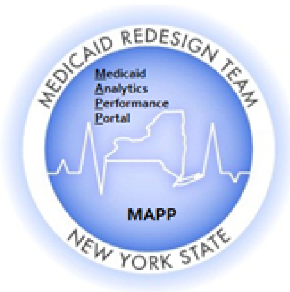
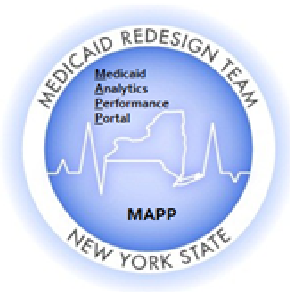
appropriate staff on the policies and procedures, monitoring of implementation to ensure adherence to the policies and procedures, and evaluation of the effectiveness of the policies and procedures in mitigating risk.

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

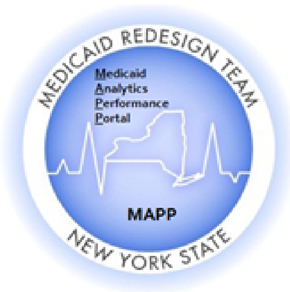
#	Regulatory Relief(RR)	RR Response
1	14 NYCRR §§ 599.3(b), 599.4(r), (ab); 14 NYCRR §§ 800.2(a)(6), (14), 810.3, 810.3(f), (l)	Project: 3.a.i. Reason for request: OMH regulations require Article 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30 percent of the provider's annual visits and the total number of visits is at least 2,000 annual visits (the OMH threshold). OASAS regulations require an Article 28 provider to obtain certification from OASAS if it provides any substance abuse services. Under 3.a.i, Article 28 providers will increase their provision of both mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is highly likely that some of the providers participating in 3.a.i will cross the OMH threshold, and all Article 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would conflict with the goals of Project 3.a.i., and the certification process would be an unnecessary administrative burden. Further, having to comply with multiple licenses would force Article 28 providers to comply with new rules that would have little benefit to patients. For example, Article 28 providers are already required to maintain medical records that meet DOH standards; requiring their records to also meet OMH standards would not improve patient care. Forcing providers to comply will new and unnecessary administrative processes and rules will discourage providers from providing such integrated care. Potential alternatives: Providers could avoid OMH and OASAS licensure by keeping their provision of mental health services below the OMH threshold and avoiding any substance abuse care. However, it would likely be difficult for certain providers to stay below the 30 percent limit, particularly if they are located in areas with a high behavioral health need, and trying to stay within that limit could result in turning away patients needing mental healthcare. Although the draft Integrated Outpatient Services regulations could address some of these issues, this and related requests are being sought because it is unclear how those new rules might be implemented. Patient safety: Waiving licensure requirements is not likely to endanger patient safety because Article 28 providers are already required to comply with a detailed regulatory regime aimed at ensuring patient safety. Nevertheless, working with OMH and OASAS, Article 28 providers that increase their provision of mental health and substance abuse services under 3.a.i will examine their policies to determine if any further policies need to be developed to ensure patient safety given the service changes. If any further policies are required, they will be modeled on OMH and OASAS regulatory requirements.
2	10 NYCRR §§ 401.2(b), 401.3(d)	Projects: 2.a.i, 3.a.i Reason for request: Section 401.2(b) allows the operating certificate of an Article 28 provider to be used only by the Article 28 operator at the Article 28 provider's site of operation. DOH has interpreted this to mean that the operator must have exclusive site control and cannot share the site with another entity. Section 401.3(d) prohibits an Article 28 provider from leasing or subletting any portion of its facility unless the entity that leases the facility



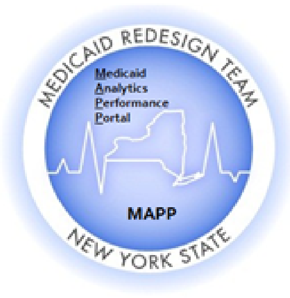
#	Regulatory Relief(RR)	RR Response
		conforms with all of the requirements imposed on Article 28 providers. At the very least, these two provisions prohibit Article 28 providers from sharing space with any provider not licensed under Article 28—including a physician group practice, a clinic licensed by OMH, or a substance abuse clinic licensed by OASAS. This would prohibit Article 28 providers from allowing other providers with expertise in mental healthcare or substance abuse services to provide care in their facilities, thereby limiting their options to integrate care under Project 3.a.i. These two provisions could also be interpreted to bar an Article 28 provider from sharing space with another Article 28 provider. This interpretation would prevent residential care facilities from sharing space with primary care clinics, a possible aspect of Project 2.a.i. Potential alternatives: Article 28 providers could avoid these rules by declining to share space altogether and instead rely on their own expertise to provide behavioral healthcare. While some providers in the PPS are likely to do so, others lack expertise in behavioral healthcare. This latter group of Article 28 providers would then be forced to refer patients to behavioral health providers in other locations, making it less likely that patients would receive the care they need. Similarly, if residential healthcare facilities were unable to share space, they would have to rely on their own personnel to provide primary and urgent care services, even though an Article 28 clinic might be able to offer greater expertise and a higher level of care. Patient safety: The purpose of the relevant regulations is to ensure that an operator has control of the site and therefore can maintain an environment conducive to patient safety. Article 28 providers who receive these waivers will have agreements in place with the leasing provider that give the Article 28 provider sufficient authority over the leased space to ensure patient safety in that space. Moreover, these providers will develop a written plan for shared space that DOH may require. Finally, the providers will comply with federal regulations on shared space, to the extent they are applicable.
3	14 NYCRR §§ 599.5(c), 599.12(a)(6)	Project: 3.a.i Reason for request: The regulations cited above allow mental health providers licensed by OMH (Article 31 providers) to share program space only if they have a written space sharing plan that has been approved by OMH. As part of the behavioral health integration project, providers licensed by OMH are likely to share space with providers of physical health services. The PPS's implementation plan will indicate which providers are planning to share space, and assuming DOH approves that implementation plan, DOH will approve the space sharing plans. Providers should not have to obtain a separate approval from OMH. Potential alternatives: Article 31 providers could follow the regulatory requirements and obtain OMH approval prior to sharing space. However, doing so could result in delays in the implementation of DSRIP projects, particularly since OMH resources may be stretched given the likely demand for such approvals as a result of DSRIP implementation. Patient safety: In cases where OMH providers do share space, they will develop a space sharing plan, and that plan will require that the OMH provider has sufficient authority over the leased space to ensure patient safety in that space. These providers will share the space sharing plan on request, and will modify the plans if OMH or DOH raise any concerns.
4	10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1	Projects: 2.a.i, 2.b.iii, 3.a.i, 3.b.i Reason for request: When medical facilities seek to undertake certain



#	Regulatory Relief(RR)	RR Response
		projects, the certificate-of-need ("CON") regulations cited above require those facilities to submit applications to DOH, demonstrate a public need for their projects, and obtain DOH prior approval. The projects listed above are likely to require providers to undertake construction and service changes that would implicate the CON rules. In particular: a) Project 2.a.i requires a large investment in primary care capacity and some providers will need to expand operations in order to meet that enhanced capacity; this may include the addition of primary care sites at residential care facilities; b) Project 2.a.i also requires investment health information technology (HIT) infrastructure, and some HIT investments enacted by providers—a group of providers that includes residential healthcare facilities—will fall within the scope of CON regulation; c) Project 3.a.i will likely require construction and renovation at Article 28 providers to create new spaces for behavioral healthcare, and likewise some Article 28 providers may provide services at new sites; and d) Projects 2.b.iii and 3.b.i will likely require the creation of new spaces to handle the increased demand for urgent care and cardiovascular services under DSRIP. Requiring a demonstration of public need and a separate application for these projects is unnecessary. DOH approval of the DSRIP projects and their implementation plans should be sufficient, particularly in light of the fact that the PPS has conducted a community needs assessment, and used the results of that assessment to inform its project selection. If DOH is unwilling to waive these regulations in full, DOH should at least provide a highly expedited review process to ensure that DSRIP projects are not delayed. Potential alternatives: The alternative to a regulatory waiver would be to continue to require providers to demonstrate public need for DSRIP projects. Doing so, however, would be highly duplicative of the DSRIP application process itself, as DOH's approval of the above projects demonstrates DOH's belief that the projects are in the public's interest. Patient safety: Waivers of CON regulations would not implicate patient safety in this context. CON regulations are designed to prevent the overutilization of services. While overutilization of services can cause patient harm in some circumstances, the potential for harm is much more likely when providers seek to increase the provision of surgeries, imaging, and other intensive services. There is little threat to patient safety when there is a potential increase in the provision of primary care services, as the Public Health and Health Planning Council recognized in its December 2012 recommendation of eliminating CON review for primary care facilities. The projects listed above all involve primary care services.
5	OMH: 14 NYCRR §§ 551.6, 551.7: OASAS: 14 NYCRR §§ 810.6, 810.7	Projects: 3.a.i Reason for request: Section 551.6 requires Article 31 providers who are licensed by OMH to undergo prior approval review if they undertake certain projects, including the establishment of a new satellite location and the expansion of caseload by 25 percent or more for clinic treatment programs. Section 551.7 requires a demonstration of public need as part of this review. Similarly, Section 810.6 requires Article 32 providers who are licensed by OASAS to undergo prior approval review if the provider offers services at a new location or increases capacity of a service where capacity is identified in the provider's operating certificate, and Section 810.7 requires the applicant to demonstrate public need for its project as part of the review. Project 3.a.i is likely to fall within the reach of these regulations. As part of behavioral health integration, Article 31 and Article 32 providers are likely to provide services at new locations—more specifically, they may provide care within an Article 28 facility. While establishing a new satellite location is technically subject to "E-Z PAR" review, in practice this process is not easy for providers: they must obtain a letter of support from a local



#	Regulatory Relief(RR)	RR Response
		government unit to demonstrate there is a public need for the project, and the process can be lengthy. Requiring prior approval review for the behavioral health integration project would be duplicative of the DSRIP process itself, since the PPS will already have to submit its implementation plan to the state for review. There is no need to impose a separate prior approval review process on top of the review process embedded into DSRIP itself. Potential alternatives: The PPS could avoid this requirement by relying on Article 28 providers to provide mental health and substance abuse services on their own. But Article 28 providers would need waivers to do so, as discussed above. Moreover, Article 31 and 32 providers have expertise in behavioral healthcare, and the PPS should have the option to utilize those providers with a deep behavioral health knowledge base in its implementation of the behavioral health integration project. Patient safety: Foregoing a demonstration of public need will not have an impact on patient safety. To the extent OMH and OASAS have any concerns about Article 31 and Article 32 providers expanding their operations into primary care settings, the PPS will work with these agencies to develop policies to ensure patient safety.
6	10 NYCRR §§ 702.3, 710.9, 711.2, 712-2.4, 715-2.2, 715-2.4	Projects: 2.a.i, 2.b.iii, 3.a.i, 3.b.i Reason for request: Sections 702.3 and 711.2 set construction standards for medical facilities in general; Section 712-2.4 provides specific standards for hospitals; and Sections 715-2.2 and 715-2.4 set standards for freestanding ambulatory care facilities. In addition, Section 710.9 requires a pre-opening survey after the completion of a construction project. In order to fulfill the goals of Project 2.a.i to provide more primary care services to underserved areas, there will be an expansion of the capacity of primary care providers, which will likely require new construction and renovation. Hospitals with aging facilities may also undertake upgrades in order to increase their provision of primary care services. Likewise, Projects 2.b.iii and 3.b.i will require an investment in primary care infrastructure; some facilities may have to be renovated in order to provide more urgent care and diabetes services, and it is also possible that new sites may need to be constructed. In addition, Project 3.a.i will require space reconfiguration for primary care providers in order to provide behavioral healthcare services at those sites, and substantial construction is likely to occur at some facilities under these projects. The design of these new spaces under these projects may conflict with particular regulatory requirements for the design of clinics and hospitals. Such regulatory requirements incorporate provisions of the Guidelines for the Design and Construction of Health Care Facilities, which set out detailed rules for these facilities. Having to follow all of these requirements could be particularly problematic in the context of the behavioral health integration requirement given that these standards where not written with physical and behavioral health integration in mind. Moreover, having to undergo the preopening survey process could lead to delays in the opening of the new unit, and therefore at the very least an expedited survey process is necessary. Potential alternatives: The PPS could follow all of these construction standards. However, doing so may result in design decisions that are suboptimal to the goals of the projects. Patient safety: Certain provisions of the construction standards, such as parts of the Life Safety Code are designed at ensuring patient safety. The PPS will work with DOH to ensure that all standards that directly relate to patient safety are followed.



#	Regulatory Relief(RR)	RR Response
7	10 NYCRR § 600.9(c)	Projects: All projects. Reason for request: Section 600.9(c) prohibits a medical facility from sharing gross income or net revenue with an individual or entity that has not received establishment approval. This could be interpreted as prohibiting a hospital that receives DOH funds under DSRIP from distributing those funds to non-established providers who are in the same PPS. Such an interpretation would be contrary to one of the key elements of DSRIP: the distribution of funds by the lead coalition provider to other providers participating in the PPS. Potential alternatives: Alternatives are not feasible, since following a strict interpretation of Section 600.9(c) would prevent lead coalition providers from distributing state funds to the PPS participating providers. Patient safety: Waiving this regulation would have no impact on patient safety.
8	10 NYCRR § 405.9(f)(7)	Projects: All projects. Reason for request: Section 405.9(f)(7) requires hospitals to ensure that patients may not be discharged or transferred to another location based upon source of payment. This regulation could be interpreted to prohibit hospitals from transferring their patients to other providers within the same PPS, since the hospital would have a financial relationship with the other provider. For example, if one hospital in a PPS were to transfer a patient to the lead coalition provider because the lead coalition provider specializes in treating the patient's condition, this could be viewed as a transfer based on source of payment since the lead coalition provider distributes DSRIP funds to the transferring hospital. Potential alternatives: Alternatives are not feasible. If Section 405.9(f)(7) were interpreted in this strict way, it would mean that hospitals could not transfer their patients to the lead coalition provider, and possibly other transfers would be restricted as well. This would harm patient care, as the lead coalition provider specializes in care that PPS patients need. Patient safety: To the extent that such policies do not yet exist, providers in the PPS will adopt policies and procedures to ensure that transfers to other facilities are made based on patient need and not based on financial relationships. Hospitals will be allowed to transfer patients to the lead coalition provider and other providers within the PPS, and they will be encouraged to do so when it is in the best interest of the patient. However, these policies will emphasize that providers should never transfer a patient based on source of funding when another destination is more appropriate for the patient's care.
9	DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)	Projects: 2.a.i, 2.b.iv, 3.a.i, 3.b.i, 3.d.ii Reason for request: Section 86-4.9(c)(8) prohibits freestanding ambulatory care facilities from billing for services provided off-site. Section 401.2(b) allows an Article 28 to use its operating certificate only for services at its designated site of operation, which has been interpreted as prohibiting providers from providing services off-site. Sections 599.14 and 822-3.1(b) impose similar rules on mental health and substance abuse providers, respectively. Providers would benefit from the ability to provide services off-site in carrying out DSRIP projects. This ability would be particularly beneficial to carryout Project 2.a.i: allowing facilities to provide care in alternative settings would help promote an integrated delivery system and would discourage facilities from providing care in silos. Similarly, as part of the care transition project, a patient who is treated by a professional in a

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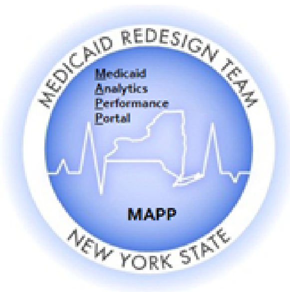
#	Regulatory Relief(RR)	RR Response
		hospital may benefit from seeing that same professional at home (2.b.iv). Projects 3.b.i and 3.d.ii aim to improve cardiovascular and asthma care, and facility-based practitioners may seek to provide services in the home as part of that enhanced care. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home (3.a.i). In short, providers seek the flexibility to provide needed care in the setting that is most conducive to treatment. Potential alternatives: The PPS could rely on providers that are licensed to provide services in the home or non-credentialed practitioners to provide home-based care under DSRIP projects. For example, the PPS plans to utilize a community-based organization and community health workers to provide care under the asthma home-based self-management program. The PPS plans to utilize these workers to the greatest extent possible. However, there likely will be instances where a patient needs a more intensive level of care and the services of a registered nurse, nurse practitioner, or physician employed by an Article 28 provider. Article 28 providers should have the ability to be reimbursed for these services when patients need them in their homes. Patient safety: Practitioners are required to protect their patients no matter the location of care, and therefore allowing those practitioners to provide services off site is not a threat to patient safety. To the extent that DOH believes that providers need to take measures to protect patients receiving care in the home, the PPS will work with DOH to develop provider policies in this area.
10	10 NYCRR § 766.4(a), (b)	Projects: 2.b.iv, 3.b.i, 3.d.ii, 3.g.i Reason for request: Section 766.4 allows doctors, midwives, and nurse practitioners to order licensed home care services, but it does not allow physician's assistants (PAs) to order such care. As part of their efforts to keep patients out of the hospital, the DSRIP projects listed above are likely to involve orders for home care. Patients often are in need of home care services back at home after staying in a hospital (2.b.iv) or receiving palliative care (3.g.i). Patients who receive cardiovascular care (3.b.i) also may need home care services . Likewise, on some occasions patients with asthma symptoms may need home care to help manage their symptoms back at home (3.d.ii). Allowing PAs to order home care as part of these projects would make it easier for these providers to order such care and thus could potentially play a role in reducing inpatient admissions. Potential alternatives: PPS providers could avoid the need for this waiver by relying on physicians, midwives, and nurse practitioners to order licensed home care services. For providers that employ few PAs, complying with Section 766.4 is not a great concern. Some providers, however, rely heavily on PAs in their everyday practice. For these providers, forcing PAs to find the appropriate physician or nurse practitioner to order care would be an inefficient use of resources. Patient safety: PAs often are given the same scope of authority as nurse practitioners. Granting physicians' assistants the power to order home care—a power already granted to midwives and nurse practitioners—is not a danger to patient safety.



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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

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

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

Scoring Process:

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

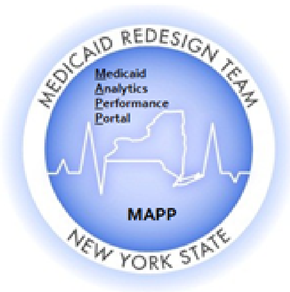
☑ Section 2.1 - Organizational Structure:

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

***Structure 1:**
Outline the organizational structure of the PPS. For example, please indicate whether the PPS has implemented a Collaborative Contracting Model, Delegated Model, Incorporated Model, or any other formal organizational structure that supports a well-integrated and highly-functioning network. Explain the organizational structure selected by the PPS and the reasons why this structure will be critical to the success of the PPS.

The New York Health and Hospitals Corporation PPS ("HHC PPS") has established an organizational and governance structure that will enable it to perform as an integrated and highly functioning network. The HHC PPS will use a Collaborative Contracting Model that is effectuated through a Master Hub Services Agreement ("MHSA") that will be entered into by and among: (1) HHC, as lead applicant; (2) HHC Assistance Corporation, which will function as the Centralized Services Organization (CSO); and, (3) the organizations and providers ("Partners") that form the PPS. The MHSA will establish the committee structure to guide decision-making for the HHC PPS.

The HHC PPS organizational structure was developed with considerable stakeholder input as part of the DSRIP planning process that was overseen by the DSRIP Steering Committee. The HHC PPS chose the Collaborative Contracting Model to maximize flexibility, given the number and diversity of partners. By relying on contracts—rather than formal corporate documents like bylaws and operating agreements to establish the terms of participation, the governance structure, and the decision-making rules - the HHC PPS has increased



flexibility and each partner retains autonomy. This flexibility also allows the HHC PPS to tailor the terms of participation based on the type of partner. Further, the Collaborative Contracting Model enables HHC to keep its DSRIP-related activities within its existing corporate structure, ensuring that DSRIP activities remain transparent.

Because of the large number of partners and geographic breadth of the HHC PPS, the HHC PPS has created a structure that allows for flexibility to meet local needs. We have created a single PPS with four "Hubs" – one for each of Brooklyn, Bronx, Queens, and Manhattan. Partners with locations in multiple geographic areas may participate in more than one Hub. Consistent with the direction of the PPS, the Hubs will review and recommend Hub-specific operating plans and budgets to implement projects, subject to approval by the HHC PPS.

The HHC PPS believes that local implementation is critical to success in the DSRIP program, and the Hub structure ensures that projects are implemented locally. While the PPS will develop clinical and operational protocols, each Hub is empowered to implement protocols in a way that meets local needs and continuums of care.

Although the HHC PPS strongly believes in the importance of local implementation, the HHC PPS also recognizes the need for consistency across Hubs in key areas (e.g., compliance, strategic direction), as well as the importance of sharing best practices. To ensure consistency and shared learning, the HHC PPS will also have a strong central PPS governance structure.

To realize economies of scale, the CSO will deliver certain core services for the PPS, such as DSRIP analytics and clinical protocol development across all Hubs and partners. With a single CSO performing many key administrative and operational functions—rather than each Hub creating its own processes—the PPS will be well-positioned to implement and manage DSRIP activities.

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.

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Currently Uploaded File: **52_SEC021_PPS Organizational Chart.pptx**

Description of File

PPS Organizational Chart

File Uploaded By: jaredaug

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***Structure 2:**

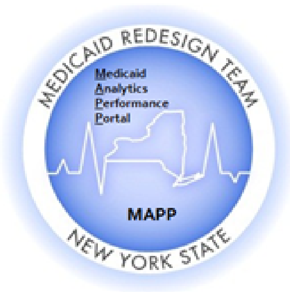
Specify how the selected governance structure and processes will ensure adequate governance and management of the DSRIP program.

The PPS governance structure includes governance at the PPS level and the Hub level, thus promoting consistency across the entire PPS while allowing flexibility to reflect the needs of each Hub. This balance is critical given the citywide reach of the PPS.

The HHC PPS will be governed by an Executive Committee and various subcommittees. The decisions made by the Executive Committee are binding upon all of the Hubs and partners.

Executive Committee. The Executive Committee will consist of 15-18 representatives and will be a working, operational committee. At least five members will be HHC representatives, and the remaining will be partner representatives, reflecting the diversity and community-driven nature of our PPS. As PPS lead and fiduciary, HHC will appoint the initial members of the Executive Committee. Members are reflective of our network across the entire continuum of care, including social service providers and CBOs. The Chair will be an HHC representative. The Executive Committee will be responsible for the following functions: (1) strategic leadership and ensuring timely decisions; (2) approving Hub budgets and operating plans; (3) approving proposals for funding allocations; and, (4) evaluating the performance of DSRIP projects and partners.

Nominating Committee. The Nominating Committee will recommend future members of the Executive Committee, sub-committees, and Hub Steering Committees, and will consist of 3 members, including at least one HHC representative who will serve as Chair.



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Subcommittees. HHC, as PPS lead and fiduciary, will appoint the initial members of the sub-committees. Going forward, the Executive Committee will appoint future members of the subcommittees, taking into account recommendations from the Nominating Committee. The subcommittees will have interlocking membership with the Executive Committee and Hub Steering Committees. The PPS will have the following subcommittees:

Care Models Subcommittee, responsible for reviewing and approving clinical processes and protocols related to DSRIP projects that will be applicable to all partners.

Business Operations and IT Subcommittee, responsible for reviewing and approving processes and protocols for the adoption and use of information technology that will be use by to all partners, and reviewing and making recommendations regarding budgets and DSRIP funds distributions, subject to approval by the Executive Committee and HHC.

Stakeholder and Patient Engagement Subcommittee, responsible for reviewing and approving processes related to community and patient engagement activities.

Project Advisory Committee (PAC). The PPS will have a PAC consisting of all entities and providers that have entered into a contract to participate in the HHC PPS. The PAC will also have Hub-based PACs focused on local community needs and local implementation and performance.

In addition, reflective of our broad and diverse service area and to ensure the opportunity for local input and decision-making, each Hub will have a Hub Steering Committee, responsible for reviewing the Hub operating plan and budget. Hub Steering Committees will meet at least quarterly to: (1) review the projects of the relevant Hub against the Hub budget and Hub operating plan; (2) provide updates to the Executive Committee on the progress of the Hub; and, (3) suggest changes to the Hub budget and operating plan to the Executive Committee as necessary.

Each Hub Steering Committee will consist of 8-12 members. At least two seats have been designated for HHC representatives, one of whom is designated as a representative of the CSO. The remaining members of each Hub Steering Committee will initially be appointed by HHC, as PPS lead and fiduciary, and will consist of representatives selected from among the partners in the Hub.

***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.

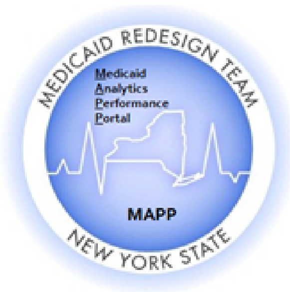
The Care Models Subcommittee will play a critical role in the PPS's clinical governance. The Care Models Subcommittee will primarily be responsible for reviewing, approving, and recommending updates to clinical processes and protocols for each DSRIP project. In doing so, the clinical processes and protocols, the Care Models Subcommittee will solicit input from partners with specific expertise relevant to a particular project. Once clinical processes or protocols are reviewed and recommended by the Care Models Subcommittee, they will be presented to the Executive Committee for final review and approval.

The Care Models Subcommittee will also review and recommend processes to ensure accountability for meeting DSRIP metrics at both the PPS and Hub levels. Among other things, the Care Models Subcommittee, in coordination with the CSO, will review and recommend performance management indicators to track progress at the PPS and Hub levels.

As is noted above, the CSO will work closely with the Care Models Subcommittee to ensure successful implementation of all projects. To do this, CSO staff will engage our partners and gather evidence-based protocols and best practices for the Subcommittee review. The CSO will also play a key role to monitor performance with respect to the care models, flagging for the Subcommittee any emerging issues of performance, safety, or quality.

The Subcommittee may establish workgroups on condition-specific issues, if necessary. Additionally, the Subcommittee may work with Hubs to refine care models, as needed.

***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 HHC PPS believes that the governance structure outlined above provides a strong starting point for DSRIP activities. Over the course of DSRIP participation, the HHC PPS recognizes that the governance structure may need to evolve to reflect a changing landscape. Specifically, the HHC PPS anticipates that it may need to evaluate the allocation of decision-making authority across the PPS and Hub levels. As the HHC PPS gains experience in the DSRIP program, it may benefit from increasing consistency across the PPS on some issues while allowing for more decentralized decision-making authority on other issues. Additionally, the HHC PPS may need to re-evaluate the geographic boundaries of the Hubs, if it becomes apparent that borough-based hubs are not the optimal structure to meet local and social needs.

Because of our flexible governance structure – with its dual citywide and local focus and diverse representation – our PPS is well-suited to oversee the transformation required under DSRIP, to a high-quality, patient- and family-centered healthcare delivery system, driven by value-based payment models.

In the event the Executive Committee recommends a change to the governance structure, the Executive Committee will consult with the PAC. The Executive Committee will also seek approval from HHC for any changes in governance structure, and the HHC PPS will notify DOH of any proposed changes.

☑ 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.

Current members of the Executive Committee include: Chief Medical Officer, HHC, Chair; Corporate Chief Operating Officer, HHC; Sr. Assistant Vice President, HHC; Sr. Vice President, HHC; TBD, HHC (1); CEO, CBC; Acting President and CEO, CHN; Health Advocacy Senior Specialist, NY Immigration Coalition; Vice President, FEGS; President or designee, SUNY; TBD, VNSNY.

Members of the Executive Committee will be responsible for strategic leadership, approving Hub operating plans and Hub budgets, reviewing and approving proposals for funding allocations, and evaluating performance.

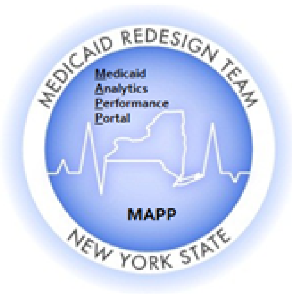
Sub-committees will be populated by the Executive Committee and have interlocking membership with the Executive Committee and Hub Steering Committees. Vacancies on the Executive Committee and membership of the Subcommittees will be populated by individuals who represent the following types of organizations: hospitals; FQHCs or community physician practices; LTC providers or nursing homes; behavioral health providers; home health providers; CBOs or HHC Council of CABs; managed care organizations; and, subject matter experts, as appropriate. Our Stakeholder Engagement Subcommittee will include our labor partner.

***Process 2:**

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

Based on feedback from partners we engaged in planning activities, we embraced several guiding principles in selecting members of the governing body. They include commitments to have the membership reflect the entire network, including clinical and social service perspectives, to limit the hospital-based sponsor to a minority of membership, and to seek consensus on all significant decisions. To select the initial members of the Executive Committee, members of the HHC leadership team consulted with several partners to identify key individuals with the appropriate skills and expertise and who represent various components of the care continuum and significant attribution, to participate in the DSRIP implementation process. The initial members of the Executive Committee will be appointed for a one-year term beginning April 1, 2015.

Reflective of these principles – derived from extensive consultation – each body within the operational governance structure will include a mix of HHC and non-HHC representatives. The Executive Committee will include 15-18 members. At least five members will be HHC representatives, the Executive Director of the CSO will serve ex officio, and the remaining members will be partner representatives. The



Executive Committee, Subcommittees, and Hub Steering Committees will have interlocking membership, both streamlining the governance structure and ensuring strong communication between PPS- and Hub-level governing bodies. Similarly, the subcommittees and Hub Steering Committees will include both HHC and non-HHC representatives to promote a diversity of perspectives on each committee.

The PPS will have a Nominating Committee responsible for recommending members of the Executive Committee, the subcommittees, and the Hub Steering Committees. After considering the recommendations of the Nominating Committee, the Executive Committee will select new members. The Executive Committee will appoint members of each subcommittee and the Nominating Committee. The Executive Committee will also appoint future members of the Hub Steering Committees, subject to approval by HHC.

***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 members of the PPS-level committees and subcommittees will reflect the diversity of partners in the HHC PPS. At least five members of the Executive Committee will be HHC representatives, but the remainder will be representatives of partner organizations, including CBOs. Further, the Executive Committee, the Subcommittees, and the Hub Steering Committees will have interlocking membership, ensuring strong pathways for communication between PPS-level and Hub-level governance. In selecting members, the Executive Committee will seek to mirror the diversity of our community and our PPS – with a significant presence of CBOs.

Additionally, the Hub Steering Committees-consisting of 8-12 members-will reflect provider and CBO partners.

***Process 4:**

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

Coalition partners will be included throughout the governance structure. Non-HHC partners will be represented on all PPS-level and Hub-level committees and subcommittees. Further, all partners may participate in governance through the PAC. The HHC PPS continues to populate its committees and subcommittees, and the HHC PPS anticipates that partners will participate in committees where their expertise is applicable.

The PPS also intends to contract with a wide array of CBOs, as discussed at length in several of the projects in Section 4 – notably 2.d.i., where CBOs will play a central role in identifying and engaging the uninsured and non- and low-utilizers. In recognition of their central role in helping the PPS engage patients and address the social determinants of health, CBOs are also represented in the governance structure – both in the operational governance structure and in the PAC.

***Process 5:**

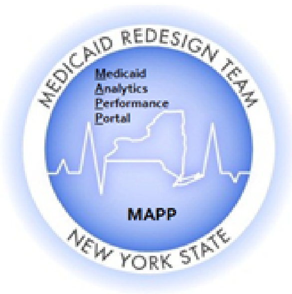
Describe the decision making/voting process that will be implemented and adhered to by the governing team.

The PPS will encourage consensus-based decision-making. To qualify as a "consensus-based" decision, a supermajority of 75% of a quorum must vote in favor.

Executive Committee. Actions by the Executive Committee that are consensus-based will be submitted to HHC for approval. If consensus is not reached, HHC will work with the Executive Committee to attempt to reach consensus. If consensus is not reached with the assistance of HHC, then HHC will determine the appropriate course of action.

Subcommittees. Actions by subcommittees that are consensus-based will be submitted to the Executive Committee for review and approval. If the relevant action is approved by the Executive Committee, it will be submitted to HHC for approval. If the relevant action is not approved by the Executive Committee, the Executive Committee and the relevant Subcommittee will work to resolve any disagreements. If consensus is reached, the relevant action will be approved by the Executive committee and be submitted to HHC for approval. If consensus is not reached, HHC will determine the appropriate course of action.

For subcommittee actions that are not consensus-based, the Executive Committee will work with the relevant Subcommittee to attempt to reach consensus. If consensus is reached, the proposals will be submitted for approval by the Executive Committee. If consensus is not



reached, then the Executive Committee will make a recommendation to HHC. HHC will evaluate the Executive Committee's proposal and will work collaboratively to establish consensus. If consensus is not reached, HHC will determine the appropriate course of action.

All actions by any Committee or Hub Steering Committee are subject to final approval by HHC, as DSRIP fiduciary.

*Process 6:

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

The Executive Committee, Subcommittees, and Hub Steering Committees have been structured to minimize conflict through the consensus-based decision making process described previously. By emphasizing the need for consensus in all decisions, the HHC PPS establishes collaboration and cooperation as key elements of its decision-making process.

In the event that a committee fails to reach consensus, there is a defined process (outlined above) to escalate the issue to another governing body. Issues that fail to reach consensus at the Executive Committee will be escalated to HHC; issues that fail to reach consensus at a subcommittee or Hub Steering Committee will be escalated to the Executive Committee. Once escalated, the other governing body will attempt to facilitate a consensus. Ultimately, HHC will have final authority to resolve any issues.

If needed, HHC is prepared to consult with DOH or other regulatory bodies.

*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.

All Committees and Subcommittees will produce detailed minutes that reflect the names of members in attendance and all non-confidential, non-proprietary business discussed. All Committees and Subcommittees will submit these minutes to the CSO, and the CSO will post the minutes on the HHC PPS partner portal within two weeks. We expect our committee members to attend PAC meetings.

*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.

The HHC PPS will emphasize clear communication and transparent decision making. Through the HHC PPS partner portal, all partners will be able to access DSRIP information and announcements. The HHC PPS will also develop a public-facing website.

The Stakeholder and Patient Engagement Subcommittee will focus primarily on activities to engage community members and other stakeholders. As part of these efforts, the Subcommittee will consult regularly with stakeholders and patients to identify emerging issues and develop resolutions.

The PPS expects to provide regular updates to and engage Community Advisory Boards, and our CBO partners will be expected to engage their constituencies.

Finally, the PAC will be a key tool to engage stakeholders. All partners will be encouraged to attend PAC meetings. Community members, too, will be welcomed at PAC meetings, allowing Medicaid beneficiaries and others in the community to provide input on key issues.

✅ Section 2.3 - Project Advisory Committee:

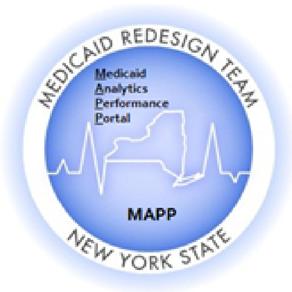
Description:

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

*Committee 1:

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

To promote transparency and engagement among all partners, the HHC PPS has elected to create an open PAC where all partners are encouraged to participate in PAC activities. Although the HHC PPS will aim to populate the Committees and Subcommittees to ensure diverse representation from the partners, the HHC PPS recognizes that some partners may not have a formal role on these committees.



The HHC PPS nevertheless values the unique perspectives of these partners and views the PAC as an appropriate forum to collect input from all partners.

The first PAC meeting was held in mid-November. Over 130 individuals attended the first PAC meeting, which demonstrates partner enthusiasm to participate in DSRIP.

PAC members include: all DSRIP partners, union and organized labor representatives, physician affiliate representatives, Community Advisory Board (CAB) representatives, consumer organizations, New York City agencies, and other key stakeholders.

***Committee 2:**

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

The PAC will be the primary mechanism through which the HHC PPS receives advice from the community. DSRIP's success depends on meeting local needs, and the PAC is the mechanism for gathering local input. We expect that each partner will also work through existing relationships to understand and meet community needs; the PAC is not expected to supplant those relationships.

The PAC will be advisory to the Executive Committee, the Subcommittees, and the Hub Steering Committee. The PAC will convene at regular intervals, as determined by the Executive Committee. PAC meetings are open to all entities and providers that have entered into an contract to participate in the HHC 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).

All members of the PPS organizational structure are also members of the PAC and the PAC serves in an advisory capacity to the PPS organizational structure. Eighty-one resident focus groups were conducted as part of the CNA process across the HHC PPS service area. Focus group participants were recruited by local organizations, CBOs, senior centers, social service providers, tenant associations, and health providers, many of whom are DSRIP partners and PAC members. We also conducted a small number of focus groups with community leaders, care coordinators and physicians. These groups highlighted the need for diversity and local flexibility – both embodied in our governance structure.

***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.

Since the PAC has open membership, the HHC PPS is confident that it will adequately represent the wide array of providers and CBOs that are partners in the HHC PPS. To ensure that the PAC captures the diverse perspectives of all members, the HHC PPS Stakeholder and Patient Engagement Committee will monitor attendance at the PAC meetings. In the event that a particular provider type or geographic region is not adequately represented at PAC meetings, the HHC PPS will target outreach efforts to the under-represented group of partners.

☑ 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.

Consistent with state guidance throughout the DSRIP application process, the HHC PPS, through the CSO, will hire a designated compliance staff member who is not legal counsel to the PPS to serve as the DSRIP compliance officer. HHC, the PPS sponsor, currently has a strong compliance team, but it recognizes the need to have an independent staff member dedicated to monitoring the unique compliance challenges that the DSRIP program presents. The DSRIP compliance officer will report regularly to the Executive Committee,

and the DSRIP compliance officer will also maintain a close working relationship with the HHC compliance team.

***Compliance 2:**

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

The PPS will leverage HHC's robust and long-standing compliance program to create an independent compliance process for the DSRIP program. This compliance process will address issues such as:

(1) Developing and distributing written standards of conduct and policies and procedures tailored to DSRIP;

(2) Developing and implementing DSRIP-specific training programs for all partners and their employees;

(3) Ensuring that the DSRIP compliance officer is aware of all major decisions with potential compliance implications by, among other things, requiring that the compliance officer attend all meetings of the Executive Committee and review all significant contracts;

(4) Establishing processes to receive and investigate complaints regarding DSRIP compliance issues, including creating a hotline/web form for employees and Medicaid beneficiaries to make anonymous reports;

(5) Developing and implementing a process to address emerging compliance issues;

(6) Using audits to identify additional compliance issues;

(7) Developing and implementing an approach to remediating systemic issues; and,

(8) Instituting appropriate monitoring and follow-up programs to ensure remediation.

***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.

All partners and employees of partners participating in DSRIP activities will complete the relevant portions of HHC's existing compliance training program. This will include training on issues such as Medicaid billing and data privacy. In addition, the compliance officer will work with the CSO to develop a training module tailored to DSRIP compliance issues. The CSO will maintain records of employees who have completed the training.

***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.

The HHC PPS will develop and maintain a process to accept and investigate compliance complaints from community members and Medicaid beneficiaries. Once developed, the HHC PPS will develop educational materials for beneficiaries and community members about the complaint process. Specifically, the public-facing DSRIP website will include information regarding potential compliance issues, how to file a compliance complaint, and a web form where individuals can submit an anonymous compliance complaint. The website will also include a compliance hotline. The website will inform community members and Medicaid beneficiaries of the anonymous nature of complaints and the HHC PPS's policies to keep complaints anonymous and to protect whistle-blowers from retaliation.

☑ Section 2.5 - PPS Financial Organizational Structure:

Description:

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

***Organization 1:**

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

the PPS' governance structure.

The PPS, guided by the Business Operations and Information Technology Subcommittee, will establish processes to ensure success in the DSRIP program. These processes will incorporate the following principles:

(1) Budgeting. The PPS and each Hub will have a detailed budget approved by the Executive Committee.

(2) Ongoing monitoring. In collaboration with the Hub Steering Committees, the Business Operations and Information Technology Subcommittee has primary responsibility to monitor progress against the approved budgets. Any emerging issues will be raised to the Executive Committee and if any significant deviations from the proposed budgets are detected, the Executive Committee will develop a remediation plan.

(3) Transparency. HHC will establish discrete structures to ensure proper accounting for DSRIP funds.

(4) Accountability. The Business Operation and Information Technology Subcommittee will review and recommend DSRIP flow of funds to the PPS, each Hub, and the partners in a way that furthers the objectives of the DSRIP program.

(5) Long-term sustainability. The Executive Committee will develop concrete goals to ensure continued transition to value-based payment models.

***Organization 2:**

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

The HHC PPS, with support from the CSO, will establish the ability to monitor funds flow, evaluate performance, generate reports, and distribute payments. Specific key financial functions within the organizational structure include:

(1) Development of PPS and Hub budgets.

(2) Ability to disburse funds, separate from authority to approve transactions.

(3) Implementation of Conflicts of Interest policy.

(4) Maintenance of records.

(5) Supervision of activities.

(6) Authorization to approve transactions by someone who did not initiate the transaction.

(7) Oversight of performance against PPS budgets on a regular basis.

(8) Establish table of accounts.

(9) Audit.

(10) Internal controls.

(11) Accounting standards.

(12) Manage incentive payments.

(13) Develop metrics.

Additionally, the Business Operations and Information Technology Subcommittee will review and recommend methodologies to allocate

and review DSRIP flow of funds across partners, adjusting as needed.

***Organization 3:**

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

The HHC PPS will use both independent internal and external auditors to ensure that the PPS's internal processes ensure the appropriate use of DSRIP funds. The CSO will have an Audit Committee to conduct internal audits and oversee external audits with support from the independent compliance officer. The compliance officer will report back to the Executive Committee, as needed. In the event that the auditors identify a systemic issue, the Audit Committee, with support from the compliance officer, will develop and oversee implementation of a remediation plan, subject to review and approval by the Executive Committee.

***Organization 4:**

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

HHC's existing compliance program complies with New York State Social Services Law Section 363-d. Since the HHC PPS's compliance program will rely extensively on HHC's existing program, the HHC PPS is confident that its compliance program will readily comply with Social Services Law Section 363-d. The PPS Executive Committee is accountable for ensuring that the HHC PPS compliance program meets all relevant city, state, and federal requirements.

To create the DSRIP compliance program, the compliance officer will conduct a gap analysis to identify areas of HHC's compliance program that may need revisions to reflect the unique nature of the DSRIP program. Once the compliance program has been finalized, the DSRIP compliance officer will conduct a final review of the compliance program to ensure that it meets the requirements of Social Services Law Section 363-d. The compliance officer will then present the program for review and approval by the Executive Committee.

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.

The Executive Committee is responsible for monitoring on-going performance of partners and the PPS and addressing emerging issues. With support from the CSO, the Executive Committee will oversee a rapid-cycle evaluation process – discussed in Section 6 -- to identify performance issues and develop corrective action programs to remediate underperformance.

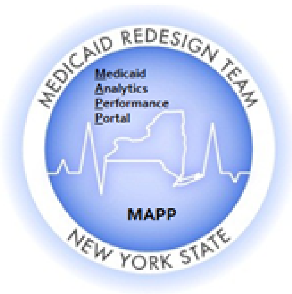
On a regular basis, on behalf of the Executive Committee and PPS partners, the CSO will generate reports assessing providers' compliance with requirements and performance on key metrics, as well as updates on project results and issues. In addition, on behalf of the Executive Committee and PPS partners, the CSO will regularly monitor the overall clinical, quality, and financial metrics of the DSRIP program. The CSO will maintain for the Executive Committee a list of partners who are near the minimum level of performance. The Executive Committee will then determine whether additional training and support, additional monitoring, or corrective action is needed. As described further below, the Executive Committee will then oversee performance improvement efforts (see Section 6, Rapid Cycle Evaluation).

***Oversight 2:**

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

After identifying lower performing members, the Executive Committee will issue a written warning to the partner describing the underperformance. Or, if the nature of the underperformance warrants a Corrective Action Plan, the Executive Committee will require the partner to develop a Corrective Action Plan for review and approval by the Executive Committee.

The Corrective Action Plan will set forth steps to correct underperformance, and may include milestones and dates by which each step must be completed. Once the Executive Committee approves the Corrective Action Plan, the partner will be responsible for implementation.



The partner will be required to submit to the Executive Committee reports describing the status of compliance with the Corrective Action Plan, including, attestations that the partner has completed each milestone by the milestone completion date, as applicable.

Failure to comply with the Corrective Action Plan may lead to temporary or permanent suspension of funding, or temporary suspension or permanent termination of the partner's participation in the PPS.

***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.

If a partner fails to comply with the Corrective Action Plan, the Executive Committee may initiate a process to remove the partner from the PPS. The Executive Committee will meet with the partner and review the partner's progress against the approved Corrective Action Plan. If the Executive Committee determines that progress is not adequate, the Executive Committee may recommend terminating the partner's participation. As part of its fiduciary role, HHC will need to approve the proposed termination. Once HHC has approved the proposed termination, HHC, the Executive Committee, and DOH will hold a joint meeting to make a final determination.

***Oversight 4:**

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

The CSO, in consultation with the Stakeholder and Patient Engagement Subcommittee, will develop a tool to collect feedback from Medicaid beneficiaries and advocates. This tool will, among other things, encourage Medicaid beneficiaries and their advocates to identify exemplary and problematic partners. The CSO will compile this information and generate lists of high performing and underperforming partners. A partner's appearance on these lists will be considered as part of the renewal and removal process.

***Oversight 5:**

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

The public-facing HHC PPS website will include lists of new partners and partners that have been removed. As part of the PPS's overall stakeholder engagement program, we will undertake a variety of patient and community-facing communications and engagement programs, to include but not be limited to communications on PPS network composition.

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

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

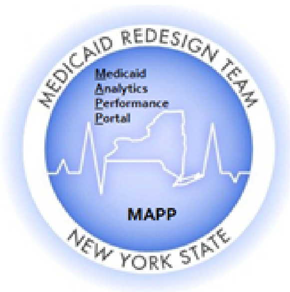
Additionally, the New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention 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



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.

The New York City Health and Hospitals Corporation (HHC) completed four borough-based CNAs, structured according to DOH Guidelines, with findings based on extensive analyses of primary and secondary data. Planning began in June 2014, and data were collected through September. Draft reports were circulated in October to solicit input and recommendations, and preliminary findings were shared in a public forum. A draft report was distributed in November for partner and community input, which has been integrated into the final CNA.

The CNA process was governed and monitored by a corporate-wide DSRIP Steering Committee. Each borough, which includes HHC hospitals and other hospital partners, formed its own interim Steering Committee to lend a local perspective to the process. The service area for each hub CNA takes into account each hospital's primary and secondary service areas (patient origin of 75% of its ambulatory patients), specific geographic areas of high clinical need ("hot spots"), concentrations of Medicaid and uninsured residents, and the reach of its clinical and community-based service partners.

HHC contracted with The New York Academy of Medicine (NYAM) and Tripp Umbach Inc. to collect and analyze primary data to elicit qualitative feedback on community health issues and concerns. Data collection was accomplished in partnership with numerous community organizations identified by the Steering Committees, and represented a range of targeted neighborhoods and populations (e.g., older adults, immigrant populations, and people with disabilities). There were over 2,500 individual surveys completed, 85 key informant interviews, and more than 80 focus groups conducted as part of this process across the four-borough HHC PPS service area.

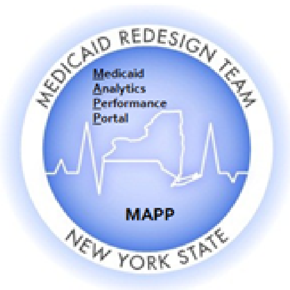
NYAM reviewed secondary source data for the Brooklyn and Bronx CNAs, and HHC's Office of Corporate Planning Services did so for Queens and Manhattan.

***Overview 2:**

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

Survey data collected for the CNA examined the relationship between health indicators and geographic, demographic, and socioeconomic variables using appropriate statistical methods. Interview and focus group discussions were translated verbatim and analyzed in NVivo, a software package for qualitative research. Data were coded according to pre-identified themes relevant to health, community needs, and DSRIP objectives, as well as themes emerging from the data themselves. The analysis focused on common perceptions of health access issues and the concerns and recommendations voiced by vulnerable populations.

Secondary data analysis followed the recommendations of the State's CNA guidance document. It included over 70 data sets, including publicly-available data resources such as the U.S. Census, NYS Prevention Agenda Tracking Indicators, NYS HIV and STD Surveillance Systems, the NYS DOH PQI and CAHPS data, SPARCS, BRFSS, data sets published by the NYC Department of Health and Mental Hygiene, and other healthcare and community-based resources. Advanced methods were used to assess resources, describe the communities served by the PPS, document disease prevalence, and identify current rates of avoidable hospital use. We created an



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Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

extensive library of maps for each borough to graphically illustrate the disparity among providers and community resources between neighborhoods and zip codes. To illustrate how the disparity may impact the community's unmet needs, we created maps to juxtapose provider and community resources against community need, such as the number of new immigrants and those living in poverty. We also created maps to identify zip codes and neighborhoods that may be opportunities for the greatest gains by juxtaposing need in numbers and need as a rate, for example, number of PQI admissions and PQI rate.

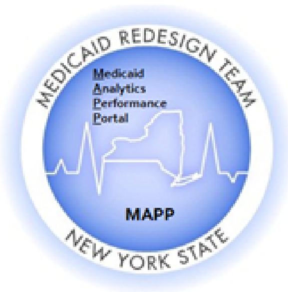
Section 3.2 – Healthcare Provider Infrastructure:

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	60	25
2	Ambulatory surgical centers	40	0
3	Urgent care centers	57	7
4	Health Homes	43	4
5	Federally qualified health centers	76	9
6	Primary care providers including private, clinics, hospital based including residency programs	8081	1285
7	Specialty medical providers including private, clinics, hospital based including residency programs	8397	5002
8	Dental providers including public and private	782	52
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	186	1
10	Behavioral health resources (including future 1915i providers)	1384	577
11	Specialty medical programs such as eating disorders program, autism spectrum early	109	0
12	diagnosis/early intervention	97	0
13	Skilled nursing homes, assisted living facilities	205	71
14	Home care services	51	27
15	Laboratory and radiology services including home care and community access	91	1
16	Specialty developmental disability services	1311	3
17	Specialty services providers such as vision care and DME	279	2
18	Pharmacies	875	27
19	Local Health Departments	4	1
20	Managed care organizations	13	4
21	Foster Children Agencies	182	0
22	Area Health Education Centers (AHECs)	4	3
23	Hospice	9	8
24	Clinics	305	120
25	Substance Abuse	168	47

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



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DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

***Infrastructure 2:**

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

Health disparities and barriers to care, two of the primary causes of high rates of PPRs and PQIs, were identified in many "hot spot" communities. The DSRIP goal to reduce avoidable hospital utilization puts a greater focus on, and demand for preventive primary care services. Community surveys and focus groups highlight this need, especially in communities with high numbers of Medicaid beneficiaries, uninsured and/or undocumented residents. There is also a need for providers to be culturally and linguistically compatible with their patients, as well as providers to hold evening and weekend hours to accommodate the irregular schedules of patients.

The prevalence of specific chronic conditions in the service area combined with low numbers of specialty providers in "hot spot" communities, with high numbers of Medicaid beneficiaries and uninsured indicates a need for increased access to these services outside of a hospital setting. Better access will reduce wait times for scheduled appointments. It will also help people manage chronic conditions in outpatient settings, thereby reducing avoidable ED visits and inpatient admissions for ambulatory care sensitive conditions.

The high prevalence of chronic physical co-morbidities in populations with behavioral health (BH) issues indicates a great need for integrated services in primary care settings. The regulatory requirements that govern BH and PC services do not support this objective, and regulatory relief may be needed to allow co-location for better care coordination and follow up. Efforts to enhance BH services in existing primary care settings have been supported for patients with mild issues, but patients with severe needs comprise a large proportion of hospital readmissions and ED use that could be better controlled through an integrated delivery system. (Note – the figures in the above table above are based on CNA findings and state-released provider counts and are subject to change as new state data becomes available.)

Section 3.3 - Community Resources Supporting PPS Approach:

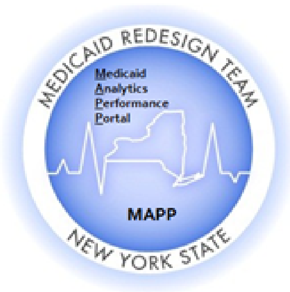
Description:

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	552	104
2	Food banks, community gardens, farmer's markets	924	19
3	Clothing, furniture banks	41	3
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	293	144
5	Community outreach agencies	578	208
6	Transportation services	75	10
7	Religious service organizations	217	5
8	Not for profit health and welfare agencies	1819	474
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	1131	137
10	Peer and Family Mental Health Advocacy Organizations	29	15
11	Self-advocacy and family support organizations and programs for individuals with disabilities	39	8
12	Youth development programs	1876	191
13	Libraries with open access computers	174	2



#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
14	Community service organizations	130	47
15	Education	2886	54
16	Local public health programs	1	1
17	Local governmental social service programs	165	15
18	Community based health education programs including for health professions/students	130	35
19	Family Support and training	7	2
20	NAMI	4	0
21	Individual Employment Support Services	1204	34
22	Peer Supports (Recovery Coaches)	99	21
23	Alternatives to Incarceration	110	3
24	Ryan White Programs	98	22
25	HIV Prevention/Outreach and Social Service Programs	1235	35
26	LGBT programs	159	8

***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.

Vulnerable populations rely on enabling services to overcome socioeconomic, cultural, and linguistic barriers to good health. The impact of these services is maximized when these services are integrated into the service delivery model (FQHC wraparound services, Health Homes, PCMH). These integrated service providers are not uniformly available in the service area, especially in "hot spot" communities where many providers do not have the infrastructure/expertise to implement or partner with other providers.

The lack of safe, well-maintained, affordable housing and grocery stores selling a variety of healthy foods in these communities contributes to high prevalence rates of chronic illness. Disproportionately high hospital admissions and readmissions for people with mental health and substance abuse issues and high rates of previously incarcerated individuals, indicate a need for community-based supportive housing to prevent unnecessary utilization of acute care services. Though NAMI is not a DSRIP partner we welcome the opportunity to work with them in the future.

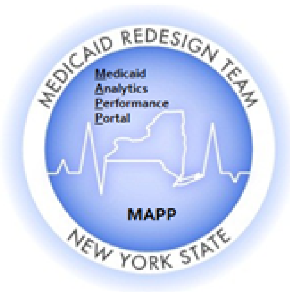
Community resources dedicated to enabling access are needed in areas with high foreign-born and immigrant populations. People unfamiliar with local healthcare resources and/or patterns of recommended care (e.g. prenatal services, pediatric immunization) fail to access healthcare in preventive settings. Limited English proficiency hampers access, treatment adherence, and follow-up care. More resources are needed to help individuals understand and address their own healthcare needs.

Many neighborhoods in the HHC PPS service area will experience a growth in residents age 65+, requiring an increase in programs such as Program of All-Inclusive Care for the Elderly, home care services, assisted living facilities, and physical environment accommodations (accessible public transportation, sidewalk and street crossing safety). An increase in CBO programs that maintain seniors in their homes through improved coordination of care, discharge planning, and aftercare services will reduce admissions to nursing homes.

☑ Section 3.4 – Community Demographic:

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

***Demographics 1:**
Age statistics of the population:



The HHC PPS service area has a population of over 7.9 million. This constitutes nearly 97% of the total NYC population and 40% of the NYS population. The age breakdown of the population is fairly consistent across the service area, ranging from approximately 22% under age 18, 66% between the ages of 18-64, and 12% age 65 or older. These demographics are similar to NYS. There are roughly equal numbers of males and females across the PPS service area, although more males than females are uninsured (57% v. 43%).

***Demographics 2:**

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

NYC is more ethnically diverse compared to the state, with Hispanics comprising 29% vs 18%, respectively; Black/African American, 26% vs 16%, respectively; Asian, 13% vs 7%, respectively, and White 33% vs 58%, respectively.
NYC has high rates of foreign-born and immigrant populations, especially in "hot spot" neighborhoods such as Flushing, Corona, Washington Heights, and Sunset Park. The percent of foreign born residents ranges from a low of 29% (Manhattan) to a high of 49% in Queens. Citywide, 37% are foreign born and nearly half of the foreign born are not U.S. citizens.
Nearly 25% of residents speak English "less than very well." The rate increases in areas where low-income, uninsured, and Medicaid beneficiaries reside (Southeast Queens, the South Bronx and Southwest and Central Brooklyn). The most prevalent languages other than English spoken by Medicaid beneficiaries are Spanish (52%), Chinese (10%) and "Other Languages" (19%).

***Demographics 3:**

Income levels:

The Bronx is particularly challenged with low income levels, where 39% of households have incomes less than $25,000. This includes NYC's top 3 neighborhoods with incomes less than $25,000: Hunts Point/Mott Haven, 56%, Crotona/Tremont, 51%, and Highbridge/Morrisania, 50%. In 2014, the federal poverty level (FPL) for a family of 4 is $27,865. Bronx also has 25% of households with incomes between $25,000 and $49,999.

In Brooklyn, 30% of households have incomes less than $25,000 and 23% of households have incomes between $25,000 and $49,999.
Manhattan household incomes are relatively higher; however, Manhattan is also home to low income neighborhoods including East Harlem, where 44% of households have incomes less than $25,000 and 22% of households have incomes between $25,000 and $49,999.
In Queens, 21% of households have incomes less than $25,000 and 23% have incomes between $25,000 and $49,999. In West Queens, half of households have incomes less than $50,000.

***Demographics 4:**

Poverty levels:

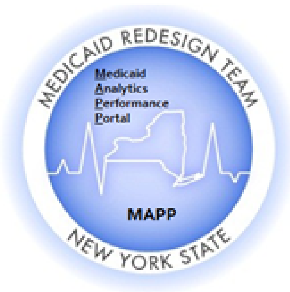
Rates of Medicaid beneficiaries and the uninsured living below 100% of the FPL are: Bronx, 29.3%; Brooklyn, 22.7%; Manhattan, 17.5%, and Queens, 14.1%, according to 2008-2012 Census data. The city's three neighborhoods with the highest percentage of people living below 100% of the FPL are in the Bronx: Hunts Point/Mott Haven, 43%; Crotona/Tremont, 39.3%, and Highbridge/Morrisania, 38.3%. The city's fourth and fifth poorest neighborhoods are in Brooklyn--East New York, where 32.8% of residents live below 100% of the FPL, and Williamsburg/Bushwick, 32.5%. The city's sixth poorest neighborhood is East Harlem in Manhattan, where 31.8% of residents live below 100% federal poverty level. In Queens, the poorest neighborhood served by the PPS is West Queens, where 18.2% of residents live below 100% of the federal poverty level.

***Demographics 5:**

Disability levels:

Individuals with disabilities are more likely to have potentially preventable ED visits or hospitalizations and are at greater risk for readmission. Having at least 2 disabilities is a marker for functional impairment and for overall ED and inpatient use, some of which could be averted with enhanced coordination and home health care.

Citywide, 5.4% of the population has two or more disabilities, with 6.8% in the Bronx, 5.4% in Brooklyn and 4.9% in both Manhattan and Queens. Neighborhoods with the highest rates are in Coney Island at 9.6%, followed by South Bronx, between 7.6% and 8.6%, and East Harlem, 7.5%. The Bronx and Brooklyn also lead the city in percent of population with disabilities regarding self-care (bathing, dressing) at 3.0%, and 2.9%, respectively; independent living (e.g., difficulty with errands) 6.6%, and 5.8% respectively; cognitive issues, 6.3%, and 4.0% respectively; ambulatory services, 8.6%, and 6.6% respectively; and vision needs, 2.8%, and 2.2%, respectively.



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

DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

***Demographics 6:**

Education levels:

Citywide, 20.5% of persons over age 25 have less than a high school education, compared to 15.1% in NYS. The rate is higher for the uninsured at 30% and Medicaid beneficiaries at 40%. In addition, 21% of uninsured, 12% of Medicaid beneficiaries, and 45% of all other payer groups have a Bachelor's degree or higher.

Of NYC's 42 neighborhoods, 16 have high school graduation rates less than the citywide average, with 5 in Brooklyn, 5 in the Bronx, 3 in Manhattan, and 3 in Queens. Two neighborhoods, Sunset Park, Brooklyn and Hunts Point/Mott Haven, Bronx have greater than 40% of their population with less than a high school education.

Neighborhood high school graduation rates are due to factors related to health status and needs. The 10 NYC neighborhoods with the worst high school graduation rate include 8 of the 10 neighborhoods with the highest poverty rates, and 7 of the 10 with the poorest English proficiency rates and highest jail rates.

***Demographics 7:**

Employment levels:

As of September 2014, the unemployment rate in NYC was 6.1%, 5.4% in Queens, 8.5% in The Bronx, 6.6% in Brooklyn and 5.1% in Manhattan. In 2012, the unemployment rate for young adults ages 16 to 24 was 18.6%—more than double the citywide average, and twice as high as for any other age cohort.

It is important to note that the unemployment rate for the target population is understated in city and borough-wide rates. The 2013 city unemployment rate for Hispanics and Blacks is 50% and 200% greater than for Whites, respectively. Less than 64% of Black males participate in the labor force, compared to 70% of White and 73% Hispanic males. Among young White adults ages 16 to 19 years, 27% participate in the labor force, compared to less than 22% of young Hispanic and Black adults.

***Demographics 8:**

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

In NYC, 1.6% of the population lives in group quarters, excluding student housing, of which 34% are in nursing facilities, 13% are in adult correctional facilities, 3% are in healthcare facilities (e.g., hospice, psychiatric), 2% are in juvenile facilities, and 49% are in non-institutional settings (e.g., shelter, group home, residential treatment). The NYC jail admissions rate is nearly twice that of NYS , at 877 and 489 per 100,000 population, respectively. The Bronx has 67% of the total NYC adult correctional population (due to the facility at Rikers Island). The Bronx also houses 26% of the city's skilled nursing homes and 23% of its non-institutional population. Manhattan has 35% of the city's total juvenile facility residents, and 31% of the city's population residing in non-institutional settings. In Manhattan, 62% of the group quarters population reside in a non-institutional setting.

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

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

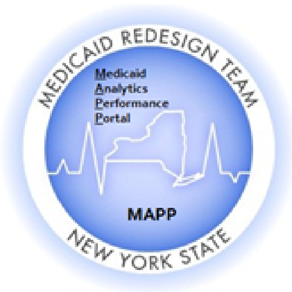
File Name	Upload Date	Description
52_SEC034_Project 3.b.i, Question 4c, HHC-Led PPS.docx	12/19/2014 11:32:47 PM	Project 3.b.i, Question 4c, HHC-Led PPS
52_SEC034_PPS Key Demographic Information.docx	12/18/2014 09:15:51 PM	PPS Key Demographic Information

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:

Among the City's White, Black, and Hispanic residents, heart disease is the leading cause of death, followed by cancer. Combined, they account for more than half of all deaths in each group in 2012. The leading cause of death for Asians and Pacific Islanders was cancer, followed by heart disease, together accounting for 57% of deaths.

For all city residents, other leading causes of death in descending order were flu/pneumonia, diabetes, chronic lower respiratory disease, cerebrovascular disease, accidents, hypertension and renal diseases, use of or poisoning by psychoactive substances, and Alzheimer's disease. AIDS is the seventh leading cause of death among Black residents, while use of or exposure to psychoactive substances was the eighth leading cause of death for Hispanics and Whites.

The leading cause of death citywide in 2012 for ages 15-24 is assault; ages 25-34, poisoning by psychoactive substances; ages 35-74, cancer; and for ages 75+, heart disease. The leading cause of premature deaths (<age 65) is cancer, followed by diseases of the circulatory system (including heart disease), and accidents.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The top 10 causes of hospitalization (primary diagnosis) in NYC are: complications related to pregnancy, labor and delivery, heart disease, digestive disease, respiratory disease, psychoses, symptoms and signs, infectious/parasitic diseases, musculoskeletal diseases, and cancer.

NYC residents had 89,077 potentially avoidable hospitalizations in 2012, with chronic conditions accounting for 72% and acute conditions for 28%. Among the chronic condition hospitalizations, respiratory conditions accounted for 37%, the majority of which were chronic obstructive pulmonary disease (COPD) or asthma in older adults (age 40 plus). Circulatory-related hospitalizations accounted for 35%, and diabetes related hospitalizations accounted for 28% of all chronic-related avoidable hospitalizations.

From 2009 to 2012, the number of avoidable chronic hospitalizations declined for all three major chronic composite Prevention Quality Indicators (PQIs): respiratory, circulatory, and diabetes in all four boroughs in the HHC PPS service area.

***Challenges 3:**

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

The HHC PPS service area observed over risk adjusted expected ratio for PPV ED visits is 1.01, which masks significant variation within the service area's 42 neighborhoods: 20 have an observed rate greater than expected: 6 in both the Bronx and Brooklyn, 4 in Manhattan, and 1 in Queens. The adult overall conditions PQI observed over risk adjusted expected ratio was 1.06 with an observed rate greater than expected in 26 neighborhoods: 8 in Manhattan, 7 in both Bronx and Brooklyn, and 3 in Queens.

Behavioral risk factors contribute to numerous diseases, and are a major contributor to premature death, led by tobacco use, physical inactivity, and poor diet. Other risk factors proven to exert strong influence on health include alcohol consumption, sexual practices, and disease screenings.

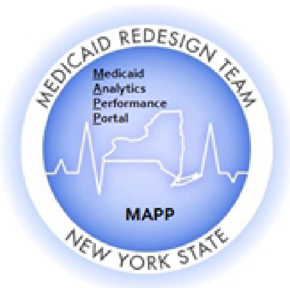
CNA surveys and interviewees revealed the following contributing factors health status: cultural, attitudinal, perceptual and knowledge-based barriers to care among the foreign born, particularly for behavioral health related conditions; difficulties navigating the health insurance and healthcare systems; low prioritization of preventive care services; and, fear of medical bills and deportation.

***Challenges 4:**

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

Disease prevalence among NYC Medicaid beneficiaries in descending order is cardiovascular disease (CVD) at 30%, with a high of 57% in Coney Island/Sheepshead Bay.

Mental health related prevalence is 20%, ranging from 23% in the Bronx to 14% in Queens, with Chelsea/Clinton having the highest neighborhood rate at 50%. Citywide, 11.3% of Medicaid beneficiaries are diagnosed with depression (includes "Depression"; "Depressive and Other Psychoses"; and "Depressive Psychosis-Severe"). The prevalence of serious psychological distress (SPD), a composite



measure of 6 questions regarding symptoms of anxiety, depression and other emotional problems, is 5.1% citywide.

Diabetes related prevalence is 11% citywide, again led by Coney Island/Sheepshead Bay. Citywide respiratory prevalence is 10%, and substance abuse is 6.2%; however, many individuals with this diagnosis are also diagnosed with mental health related illnesses.
Among all NYC residents, there are 41.6 HIV diagnosed individuals per 100,000, and the prevalence of persons living with HIV/AIDS is 1.4%, ranging from 1.7% in the Bronx to 0.7% in Queens. Eight neighborhoods have a rate greater than 2%, led by Chelsea/Clinton in Manhattan at 4.2%. Of the 3,141 individuals in NYC diagnosed with HIV, 81% are without AIDS and 19% are concurrent with an AIDS diagnosis.

The chlamydia and gonorrhea incidence rate in NYC is 698 and 130 per 100,000 citywide, respectively. Given the high rate of chlamydia and gonorrhea in our services area, the testing and treatment of sexually transmitted infections (STIs) can be an effective tool to prevent the spread of HIV. Individuals with STIs are at least two to five times more likely to acquire HIV infection if exposed to the virus through sexual contact.

Medicaid beneficiaries with a substance abuse related condition have the highest utilization rate, 65% of whom are diagnosed with at least one hospitalization and 58% at least one ED visit over a 12 month period. CVD has the second highest hospitalization rate at 40% of beneficiaries diagnosed, ranging from 45% in the Bronx to 36% in Queens. The CVD ED use rate citywide is 28%, less than that of respiratory and diabetes, at 47% and 29%, respectively. The HIV hospitalization and ED use rate is 25% and 35%, respectively.

Respiratory-related conditions (PQI S03) have a potentially avoidable hospitalization rate of 507 per 100,000 Medicaid beneficiaries, higher than for circulatory related conditions (PQI S02) at 461, and diabetes related conditions (PQI S01) at 388.

Patients with a behavioral health related condition have a high likelihood of a chronic physical condition diagnosis. Among HHC patients with a behavioral health related hospitalization over a 12 month period, 32% were also diagnosed with hypertension, 22% with a respiratory condition, and 17% with diabetes (not exclusive categories) over the same period. In total, 55% of behavioral health patients have one or more chronic conditions.

***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:

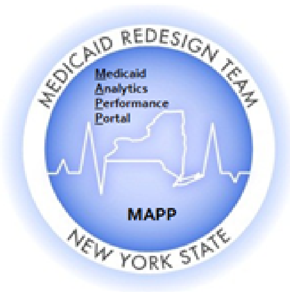
The infant mortality rate in NYC is 4.4 per 1,000 births. Among the 18 neighborhoods greater than the citywide average, 5 are in Bronx, 5 in the Brooklyn, 2 in Manhattan, and 3 in Queens. Low birth-weight babies are at high risk for complications including respiratory infection, blindness, learning disabilities, cerebral palsy, heart infection, and infant mortality. In NYC, 8.5% of births are of low birth weight, with 6 neighborhoods in in the Bronx, 4 in Brooklyn, 4 in Manhattan, and 3 in Queens exceeding the NYC average. Central Harlem/Morningside Heights and Jamaica lead the city's 42 neighborhoods in both the rate of low birth-weight births and infant mortality.

Preterm birth (i.e., birth at or before 37 weeks) is a leading cause of long-term neurological disorders. In NYC, 11.3% of births are preterm, with 6 neighborhoods in the Bronx, 5 in Brooklyn, 2 in Manhattan, and 4 in Queens exceeding the NYC average. In NYC, 7.0% of pregnancies have prenatal care initiated in the third trimester or not at all, with 6 neighborhoods in the Bronx, 5 in Brooklyn, 3 in Manhattan, and 5 in Queens exceeding the citywide average.

***Challenges 6:**

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

Leading behavioral risk factors that impact the health status of the NYC population include obesity (BMI greater than 30), binge drinking (within past 30 days), little or no physical activity, and smoking. South Bronx, North and Central Brooklyn, and East and Central Harlem have been identified as high-risk neighborhoods, as rates for these behavioral factors far exceed citywide rates. For example, in the South Bronx, 31% of residents are obese (25% citywide), and 29% reported no exercise (22% citywide). In East and Central Harlem, 24% residents reported binge drinking (13% citywide) and 18% are current smokers (16% citywide). Respondents in the primary data activities also indicated that substance use and alcohol abuse are pressing issues. In 2012, the last year for which data are available, an estimated 639.2 per 100,000 ED visits in NYC were due to non-alcohol, illicit drugs. About 9,000 NYC residents died of an unintentional drug poisoning (overdose) from 2000-2012, an average of 700 overdose deaths per year. Nearly all unintentional drug poisoning deaths involved more than one substance, including alcohol, licit and illicit drugs.



***Challenges 7:**

Any other challenges:

Environmental risk factors, which include the presence of roaches, rodents, and mold in the home, pose considerable consequences for NYC residents. According to the New York Community Health Survey, 10% reported having mold, 16% reported having mice, and 21% reported leaks in the home. Vulnerable populations typically face greater environmental risks. For example, data suggest that 40% of uninsured and 37% of NYC Medicaid beneficiaries reported having seen cockroaches inside their home in the past month.

Primary data findings also identified the cost of healthcare and lack of insurance as key challenges faced by the population to be served by the PPS. From the perspective of community members, costs incurred for medical care, both time and money, remain problematic and act as a barrier to effective use of prevention and disease management services. Income criteria for Medicaid are described as unrealistic, given the cost of living in NYC. Further, the working poor do not qualify for Medicaid and cannot afford the premiums of insurance offered through the New York State of Health, the State's Marketplace.

Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

Description:

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

***Gaps 1:**

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

Although NYC has a sophisticated medical services infrastructure, many providers practice within large voluntary hospital systems that primarily serve more affluent communities, leaving areas with high numbers of Medicaid beneficiaries and uninsured residents to be cared for by public hospitals and safety net systems. Neighborhoods that face additional challenges (e.g., high poverty, immigration, and behavioral risk factor rates) are more likely to have greater gaps.

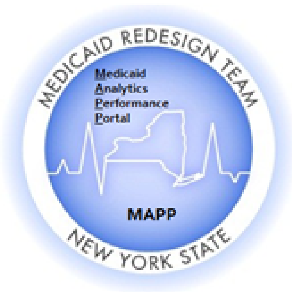
This leaves a distinct capacity gap in the HHC PPS "hot spot" communities, where disproportionate rates of chronic health conditions including CVD, diabetes, asthma, behavioral health issues, HIV/AIDS and STIs strain limited provider and community based resources.

Primary data collection efforts identified several service gaps in ambulatory care that negatively impact ED visits, inpatient admissions, and readmissions. These include daytime only services, lengthy clinic waits, and a shortage of culturally responsive providers for immigrants. Behavioral health outpatient care is relatively scarce, particularly for children and adolescents, and is largely facility-based. This is partly because few private practitioners accept Medicaid reimbursement.

DSRIP initiatives implemented by the HHC PPS will reduce the overall rate and neighborhood disparity of potentially avoidable inpatient admissions and ED visits. Maldistributed hospital and nursing home occupancy rates across the HHC PPS service area make it difficult to definitively identify excess bed capacity. For example, Queens hospitals have an 86% occupancy rate, which is consistent with SDOH guidelines for bed certification, while Manhattan hospitals have consistently lower occupancy rates. However, it is difficult to pinpoint exactly how reductions in admissions and ED utilization will affect performance at the specific provider level. Extrapolating a 25% admission reduction across all hospitals could potentially have an adverse effect on heavily utilized facilities in "hot spot" communities, therefore bed reductions must be made on a more informed level as inpatient and ED utilization reduction is achieved.

The greatest gaps between health outcomes and healthcare resources occur in "hot spot" communities that also exhibit the highest rates of PPV and PQI. The CNAs show that although there are large numbers of medical providers in NYC, too few accept Medicaid or are willing to treat uninsured patients, especially in low socioeconomic status (SES) neighborhoods, leaving many high-need patients with poor access to care. Language barriers compound these challenges. Many safety net providers do not practice within larger systems of care, and do not have the technical or personal resources to fully participate in coordinated, patient-centered systems of care that are at the heart of DSRIP. Integrating these resources in PPS initiatives is necessary to close gaps, but will be challenging. The level of resources to support care coordination in hot spot communities is not sufficient to address existing need, which varies by community based on the challenges they face.

***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.

Community surveys, focus groups, and individual interviews conducted in each borough to be served by the HHC PPS revealed cross-borough consensus on gaps that challenge individuals to access primary care that reduce ED visits and hospitalizations. Gap-related themes included:

(1) accessibility: particularly service hours inconvenient to persons working multiple jobs, lengthy waits for appointments, and lengthy waiting room waits;

(2) failure of primary care to adequately address domestic violence, behavioral health and substance abuse issues, and lack of integration with specialty care;

(3) immigration-related gaps: including language and cultural barriers , lack of navigators to help patients through the unfamiliar healthcare and insurance systems;

(4) lack of community-based behavioral health services, waiting lists at institutions, lack of child and adolescent behavioral health providers, and lack of integration between behavioral health and substance use care due to governmental licensing issues;

(5) broader socioeconomic issues that must be addressed in closing healthcare gaps, including the lack of stable housing that interferes with self-care, stigmatization of certain conditions, and poverty issues (e.g., concern for food availability) that takes precedence over seeking primary care;

(6) significant lack of care for persons involved in the criminal justice system who, after release, face multiple conditions that are not easy to address; and,

(7) a significant lack of interventions for street homeless who are high users of ED services and "social" admissions.

The data indicated that the largest health gaps are found in communities with the highest rates of household poverty, unemployment, violence, housing violations, low educational attainment, uninsured persons and persons unfamiliar with U.S. healthcare. Primary data collected for the CNA further suggests that limited transportation options hinder access to care.

***Gaps 3:**

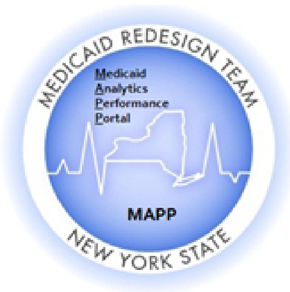
Identify the strategy and plan to sufficiently address the identified gaps in order to meet the needs of the community. For example, please identify the approach to developing new or expanding current resources or alternatively to repurposing existing resources (e.g. bed reduction) to meet the needs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

The strategy to address identified gaps in care for Medicaid beneficiaries suffering disproportionately from chronic conditions such as asthma, behavioral health issues, CVD, and HIV will have several focus areas. Focus areas include strengthening care linkages, integrating services in order to provide "one stop shopping" for routine needs, and increasing operating hours to allow individuals with competing family and work obligations to meet basic health needs in appropriate care settings.

Expanded and strengthened partnerships with CBOs and community-based providers health centers will ensure a continuum of care for at-risk populations. Further, enhancing access to community programs can reduce PPR readmissions by ensuring that patients have the resources necessary to manage their chronic conditions effectively.

The PPS will leverage its Health Home and PCMH capacity and close gaps in care by supporting patient self-management, action plan development, and linkages to community services and navigation services. The PPS will also integrate behavioral health services with primary care to address co-morbid conditions that sometimes result in inappropriate admissions and ED visits.

ED care triage for at-risk populations will strengthen patient relationships with PCPs, provide triage and navigation support for patients with non-emergent illnesses, and support care coordination for patients treated and released from the ED. Patient activation activities will be used to engage the uninsured/Medicaid low- and non-utilizers in community-based care, and away from EDs and acute care services.



The PPS will implement evidence-based strategies to address the prevalence of CVD and asthma in high-risk populations. Strategies will include updating and strengthening treatment and self-management guidelines, environmental evaluation and strategies for remediation, and establishing procedures to provide, coordinate, and link patients to evidence-based trigger reduction interventions.

HHC will collaborate with its PPS partners to reduce the prevalence and impact of HIV in local communities. Efforts will emphasize Pre-Exposure Prophylaxis (PrEP), peer support programs, evidence-based patient education/participation and social marketing, Virology Fast Track Plus, and a multi-layered cultural competency campaign.

Section 3.7 - Stakeholder & Community Engagement:

Description:

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

***Community 1:**

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

In support of the overall aims of the CNA, primary data were collected and analyzed to ensure that community members and stakeholders' perspectives were incorporated into the reported findings and to respond to specific questions that could not be sufficiently addressed through secondary source data alone, such as:

(1) To what extent are community and environmental conditions conducive to health promotion and disease prevention?

(2) What are the primary health concerns and health needs of residents?

(3) What are the health related programs and services available to community residents, what organizations provide the services, and what are the service gaps?

(4) Are there differences in access, use, and perceptions of health related programming and services according to neighborhood and according to ethnic, racial, and language groups?

(5) In what ways can healthcare needs and health promotion activities be better addressed overall and for distinct populations?

(6) Questions focused on health concerns, utilization, barriers to care, and use of community and other services.

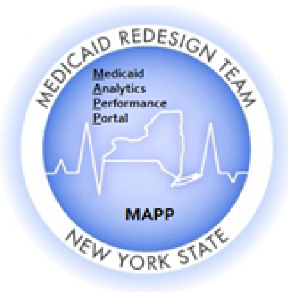
Key informant interviews, led by people with population-specific expertise among constituencies such as immigrant groups, older adults, children and adolescents. Others had expertise in specific issues, including substance abuse, supportive housing, care coordination, corrections, and homelessness.

Focus groups and survey questions addressed community conditions conducive to health promotion, primary health concerns, available programming and services, disparities in access and use, and recommendations regarding strategies to promote improved health. Information was gathered in partnership with numerous community organizations which were identified in collaboration with PPS representatives that represented a range of populations (e.g., older adults, immigrant populations, and people with disabilities, and neighborhoods). HHC's consultants also used street outreach for survey administration, focusing on neighborhoods identified with large numbers of Medicaid and/or uninsured populations. The data collection materials were translated into 10 languages.

***Community 2:**

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

Eighty-one focus groups were conducted as part of the CNA process across the HHC PPS service area. Most focus groups were with community members, including residents from low-income neighborhoods and residents identified as having unique health and service needs, including individuals with behavioral health issues, older adults, LGBT, and immigrants and/or other LEP individuals. Focus group participants were recruited by CBOs, senior centers, social service providers, tenant associations, and health providers. Community



member interest in the focus groups was high, with some groups including up to 30 individuals. In addition to the resident groups, HHC conducted a small number of focus groups with community leaders and providers, including behavioral health providers, care coordinators, and physicians. Collaborating PPSs coordinated these groups to ensure that the perspective of key stakeholders was incorporated into the findings.

***Community 3:**

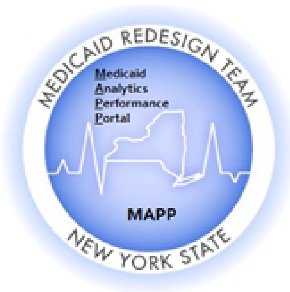
Summarize the key findings, insights, and conclusions that were identified through the stakeholder and community engagement process.

Focus groups and interview participants articulated specific barriers to good health and good healthcare, many of which related to poverty and its consequences. Barriers included long work hours, unstable housing, unsafe neighborhoods and the need to prioritize expenditures—even among basic needs. Respondents made several recommendations, such as increased ease of access for medical visits, improved provider sensitivity, and an expanded range of supportive services, including the use of community health workers, care coordinators, and navigators. Health education addressing prevention, screening, disease management, insurance, and the normalizing of mental health issues was considered essential for individuals and communities to ensure that the community has the knowledge and skills necessary for independent action to promote good health practices. Outreach and education regarding diet and nutrition was identified as a major gap. Overwhelmingly, community members were enthusiastic to participate in the CNA process and expressed both a desire for continued engagement in DSRIP development and for stronger partnerships with hospitals and healthcare providers.

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.

[New York City Health and Hospitals-led PPS] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Academy of Medical & Public Health Services	A not-for-profit organization that offers accessible healthcare to underserved immigrant populations by providing clinical services and fostering public health research.	Improving engagement with immigrant and foreign-born populations is a priority area of the PPS strategy.
2	African Services Committee	A multiservice agency dedicated to assisting immigrants, refugees and asylees from across the African Diaspora.	Expanding HIV prevention and access to AIDS treatment is a prioritized goal for the PPS.
3	AHRC NYC	AHRC serves individuals with intellectual and developmental disabilities through a vast array of programs and service supports.	Education on the health needs of at-risk populations provides necessary information to improve healthcare for all.
4	APICHA	APICHA provides comprehensive and culturally competent healthcare and wellness services to underserved and vulnerable people living in NYC.	Improving engagement with underserved populations is an important step to reduce preventable ED visits.
5	Arab American Family Support Center (AAFSC)	The largest Arabic-speaking social service agency in NYC, AAFSC provides educational, legal, and social services to low-income individuals, and provides health insurance navigation services.	Making healthcare more accessible for vulnerable and at-risk populations is a key part of the PPS strategy.
6	Arthur Ashe Institute	The Arthur Ashe Institute for Urban Health collaborates with community members to deliver neighborhood-based interventions that address health conditions disproportionately affecting minorities.	Engaging neighborhoods in health prevention and promotional efforts is key in the goal to reduce ED visits.
7	Boom! Health	A Bronx-based organization that delivers a full range of prevention, health coordination, behavioral health, housing, legal, advocacy and wellness services to hard to reach communities.	Improving engagement among underserved populations is an important step to reduce preventable ED visits.
8	Bronx Health Link (BHL)	BHL coordinates education, outreach, and access to city and state health programs, and advocates among policymakers for the adoption of laws and policies	Providing health education and outreach is a critical component of population health initiatives.



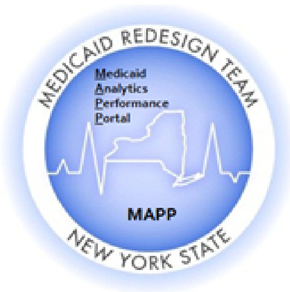
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

[New York City Health and Hospitals-led PPS] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		that improve the health of Bronx residents.	
9	BronxWorks	BronxWorks provides an array of social services, offers outreach, workshops, and counseling, and helps people to enroll in free or low-cost healthcare programs.	Expanding prevention education and outreach is a key factor in improving population health. CBOs are invaluable partners in outreach efforts.
10	Brooklyn Alliance	The Brooklyn Alliance provides health insurance outreach and enrollment services for the New York State of Health Exchange to both individuals and small businesses.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
11	Brooklyn Perinatal Network	A network of several community organizations that provides medical care, offers psychosocial health and educational services and referrals to providers, and coordinates and provides social health and supportive services.	Efforts to increase health insurance outreach and enrollment services are necessary to support DSRIP goals.
12	Callen Lorde	Callen-Lorde Community Health Center provides sensitive, quality healthcare and related services targeted to NYC's lesbian, gay, bisexual, and transgender communities — in all their diversity — regardless of ability to pay.	Increased access to services for vulnerable populations, including low-income families, the homeless, and people living with HIV/AIDS, is critical to meet the DSRIP objectives.
13	CAMBA	CAMBA offers more than 150 integrated services and programs to foster economic development, education and youth development, family support, health, housing and legal services.	Increased access to services for vulnerable populations, including low-income families, the homeless, and people living with HIV/AIDS, is critical to meet the DSRIP objectives.
14	Care for Homeless NYC	Care for the Homeless provides direct services for homeless single adults and families, conducts public education, research, analysis, and shapes policies to prevent future homelessness.	Access to supportive housing is a large part of the PPS strategy.
15	Caribbean Women's Health Association (CWHA)	CWHA provides comprehensive, integrated, culturally appropriate and coordinated "one-stop" services to strengthen families and empower communities.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
16	Casa Mexico Inc. NY	A non-profit community organization that advocates on behalf of the Mexican immigrant community, and offers educational, health, art and cultural programs to the Hispanic community.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
17	Center for Independence for the Disabled of New York (CIDNY)	CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by eliminating barriers to the social, economic, cultural and civic life of the community.	Increased access to services for vulnerable populations, including those living with physical and/or cognitive disabilities, is critical to meet the DSRIP objectives.
18	Children's Defense Fund	A non-profit child advocacy organization that champions policies and programs that lift children out of poverty, protect them from abuse and neglect, and ensure their access to healthcare, quality education and a moral and spiritual foundation.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
19	Chinese American Planning Council	Provides services, skills and resources towards economic self-sufficiency to Chinese-American, immigrant and low-income communities in NYC.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS.
20	Common Ground	Common Ground prioritizes individuals who historically were perceived as unreachable and "unhouseable": those who have lived on the streets for years, who have the most debilitating mental and physical health conditions, and/or who have suffered	Access to supportive housing is a large part of the PPS strategy.



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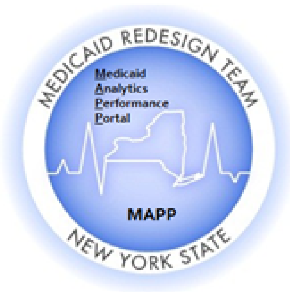
[New York City Health and Hospitals-led PPS] Stakeholder and Community Engagement

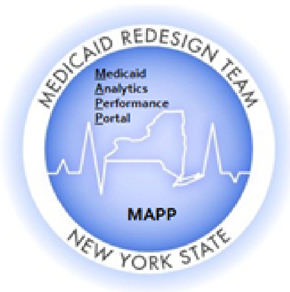
#	Organization	Brief Description	Rationale
		significant adversity.	
21	CommuniLife	A community-based health and housing service provider that supports the needs of low-income and vulnerable New Yorkers.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
22	Community Service Society (CSS)	Through research, advocacy, litigation, and innovative program models, CSS addresses the root causes of economic disparity and has subcontracted with CBOs across the state to provide health insurance navigator assistance in underserved communities.	Making healthcare more accessible to vulnerable and at-risk populations is a key part of the PPS strategy.
23	The Council of Peoples Organization's (COPO) USA	COPO empowers marginalized communities to advocate for their rights, and helps build community relations among Muslim and non-Muslim community groups and government agencies.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
24	Corporation for Supportive Housing (CSH)	CSH offers capital, expertise, information and innovation to allow partners to use supportive housing to achieve stability, strength and success for the people with the most need.	Access to supportive housing is a large part of the PPS strategy.
25	Diaspora Community Services (DCS)	DCS is a Brooklyn-based multi-service and multi-cultural nonprofit organization providing comprehensive support to low income residents, immigrants, and the chronically ill.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
26	Dominican Women's Development Center (DWDC)	DWDC has developed a matrix of program services to foster the empowerment of Latinas and their families and to support them as agents of change in our communities.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
27	Haitian-American Community Coalition, Inc. (HCC)	HCC is a CBO that provides services to the Haitian, Caribbean, immigrant community as well as the American community at large.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
28	Hispanic Federation	An umbrella organization for Latino social service agencies, the Federation has been improving the health and well-being of the Latino community through health-related assistance, education, and advocacy for at-risk and underserved Latinos.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
29	Independence Care Systems	Independence Care System supports adults with physical disabilities and chronic conditions to live at home and participate fully in community life.	Providing quality access and services to vulnerable groups, such as those with disabilities, is a key part of the strategy.
30	Integrated Cancer Care Access Network	Offered by the Memorial Sloan Kettering's Immigrant Health and Cancer Disparities Service, the Integrated Cancer Care Access Network offers case management services to immigrants with cancer at 11 hospitals in NYC, and conducts research to identify and alleviate barriers to obtaining cancer treatment.	Decreasing barriers and improving access to care for individuals with chronic diseases is a key component in the PPS strategy.
31	Jewish Association Serving the Aging (JASA)	A provider of services to adults 55+, offers adult protective services, benefits and entitlements assistance, caregiver assistance, case management and counseling, housing, legal assistance, meals, mental health services, senior centers, and social adult care.	Reducing preventable hospitalizations and readmissions for seniors with chronic conditions is part of the PPS strategy.
32	Make the Road NY	Make the Road promotes equal rights and economic and political opportunity for immigrants through community and electoral organizing, leadership	Improving engagement with immigrant and foreign-born populations is a priority area for the



New York City Health and Hospitals-led PPS (PPS ID:52)

[New York City Health and Hospitals-led PPS] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		development, adult education, workforce, youth development, legal and support services and strategic policy advocacy.	PPS strategy.
33	Mixteca Organization, Inc.	Mixteca Organization provides services to Mexican and Latin-American immigrants that enhance their quality of life and will allow them to reach sustainable social and economic development.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
34	NADAP	A private nonprofit corporation that offers services in employment, assessment, case management and Health Home care coordination programs to adults, youth, dislocated workers, public assistance recipients, people living with chronic illnesses, workforce development professionals, the business community at large and others in the general population who may benefit.	Lowering preventable hospitalizations and readmissions among individuals with chronic conditions is a key part of the PPS strategy.
35	New York Association of Psychiatric Rehabilitation Services (NYAPRS)	NYAPRS is a statewide coalition of people who use and/or provide recovery oriented community based mental health services.	Improving behavioral health services and removing stigma is a large part of the PPS strategy.
36	New York Immigration Coalition (NYIC)	The NYIC is an umbrella policy and advocacy organization for nearly 200 groups in New York State that work with immigrants and refugees. The NYIC is a leading advocate for immigrant communities on the local, state, and national levels, serving one of the largest and most diverse newcomer populations in the United States.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
37	New York Legal Assistance Group	The New York Legal Assistance Group provides high quality, free civil legal services to low-income New Yorkers who cannot afford attorneys. Their range of services includes direct representation, case consultation, advocacy, community education, training, financial counseling, and impact litigation.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
38	Northern Manhattan Perinatal Partnership	NMPP is a not-for-profit CBO comprised of a network of public and private agencies, community residents, health organizations and local businesses that provides services to women, children, men and families in many neighborhoods throughout Manhattan.	Improving maternal health and supporting families is a priority area for NYC.
39	Northwest Bronx Community & Clergy Coalition	Northwest Bronx Community and Clergy Coalition is a grassroots social justice organization that organizes residents to fight for long-term solutions to the problems in the Northwest Bronx.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
40	Pathways to Housing	Pathways to Housing is widely credited as being the originator of the Housing First model to address homelessness among people with psychiatric disabilities. The Housing First model provides housing first, and then combines that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment.	Improving behavioral health services and removing stigma is a large part of the PPS strategy.
41	Project Hospitality	Project Hospitality is an interfaith effort, committed to serving the needs of hungry and homeless people.	Providing access to food and shelter has been shown to reduce hospital visits and costs, a primary goal of the PPS.
42	Public Health Solutions	Public Health Solutions is a nonprofit organization that develops, implements and advocates solutions to prevent disease and improve community health for more than 200,000 low-income, high risk New	Lowering preventable hospitalizations and readmissions among individuals with chronic conditions is a key part of the PPS strategy.



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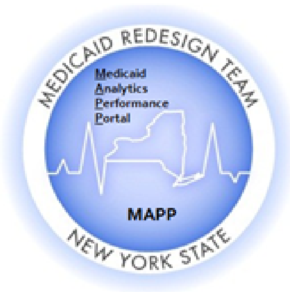
		Yorkers every year. They conduct comprehensive research that provides insight on public health issues, creates and manages community health programs, and provide services to organizations to address public health challenges.	
43	Regional Aid for Interim Needs (R.A.I.N.)	R.A.I.N., Inc. is a multi-social service agency offering services with a Continuum of Care that includes a range of services for seniors and people with disabilities. R.A.I.N. has full-service neighborhood senior centers, home-delivered meals, transportation services, assistance with benefits and entitlements, case management and elder abuse services, in addition to community-based mobile meals for homeless and hungry persons.	Reducing preventable hospitalizations and readmissions among seniors with chronic conditions is part of the PPS strategy.
44	Safe Space	Safe Space Family Resource Centers, located in Southeast Queens, provides access to a comprehensive range of health and wellness, maternal/child health, school-based and youth services.	Improving maternal health and supporting families is a priority area for NYS.
45	Seedco	Seedco designs and implements innovative programs and services for workers, families, and businesses. They partner with CBOs to provide direct services to residents in low-income and underinvested neighborhoods to advance community economic development.	Making healthcare more accessible to vulnerable and at-risk populations is a key part of the PPS strategy.
46	Services and Advocacy for LGBT Elders (SAGE)	SAGE is the country's largest and oldest organization dedicated to improving the lives of lesbian, gay, bisexual and transgender (LGBT) older adults.	Reducing preventable hospitalizations and readmissions among seniors with chronic conditions is part of the PPS strategy.
47	Settlement Housing Fund	Settlement Housing Fund creates and sustains high quality affordable housing and programs, building strong and economically diverse neighborhoods throughout NYC. Settlement Housing Fund works closely with community partners to provide low- and moderate-income New Yorkers with pathways to long-term affordable housing, education, employment and wellness.	Access to affordable housing is a large part of the PPS strategy.
48	Single Stop USA	Single Stop USA creates a "one-stop shop" for low-income Americans to access existing funds and services (e.g., public benefit programs, SNAP, etc.)	Access to affordable housing and healthy food is a large part of the PPS strategy.
49	South Asian Council for Social Services (SACSS)	SACSS is a member of the South Asian Health Initiative (SAHI), a collaborative of various South Asian Organizations based in New York. The collaborative is working to increase awareness and treatment of the most common health problems affecting the South Asian immigrant community in NYC, including oral cancer, diabetes, high blood pressure, and high cholesterol. SACSS also assists individuals, families and small businesses in accessing and maintaining their health insurance.	Improving engagement with immigrant and foreign-born populations is a priority area for the PPS strategy.
50	The Lesbian, Gay, Bisexual & Transgender Community Center	The Center offers the LGBT communities of NYC health and wellness programs, arts, entertainment and cultural events, recovery, wellness, parenthood and family support services.	Providing quality access and services to vulnerable groups, such as LGBT individuals, is a key part of the strategy.
51	United Neighborhood Houses (UNH)	UNH member agencies provide nearly 1.8 million meals each year through their child care centers, senior centers, meals on wheels, afterschool	Improving engagement with underserved populations is an important step in reducing



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		programs, homeless shelters, and HIV/AIDS programs. UNH is helping its members include fresher and healthier food in preparing these meals.	preventable ED visits.
52	Urban Justice Center (UJC)	The UJC defends the rights of people who have been overlooked or turned away by other organizations, such as the working poor, with legal issues related to such things as discrimination and oppression, domestic violence, mental health and refugee assistance.	Improving engagement with underserved populations is an important step in reducing preventable ED visits.
53	West Side Campaign Against Hunger	West Side Campaign Against Hunger serves low-income residents from all 5 boroughs of NYC, regardless of household size or immigration status.	Increasing access to healthy and affordable food and nutrition counseling is paramount in improving population health.

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.

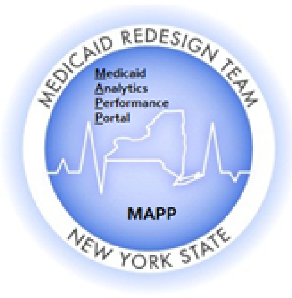
You will use this table to complete the Projects section of the application. You may not complete the Projects Section (Section 4) until this table is completed, and any changes to this table will require updates to the Projects Section.

[New York City Health and Hospitals-led PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for an integrated delivery system	The need for an integrated delivery system (IDS) across the continuum is reflected in: (1) high rates of avoidable admissions, readmissions, and ED visits; (2) high numbers of uninsured, non- and low-utilizers of services; and, (3) the need to improve quality and increased access to appropriate and timely care. According to the CNA, the observed readmission rate among NYC hospitals is 6.95%. After adjusting for demographics and case mix, the NYC PPR rate is 7.19%, which is 7% higher than the state overall, signifying an opportunity for improvement. The overall gap (number of events that should be reduced) in the DSRIP service area is 842 re-hospitalizations. The CNA also identified 1.09 million risk-adjusted	NYC Health and Provider Partnership, Queens CNA, Nov 18, 2014 NYC Health and Provider Partnership, Manhattan CNA, Nov 18, 2014 NYC Health and Provider Partnership, Bronx CNA, Nov 18, 2014 NYC Health and Provider Partnership, Brooklyn CNA, Nov 18, 2014 HHC Corporate Planning

[New York City Health and Hospitals-led PPS] Summary of CNA Findings

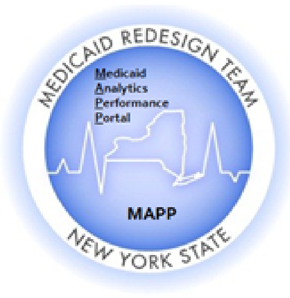
Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		expected PPVs across NYC. In 2012, the proportion of potentially preventable ED visits in the PPS service area was 33.06%. At the borough level, this rate ranged from 42.19% in the Bronx to 26.89% in Queens. It has been estimated that the current number of uninsured in our PPS is 1.3 million. In addition, there are nearly 800,000 low-and non-utilizers. These individuals likely need assistance with accessing care and navigating the health system.	
2	Need to improve access to and capacity of primary care	CNA focus group participants noted that, "ambulatory care providers' capacity, perceived quality, linkages to broader healthcare delivery systems, and insufficient evening and weekend service exacerbate access issues in some high-need areas..." This is supported by a range of data, including the number of medically underserved areas (MUAs), and health professional shortage areas (HPSAs) across our service area: the Bronx has 18 and 8, Brooklyn has 15 and 9, Queens has 7 and 4, and Manhattan has 8 and 4, respectively. Additionally, approximately 25% of Queens and Brooklyn CNA survey respondents indicated that they had a need for health services at least once in the last 12 months, but did not receive them. Similarly, Manhattan residents cited the lack of available appointments and the cost of co-pays as factors in their decision not to seek care. CNA respondents noted that there is a perception that the ED is a rational choice for "one stop shopping" as a result of long PCP wait times, the need for multiple visits, etc. The CNA notes that the prevalence of chronic conditions benefitting from palliative services is higher than the availability of those resources. Given the aging of the population, this disparity is likely to worsen. For example, by 2020, 11.7% and 13.6% of Queens and Manhattan residents respectively will be 65 or older. Giving population aging, this disparity will likely worsen as the prevalence of conditions suitable for palliative care increase with age.	NYC Health and Provider Partnership, Queens CNA, Nov 18, 2014 NYC Health and Provider Partnership, Manhattan CNA, Nov 18, 2014 NYC Health and Provider Partnership, Bronx CNA, Nov 18, 2014 NYC Health and Provider Partnership, Brooklyn CNA, Nov 18, 2014
3	Need to improve the provision of and access to culturally and linguistically appropriate care	The CNA identified barriers to care, particularly among immigrant populations and neighborhoods with high concentrations of minority groups. Barriers include linguistic challenges, insurance eligibility, the cost and time needed to travel, and familiarity with the US healthcare system.	NYC Health and Provider Partnership, Queens CNA, Nov 18, 2014 NYC Health and Provider Partnership, Manhattan



New York City Health and Hospitals-led PPS (PPS ID:52)

[New York City Health and Hospitals-led PPS] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		For immigrant groups across NYC, the CNA found that depression and isolation may result from the pressures of migration and assimilation, long work hours, and social isolation. In addition, behavioral health issues generally carry greater stigma than other health concerns and thus patients may be reluctant to seek care. Key informants and focus group participants reported that many affected individuals and families try to address problems internally—or not at all. The CNA reports a shortage of culturally and linguistically competent specialists and multi-specialty centers, particularly those that provide behavioral health services. According to the CNA, 35% of the NYC Medicaid population and 65% of the NYC uninsured population is foreign born, and 18% of NYC residents are non-US citizens. The CNA reports that 24.6% of NYC residents speak English less than "very well." Approximately half of New Yorkers speak a different language at home. Challenges due to language barriers include the inability to effectively communicate with patients and issues around quality of and access to bilingual providers and interpretation services.	CNA, Nov 18, 2014 NYC Health and Provider Partnership, Bronx CNA, Nov 18, 2014 NYC Health and Provider Partnership, Brooklyn CNA, Nov 18, 2014 CNA, Appendix F HHC Corporate Planning
4	Need to provide integrated primary and behavioral health services	As of 2012, 19.1% of Medicaid beneficiaries in the PPS Service Area had a mental health diagnosis and 6.1% had a substance abuse diagnosis. Compared to those with chronic physical health conditions, hospital-based utilization is substantially higher among the Medicaid enrollee population with a Mental Health CRG diagnosis. Both populations are high users of ED and inpatient services: 42.3% and 58.4% of mental health and substance abuse patients, respectively, had at least one ED visit and 32.3% and 65.0% had at least one admission. The 30-day readmission rate among NYC Medicaid Fee for Service adult beneficiaries for mental health discharges is 24.3%. This is 8.5% higher than NYS. Within NYC, the 30-day readmission rate for substance abuse discharges is 42.9%, substantially higher than the NYC rate of 32.9%. The CNA found that readmissions are likely driven by low rates of engagement, continuity of care, and medication management. As a conservative proxy of the comorbidity rate for behavioral and physical chronic conditions, 44.5% of patients with one or more hospitalizations in one of HHC's 11 acute care hospitals for a behavioral	CNA, Appendix F HHC Corporate Planning



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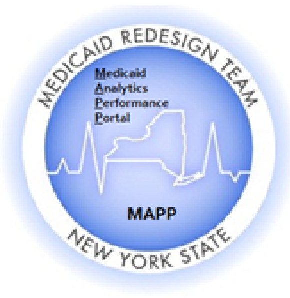
		health related condition in 2013 also had a hospitalization for a chronic related condition in the same year. Despite these numbers, HHC found that only 35.7% of patients received follow-up within seven days of a hospitalization for mental illness.	
5	Need to improve care management and care coordination services for high-need patients	Enhancing the availability of care management, care coordination and patient navigation can help close gaps in access, language, and patient activation. Very high need populations, including the chronically homeless, those with severe alcohol dependence and/or serious mental illness, victims and survivors of domestic violence, individuals released from jails and prisons, and individuals with particular disabilities are in need of, but have been unable to access, targeted and intensive care management services. There is a high prevalence of chronic diseases within our PPS. For example, in 2012, 30% of Medicaid beneficiaries had a cardiovascular diagnosis, 11.4% had diabetes, and 6.7% had asthma. Combined, these populations had 33,546 potentially preventable hospitalizations for the following: hypertension, circulatory conditions, heart failure, diabetes, or asthma. Across the PPS service area, there were 634,219 Medicaid beneficiaries with a mental health diagnosis and 202,634 Medicaid beneficiaries with a substance abuse diagnosis. In addition, 32.3% and 65.1%, respectively, had at least one all-cause admission and 42.4% and 58.4% had at least one all-cause ED visit. The CNA found that the gravity of behavioral health conditions for which psychotropic medicines are prescribed, and the readmissions likely caused by a lack of adherence, indicates the compelling need for post-discharge care management.	NYC Health and Provider Partnership, Queens CNA, Nov 18, 2014 NYC Health and Provider Partnership, Manhattan CNA, Nov 18, 2014 NYC Health and Provider Partnership, Bronx CNA, Nov 18, 2014 NYC Health and Provider Partnership, Brooklyn CNA, Nov 18, 2014 NYAM Primary Data Findings, September 2014
6	Need to improve infrastructure to support delivery of population-wide services	Nearly one-third of respondents reported that pediatric and adolescent services were "not very available" or "not available at all." CNA primary data suggest that there are particular high need populations, including those with serious alcohol dependence and/or mental illness, who would benefit from more targeted and intensive services to ensure that a wide range of needs are addressed and systemic barriers are ameliorated. Primary data also suggest that individuals with behavioral health disorders would often benefit from more targeted and intensive services in order to ensure that a wide range of needs are addressed	NYAM primary data findings, as of September 15, 2014. NYC Health and Provider Partnership, Bronx CNA – Appendix B, Table 27, Nov 18, 2014



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Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		and that systemic barriers are ameliorated. In NYC, 19.5% of Medicaid beneficiaries have a mental health diagnosis, and 6.21% have a substance abuse diagnosis. AIDS is the fifth leading cause of premature death in NYC. In NYC, 1.4% of the population is afflicted with HIV/AIDS, with higher rates in Manhattan (2.2%) and the Bronx (1.7%). In addition, 25.1% of Medicaid beneficiaries with an HIV/AIDS condition diagnosis have at least one all-cause admission. This is highest in the Bronx (30.2%) and the lowest in Queens (17.7%). ED visits were similarly variable. On average, 35.4% of the HIV population had at least one all cause ED visit. This rate ranged from a high of 40.7% in the Bronx to a low of 33.4% in Manhattan.	

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
52_SEC038_PPS Community Needs Assessment_Part 7.pdf	12/18/2014 10:51:10 PM	PPS Community Needs Assessment_Part 7
52_SEC038_PPS Community Needs Assessment_Part 6.pdf	12/18/2014 10:49:49 PM	PPS Community Needs Assessment_Part 6
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52_SEC038_PPS Community Needs Assessment_Part 5C.pdf	12/18/2014 10:34:22 PM	PPS Community Needs Assessment_Part 5C
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52_SEC038_PPS Community Needs Assessment_Part 5A.pdf	12/18/2014 10:32:17 PM	PPS Community Needs Assessment_Part 5A
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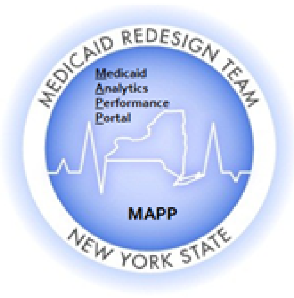

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4.pdf		
52_SEC038_PPS Community Needs Assessment_Part 3.pdf	12/18/2014 10:30:20 PM	PPS Community Needs Assessment_Part 3
52_SEC038_PPS Community Needs Assessment_Part 2.pdf	12/18/2014 10:21:12 PM	PPS Community Needs Assessment_Part 2
52_SEC038_PPS Community Needs Assessment_Part 1.pdf	12/18/2014 10:12:08 PM	PPS Community Needs Assessment_Part 1

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: **HHC_Section4_Text_PPS Project Plan Application.docx**

Description of File

PPS Project Plan Application

File Uploaded By: jaredaug

File Uploaded On: 12/19/2014 11:14 PM

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

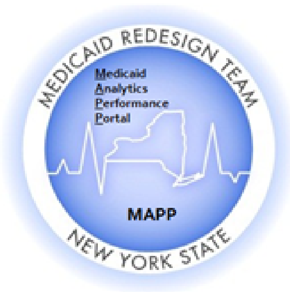
Currently Uploaded File: **HHC_Section4_ScopeAndScale_PPS Scale and Speed.xlsx**

Description of File

PPS Scale and Speed

File Uploaded By: jaredaug

File Uploaded On: 12/19/2014 11:30 PM



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:

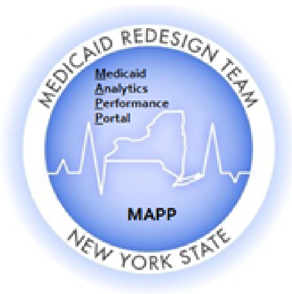
In this section, please describe the anticipated impacts that the DSRIP program will have on the workforce and the overall strategy to minimize the negative impacts.

***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.

As care shifts from inpatient to outpatient settings and we expand access to primary care and other community-based providers, we recognize that our workforce will need to adapt. Even prior to DSRIP, our PPS experienced year-over-year declines in inpatient utilization, which will only be accelerated as our PPS seeks to meet the DSRIP goals. Our PPS is committed to minimizing the impact of DSRIP on the existing staff of our many partners, and we understand that a robust set of redeployment and retraining activities will be essential to help our workforce adapt to the rapidly-changing demands of our communities. As part of implementation planning, we will validate our working assumption that partners in our PPS employ over 60,000 individuals – many whose roles and responsibilities will continue largely



DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

unchanged by the trends outlined above. However, we acknowledge that our transformation will require new skills for many of our partners' workforces. The Stakeholder Engagement Subcommittee of our PPS will help guide a survey of the PPS's workforce. Based on this survey, our PPS will work closely with our PAC to create a workforce development plan, which will leverage existing and emerging roles across our partner organizations and will contemplate redeployment strategies to minimize impact on workers.

In addition to the steps outlined above, we also expect to work with other PPSs across the City and State to define common taxonomies for roles related to care management and care coordination activities. By aligning roles and responsibilities across delivery systems, we will create a foundation for the regional workforce development strategies.

We expect that our PPS must provide workforce training around prevention, integrated care, community-based outreach, care coordination, and patient engagement and self-management. We expect to rely increasingly on community-based PCPs, and expect increased demand for clinical and non-clinical staff who are key to providing a team-based approach.

As the only NYC-based PPS with public hospitals, our PPS embraces its mission-based commitment to serve all and its obligation to increase patient engagement. As a result of our activities to engage low- and non-utilizers – as described in detail under Section 4, Project 2.d.i – may offset some expected reduction in demand for inpatient services. We expect that while the number of inpatient visits may diminish, the nature of the work will not change.

We anticipate that the following job categories will experience changes in workflow and/or required skills:

Primary care providers – especially those managing large panels of chronically ill patients, and those whose patients are less engaged in care;

Specialists – especially those managing patients with acute or post-acute care needs;

Nurses – especially those managing patient who are chronically ill or who have acute or post-acute care needs;

Pharmacists – especially those managing the chronically ill in order to address polypharmacy issues;

Psychiatrists and psychologists – in geographies where our CNA findings reveal an overall shortage of behavioral health professionals and a need for better integration with primary care services;

Social workers, including LCSWs – to fill the CNA-identified behavioral health provider shortage;

Healthcare navigators, care coordinators, and care managers – who will need to be trained on emerging PPS-based care models and systems and who possess the skills necessary to meet the goals of these models;

Population health management experts, including process redesign experts, data analysts and statisticians, and health IT programmers and support; and,

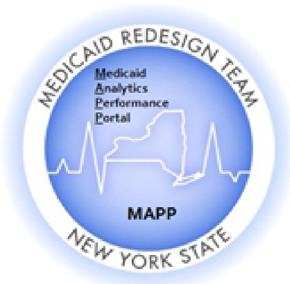
Home health professionals and paraprofessionals, as they support new programs to ensure appropriate transitions of care between acute care and post-acute and home care settings.

***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.

We expect that many of our PPS partners' employees will initially see little change in day-to-day work requirements. Over time, however, nearly all of our workforce will be affected by the changes associated with delivering evidence-based, patient-centered care to patients



across the continuum, including increased focus on the social determinants of health. In addition, there will be a number of employees whose jobs will be affected more significantly and in a shorter timeframe.

Our best estimate for our PPS turnover rate is 6.5-7%, consistent across a wide range of job categories. While we do not expect to immediately or significantly reduce staffing levels in the aggregate, as a result of our natural turnover rate we will seek to re-balance our workforce against emerging needs through strategic replacement hiring, redeployment and retraining. We expect to rely on our experienced partners to strengthen and expand existing training and re-training programs.

Based on feedback from PPS partners, including labor representatives, as appropriate, we will identify strategies to minimize any negative impact to the workforce, including:

Training/retraining of many incumbent workers who will remain in their current jobs but may require new skills. New skills – acquired through training and/or retraining – may include care coordination, interdisciplinary team care planning, chronic disease management, virtual and cross-sector communications, care transitions, triage and health IT training.

For at-risk positions facing job loss and/or redeployment, PPS partners will follow any existing labor agreements regarding redeployment, and will seek to provide training support to fill identified skill gaps for potentially eliminated/redeployed positions in order to minimize impact on these employees. Analyses of at-risk positions and skill transferability will facilitate minimizing potential workforce disruptions.

Working with partners to develop appropriate change management strategies to effectively implement DSRIP. As new relationships within the PPS emerge, we anticipate creating systems to support the new interactions in a collaborative way.

In addition, based on preliminary assessments and our CNA findings, there is a high prevalence of federally designated medically underserved areas (MUAs) and health professional shortage areas (HPSAs) in our PPS service area – the Bronx has 18 and 8, Brooklyn has 15 and 9, Queens has 7 and 4, and Manhattan has 8 and 4, respectively. In addition, shortages appear to exist among PCPs, psychiatrists, social workers, behavioral health providers, certified asthma educators, and certified diabetes educators.

Indeed, across NYC, there are only 49 general psychiatrists per 100,000 residents and 231 social workers per 100,000 residents. While the distribution of these professionals varies -- with Brooklyn and the Bronx having significantly lower rates than NYC overall -- there is a need for a wide range of mental health and substance abuse programs throughout NYC.

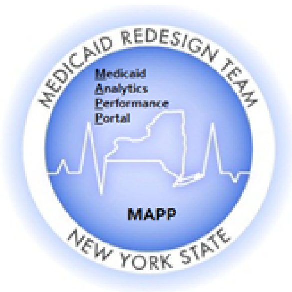
Workforce needs present opportunities for incumbent workers and community members to upgrade skills, gain new credentials and play new roles in the delivery system. Through this, our worker and stakeholder engagement efforts, we hope to minimize the immediate negative impact to the workforce and also have a positive community impact by helping to re-shape the future workforce design for the healthcare industry.

***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	5%
Retrain	20%
New Hire	1%

☑ 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.

Our PPS intends to develop project-specific implementation and operating plans, defining the clinical and administrative processes needed to deliver care, care management, and patient/family engagement services. As part of these plans, we will work with relevant partners to define the project's workforce needs. We expect that in some cases and for some partners, especially our hospital partners, our project plans will suggest opportunities to re-train employees capable of continuing to adapt to the changing needs of our communities.

Retraining is defined by the Society for Human Resource Management as "training that is provided for a certain job to enable an employee to acquire the necessary skills to work with new processes, procedures or equipment." Using this definition, and with guidance from the PPS Executive Committee and Stakeholder Engagement Subcommittee, we will develop concrete workforce strategies to target required training and re-training needs. We estimate that we may retrain up to approximately 20% of employees to meet DSRIP requirements. As discussed below, we will enter into contracts with established training organizations, such as 1199SEIU, to conduct this training.

Some examples of training and retraining opportunities include:

(1) Increasing the ability of advanced home health aides, community health workers, peer counselors, and community navigators, to leverage their community connections and teach/develop cultural and linguistic competencies through a train-the-trainer model;

(2) Expanding engagement skills for discharge planners and pharmacists to manage transitions in care between nursing homes, home health agencies and other post-acute providers;

(3) Enhancing basic care coordination skills among social workers, and social service navigation skills to care coordinators to create integrated expertise across the continuum;

(4) Additional training on patient/family customer service skills for frontline staff members who interact with patients.

Although our PPS partners will retain ultimate authority regarding training decisions for their employees, we will encourage all participants to offer retraining on a voluntary basis. Our PPS will work with the unions on the protocols for displaced union workers. 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, training or credentialing may be mandatory (e.g. asthma certification).

***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 evolution of New York's healthcare delivery system from an inpatient, volume-focused system to an outpatient, value-focused system will accelerate under DSRIP. The PPS will strive to ensure the workforce have the skills and wages and benefits to sustain the quality of care needed to improve patient outcomes. Based on initial consultations with union and other partners, we are reasonably confident that our retraining programs will create long-term opportunities for employees by providing them skills essential to a transformed healthcare system. With the attainment of new and expanded skills, we do not expect a negative impact on individual existing employees' wage and benefit levels. Our Stakeholder Engagement Subcommittee will provide regular input to our PPS as we develop project-specific strategies and analyses to inform the evolution of the workforce. This will be a collaborative effort including employee stakeholders across the continuum and labor unions. Our common goal is to expand employment opportunities, and to mitigate any risk of downward mobility and/or job loss.

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

The PPS will establish a process to educate all employees regarding the changes anticipated as a result of system transformation. We will make every effort to provide appropriate retraining to employees impacted by DSRIP-related changes. The PPS will follow existing protocols and agreements to inform employees of possible retrenchments, bumping and seniority rights and any other appropriate considerations. In cases where retraining is voluntary, refusal may simply impact the available opportunities within our PPS for an individual, who may choose to resign, may be redeployed at a later date, may be referred to employee counseling, and/or may be subject to disciplinary action, consistent with current policies.

***Retraining 4:**

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

The Stakeholder Engagement Subcommittee will serve as the formal mechanism to engage labor representatives, patient advocates, and community partners in supporting our PPS workforce during our transformation to an IDS. The Subcommittee will be responsible for overseeing and recommending any retraining initiatives to the Executive Committee. In addition, we expect our labor partners to be members of our PAC and we look forward to continued partnership with our labor representatives.

***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	95%
Partial Placement	5%

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:

Please outline expected workforce redeployments.

***Redeployment 1:**

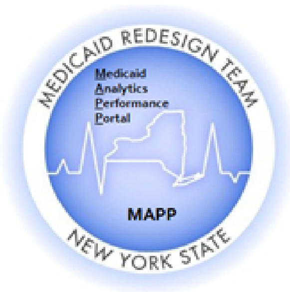
Describe the process by which the identified employees and job functions will be redeployed.

According to the Society for Human Resource Management, redeployment is defined as "the reassignment of employees to other departments or functions as an alternative to laying them off". Our PPS intends to develop project-specific implementation and operating plans, defining the precise clinical and administrative processes needed to deliver care, care management, and patient/family engagement services. As part of these plans, we will work across affected partners to define workforce needs. Given the diversity of our partners, our natural attrition rate, and the scale of our PPS and each of its Hubs, we do not expect that our workforce strategy will result in substantial redeployment of workers. We estimate that we may redeploy up to 5% of our workforce to meet DSRIP requirements. We are reasonably confident that, with retraining, the current workforce is capable of managing the patients, populations, and projects required under DSRIP. With guidance from the PPS Executive Committee and Stakeholder Engagement Subcommittee, we will develop workforce strategies to address potential shortfalls and redeployment requirements as necessary.

***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.

Our PPS will strive to ensure that members of the workforce have the skills necessary to sustain the quality of care needed to improve patient outcomes. Based on initial consultations with union and other partners, we expect limited redeployment. Our Stakeholder Engagement Subcommittee will provide regular input to our PPS as we develop project-specific strategies to inform decisions on workforce requirements for each project in each Hub. In cases of redeployment, we will endeavor to limit any impact on existing employees' wage and benefit levels. A redeployment agreement would be drafted, in consultation with the relevant labor unions and as part of a collaborative effort with other stakeholders, which would define the number of excess employees by title. Redeployment would be implemented first for volunteers based on seniority and then for involunteers, based on juniority. Our common goal is to expand employment opportunities, minimize disruption, and mitigate any risk of downward mobility and/or job loss. Generally, in a redeployment,



there are no significant gains or losses in compensation for affected employees.

***Redeployment 3:**

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

The PPS will establish a process to educate all employees regarding anticipated changes as a result of system transformation. We will make every effort to provide appropriate retraining within their current work locations. The PPS will follow existing organizational protocols and collective bargaining agreements, including the development of required redeployment agreements for HHC employees. Should an employee refuse redeployment, every effort will be made to understand his/her concerns and appeals will be accepted in accordance with current organizational procedures. Should that process continue to result in the employee's refusal, the employee will be referred to employment counseling, where applicable, or other channels as defined by current policies.

***Redeployment 4:**

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

The Stakeholder Engagement Subcommittee will serve as the formal mechanism to engage labor representatives, patient advocates, and community partners on supporting our PPS workforce during our transformation to an IDS. The Subcommittee will be responsible for overseeing and recommending any redeployment initiatives to the Executive Committee. In addition, we expect labor partners to be members of our PAC and we look forward to continued partnership with them.

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-driven changes, combined with an aging population, will likely create demand for additional behavioral health providers, PCPs, community health workers, care managers, home health aides, personal care workers, and nurses. We also expect growth in new occupational categories such as care navigation and anticipate increased demand for professionals working in occupations that extend patients' ability to remain in non-institutionalized settings. While the PPS – through its partners – already employs workers in each of the below-listed fields, we expect moderate to significant increases in demand for all listed occupations. We estimate that across our PPS, we will have 1% new hires to meet DSRIP requirements. We anticipate the following jobs being created:

(1) Primary care providers - To expand primary care services and access for patients in behavioral health sites, and in the community

(2) Mental health specialists, psychologists, MD psychiatrists - To meet the needs of patients in primary care clinics, multi-specialty clinics, and community-based settings

(3) Physician Assistants, Nurse Practitioners and Family Nurse Practitioners - To staff primary care and multi-specialty clinics and emergency departments, as well as post-acute care providers

(4) Registered Nurse and Licensed Practical Nurse - To staff primary care and multi-specialty clinics and emergency departments, as well as post-acute care providers

(5) Healthcare navigators / care coordinators / care managers - To manage the clinical and social service needs of high-risk and rising-risk patients and support patients in effectively navigating the various services that are appropriate for their needs. These will be particularly important for patients with multiple and chronic needs. In addition, they will engage in assertive follow up for targeted patient groups and will collaborate with population health management experts in targeting and engaging low/non-utilizers

(6) Social Workers - To identify and engage the uninsured and low- and non-utilizers, and to increase guidance and assistance to patients and their families across the continuum

(7) Home health workers - To provide enhanced assistance to patients in their homes and decrease unnecessary admissions and re-admissions

(8) Financial counseling staff - To assist patients in obtaining appropriate financial information and eligibility determination for Medicaid

(9) Population Health Management experts - To support development of, manage, and monitor the creation of an IDS

(10) Data analysts and statisticians - To provide data collection, analysis, reporting, and monitoring to support the provision of evidence-based medicine, performance management, and DSRIP projects

(11) Health information technology programmers and support - To support implementation and management of health IT systems

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	50
Physician	75
Mental Health Providers Case Managers	90
Social Workers	100
IT Staff	10
Nurse Practitioners	70
Other	205

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.

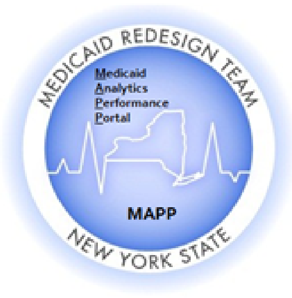
Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000
Redeployment	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000
Recruiting	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	10,000,000
Other	0	0	0	0	0	0

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

Our PPS partners have experience with several existing State programs to address workforce skill and composition, including the Health Workforce Retraining Initiative (HWRI) which supports the training or retraining of health industry workers to obtain new positions. Under HWRI, the PPS experience has focused on a number of career transition/training activities, with an emphasis on supporting LPNs and RNs maximize skillsets within their scopes of practice. In addition, members of our PPS are active participants in the National Health Service Corps and Nurse Corps (NHSC/NC) programs, designed to address critical local shortages in healthcare professionals. At present, our PPS partners provide at least 117 placement sites for NHSC/NC awardees. Our PPS plans to assess and pursue additional local, state, federal, and non-governmental programs to assist our PPS workforce in adapting to the changing needs of our healthcare system.



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.

Our PPS engaged our key workforce stakeholders throughout our application planning process, beginning with a focused set of inquiries and analyses embedded in our Community Needs Assessment (CNA). Prior to forming our PAC and operational governance structure, our PPS lead met with our union partners several times to discuss DSRIP, our approach, and ways in which our union stakeholders and partners could collaborate in developing the PPS and in implementing our projects. In addition to their participation in these meetings, our labor partners are also part of our PAC, which had its first meeting on November 18, 2014. We have also reached out to selected unions for guidance and support in developing PPS training curricula. Finally, in preparing this application, we invited all of union partners to submit suggestions on developing our PPS's workforce strategy; many of the comments received in response to this solicitation are included in our response to the section.

***Engagement 2:**

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

Throughout our PPS planning process, we have consulted with labor groups and worker representatives in several ways. For example:

(1) We held a series of three meetings with 1199SEIU, CIR/SEIU, DC37, Doctors Council, and NYSNA related to the development of our PPS approach.

(2) We invited the above groups to participate in planning workshops.

(3) We consulted and received input on PPS workforce planning.

(4) The above organizations attended our initial formal PAC meeting in mid-November.

With SUNY Downstate Medical Center joining our PPS we will be expanding our partnerships with labor groups in Brooklyn to include UUP, PEF, and CSEA. Representatives from those collective bargaining organizations will be members of our PAC and will be involved in implementation planning related to the workforce components of our application.

***Engagement 3:**

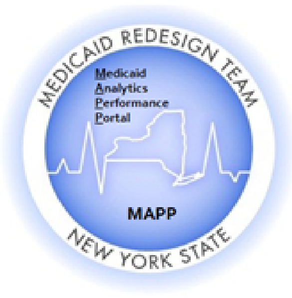
Outline how the PPS has engaged and will continue to engage frontline workers in the planning and implementation of system change.

Our PPS understands the importance of engaging frontline workers, and intends to work closely with our Stakeholder Engagement Subcommittee to develop a change management program to assist our PPS's workforce in managing through the transformation. We expect to engage employees participating in DSRIP projects with regular dialogue and communications on how individual job functions and roles contribute to better health for our patients, families, and communities, and to provide regular context-setting materials to ensure employees understand their role as part of a care continuum, spanning multiple sites of care. Specifically, we expect our partners and the PPS to engage staff in ongoing process improvement and operational effectiveness programs, as well as organizational development, management and leadership programs. We also expect to survey staff associated with the PPS regularly to assess our progress in creating an aligned, engaged workforce, and to develop and implement plans to increase workforce engagement over the course of DSRIP.

***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.

In addition to our Stakeholder Engagement Subcommittee, our Executive Committee, our Hub Steering Committees, and our PAC, we expect each of our significant partners to develop partner-specific strategies to increase their respective workforce engagement levels.



Consistent with any large, multi-stakeholder change initiative, we will need to ensure that all stakeholders can continue to provide high-quality health and social services in an environment of uncertainty. In addition, we expect that some workers will feel especially challenged in integrating clinical and administrative approaches across partners and geographies. Our general strategy to address both sets of barriers is regular communication and regular engagement with frontline workers – making sure each employee has a clear sense of what is expected and why his/her role is vital to improving the health of patients, families, and communities.

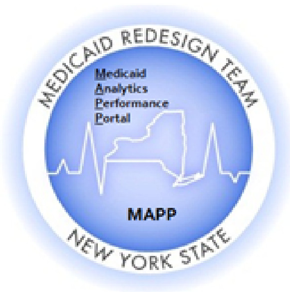
☑ Section 5.8 - Domain 1 Workforce Process Measures:

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.



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.

The sharing of patient information will be enabled through the development of a concrete data sharing plan. As part of this plan, the PPS will foster clinical collaboration and data sharing to the greatest extent possible while carefully adhering to federal and state privacy laws.

Under the direction and oversight of our Executive Committee, and as part of our collaborative contracting model, each DSRIP participant will agree to adhere to standard data sharing, use and confidentiality protocols (see below) in order to be eligible to provide services to foster care transformation and possible financial incentives.

The PPS's experience with data sharing in the RHIO and Health Home contexts will guide its approach. HHC has played an instrumental role in the Interboro RHIO, and its representative is the board chair of the RHIO. This experience will serve as critical foundational expertise for ensuring privacy of patient information while promoting information exchange.

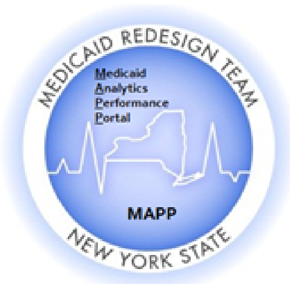
***Confidentiality 2:**

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

As a condition of joining the PPS, each partner organization will sign a data sharing agreement that requires adherence to federal and state privacy requirements, including requirements that (a) data only be used for permitted uses under HIPAA; (b) PPS patients have consented to the disclosure of their information; (c) certain alcohol/drug abuse information is only exchanged in accordance with 42 CFR Part 2; and, (d) data storage complies with HIPAA security standards. Acting through its Business Operations and IT Subcommittee, the PPS will establish a formal program for data sharing compliance. The PPS will provide privacy law trainings, monitor participant compliance, and impose corrective actions when necessary. The PPS will implement an IT system that allows for dynamic tracking of patient consent to ensure privacy law compliance.

***Confidentiality 3:**

Describe how the PPS will have/develop an ability to share relevant patient information in real-time so as to ensure that patient needs are met



and care is provided efficiently and effectively while maintaining patient privacy.

The PPS will make the Interboro RHIO the central platform for sharing patient information. Providers with EHR systems that have data exchange capabilities will be encouraged to connect to the RHIO as soon as they are able so that information can be exchanged in real time during the early stages of DSRIP. For providers with EHRs without sufficient functionality to connect to the RHIO in Years 1 and 2, the PPS will ensure that traditional, one-to-one exchanges are in place for projects that rely on the exchange of information. For example, connections will be established between providers sharing physical space. Providers that do not have EHRs will be given access to RHIO data through HHC's Care Coordination Management System —in accordance with federal and state privacy laws—so that they can understand the health needs of their patients. In addition, the PPS will work with Medicaid MCOs to obtain claims data and with partners to obtain billing/registration and regular reporting data.

The PPS will provide guidance and assistance to participants in order to foster this real time exchange of information. The PPS will identify specific data elements which are required to be shared by each PPS participant to support DSRIP projects and will provide assistance to participants in selecting EHR vendors to ensure that standards related to these specific data elements and interoperability are met. The PPS will also provide trainings to participants on how to use clinical and claims data and health information exchange to improve patient care, as necessary.

Our Business Operations and IT Subcommittee will monitor performance against these goals and address any issues with compliance or performance.

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.

The PPS will use the characteristics of and recommendations from the IOM's Learning Health Care System as a framework for Rapid Cycle Evaluation (RCE). To start, the Care Models Subcommittee will finalize RCE framework principles for ratification by the PPS Executive Committee. Principles will be used as a guide for a detailed plan to:

(1) identify and capture insights from evidence;

(2) translate insights into the development and updating of care delivery protocols consistent with DSRIP project objectives;

(3) review performance evidence gathered in the PPS;

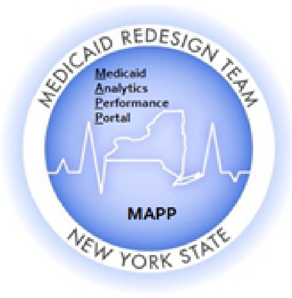
(4) review patient experience and patient satisfaction data, as captured in surveys and anecdotally; and,

(5) report progress and recommendations for improvement to the Executive Committee, PPS participants and external stakeholders, including DOH and CMS.

***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.

The PPS's CSO will establish a quality management and analytics unit which will develop a process to evaluate the performance of PPS partners and providers, propose and carry-out quality assessment and improvement activities based on these data, and conduct population-based activities to improve the health of the targeted population.

The unit will leverage a range of data, including those from EHRs, care coordination and management records, claims, and surveys. Based on these data, the unit will support the Care Models Subcommittee in developing recommendations for improvements to existing protocols as well as practice redesign and quality improvement activities that should improve clinical, patient experience and efficiency outcomes. It will also develop a process to support providers whose performance falls below established thresholds and regularly review data for population-level trends.

***RCE 3:**

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

The Care Models Subcommittee will communicate recommendations and progress against performance metric objectives quarterly, in writing, to the PPS Executive Committee and to all PPS participants. Quarterly reports will be posted to the PPS website. Recommendations will be by category, related to the 10 topic areas in the IOM Learning Health Care System framework.

The Executive Committee will review the Care Models Subcommittee's recommendations in quarterly meetings and act formally to accept, reject or continue analysis of each. The Care Models Subcommittee will implement recommendations by disseminating new or revised protocols, recommending changes to PPS operational procedures or workflows, and overseeing changes to rules or workflows.

***RCE 4:**

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

The Care Models Subcommittee and individual partners will be empowered to act immediately on improvements and to correct any protocols that may cause harm, without waiting for Executive Committee review and approval, so long as the Executive Committee is notified in writing of the intention and justification. Together, these processes will result in a rigorous, transparent and comprehensive program of continuous quality improvement across the PPS and all dimensions of the IOM Learning Health Care System framework. This data-driven and dynamic approach will result in the full engagement of each provider within the PPS to improve its delivery of high-quality, patient centered care and to improve the health of the population.

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.

Our PPS service area population is extremely diverse, with high concentrations of foreign-born, immigrant, and non-English speaking populations. The proportion of residents who are foreign born ranges from 29% (Manhattan) to nearly 48% in Queens, and these rates are especially high in targeted "hot spot" communities such as Flushing, Corona, Washington Heights, and Sunset Park. In addition, 24.6% of PPS service area residents report speaking English "less than very well," with significantly higher rates in communities with disproportionate numbers of low-income, uninsured, and Medicaid beneficiaries, such as Southeast Queens, the South Bronx and areas of Southwest and Central Brooklyn.

Patients with low literacy skills, those who have recently arrived to the U.S., and LEP individuals face significant challenges when accessing and navigating the healthcare system. People unfamiliar with local healthcare resources and/or patterns of recommended care fail to access healthcare needs in preventive settings, and limited English proficiency significantly hampers treatment adherence and follow-up care. In focus groups conducted as part of the CNA, access barriers resulting from providers not speaking languages other than English and/or not providing culturally sensitive care emerged as a prevailing theme. Integrated service providers with the resources and partnerships necessary to provide culturally competent care are not uniformly available across the PPS service area, especially in "hot spot" communities.
The HHC PPS considers improving access to and provision of culturally competent care to be a key underpinning for patient engagement, closing of health disparity gaps, and achievement of DSRIP goals.

***Competency 2:**

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

The PPS will follow a multi-pronged strategy to ensure culturally competent care: (1) assess cultural competency strengths and gaps across PPS providers; (2) develop a set of core cultural competence "best practices" to inform design and implementation of DSRIP projects; and (3) develop a robust supplemental training program available to all PPS providers, with a particular focus on frontline providers in "hot spot" areas and providers with identified gaps in cultural competency resources.

In executing on this strategy, the PPS will build on the longstanding commitment among HHC and its partners to provide respectful, patient-centered, culturally competent healthcare and social services. This commitment is reflected in HHC's deep foundational expertise in cultural competency training, creating unique programs tailored to meet individual community needs, and providing expansive language access services.

HHC provides in-person and e-learning cultural competency training across all facilities, including LGBT-specific educational modules. Curricula are aligned with Joint Commission standards and facility-specific demographics.

Examples of innovative community-specific HHC programs include the Harlem Hospital Medina Health Center (serving African immigrants and members of the Muslim community), multi-lingual psychiatric inpatient units at Elmhurst Hospital Center, and Lincoln Hospital's Viva Mujer/Viva Los Hombres cancer outreach programs serving immigrant residents of the South Bronx.

In addition, since 2007, the HHC Center for Culturally and Linguistically Appropriate Services has overseen the implementation of HHC's Language Access Plan by providing centralized support for culturally and linguistically appropriate services throughout all HHC facilities, including the translation of all key HHC documents into 13 languages.

The DSRIP program will allow for the standardization and dissemination of these and other PPS partner best practices across the PPS continuum.

***Competency 3:**

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

HHC will create and deepen strategic partnerships with PPS citywide and Hub partners, its PAC, and other key community stakeholders to achieve and maintain cultural competence throughout the DSRIP Program. These relationships will build on a deep prior experience in working with CBOs to build capacity and improve effectiveness of outreach efforts. For example, as part of Lincoln Medical Center's Community Health Education and Outreach (CHEO) program, over 700 linkages were created with schools/parent coordinators, day care centers, CBOs, youth centers, community boards, faith-based organizations, and senior centers. Also, in cases where Community-based organizations have unique expertise in serving specific communities, the PPS will seek to contract with these organizations to provide community navigation services and technical assistance in program design, and training curriculum development. These efforts will be overseen by Stakeholder and Patient Engagement Subcommittee.

☑ 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:

- 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.

Consistent with the mission and tradition of its participating institutions, the promotion of health literacy is considered a core organizational responsibility of the HHC PPS. As such, the PPS will incorporate existing best practices from across its partner organizations into clinical models, training plans, and marketing campaigns associated with each project. Examples of these best practices include deep expertise among participant organizations in the following areas: (1) establishing health literacy partnerships among community-based, healthcare, and educational institutions, such as the Brooklyn Health Literacy Collaborative (BkLHC); (2) creating innovative and culturally-tailored health literacy programs, such as the Harlem Hospital Hip-Hop Public Health Education Center, which provides culturally- and age-appropriate methods to introduce health education initiatives of any type to children and their family members; (3) developing adult learning curriculum to accompany the dissemination of critical health information, such as educational workshops to promote understanding among undocumented immigrants that any person, regardless of status and ability to pay, can receive care at HHC facilities; (4) partnering with the Literacy Assistance Center to review and update patient education and consent materials to ensure consistency with appropriate literacy levels; and, (5) providing extensive training to meet the educational needs of physicians, nurses, allied health professionals, financial advisors, and other patient-facing staff in promoting health literacy.

The PPS will assess its network of partners to determine gaps in core competencies related to the promotion of health literacy and will establish PPS-wide standards around workforce competencies and patient educational materials. For example, patient outreach and engagement protocols that will support the PPS' Project 2.d.i patient activation efforts will be heavily informed by health literacy standards that may include use of "plain language" and "teach back" techniques. In order to address identified competency gaps among providers, the PPS will contract with CBOs to develop training programs and support resources.

In addition, under the stewardship of the Stakeholder and Patient Engagement Subcommittee the HHC PPS will develop a strategic marketing plan with multiple touch points to engage consumers and influence their behavior in support of individual health outcomes and healthy communities. The plan will include the development of key patient education materials, comprehensive outreach and a digital marketing strategy. The plan will leverage the support of PPS partners.

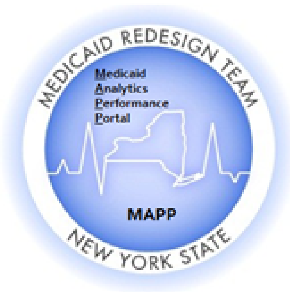
Section 7.3 - Domain 1 – Cultural Competency/Health Literacy Milestones :

Description:

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

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

☑ Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

New York City Health and Hospitals-led PPS (PPS ID:52)

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:**

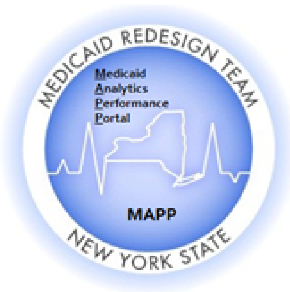
In the response below, please address the following on the DSRIP budget and flow of funds:

- 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.

The HHC PPS flow of funds distribution framework balances implementation-related investments required to build transformational PPS infrastructure with alignment of performance incentives among participants to successfully achieve DSRIP goals.

Governed by our Executive Committee and guided by a commitment to transparency, the HHC PPS will allocate DSRIP payments into five funding use categories. Our estimates are subject to change consistent with final awards, partner negotiations, and governance decisions made by the Executive Committee, in consultation with the PAC. All partners in this network are eligible for implementation funds, bonus payments, revenue loss mitigation, and funding for uncovered services. Funds related to project implementation costs will be directed to the CSO and to PPS participants for services provided in support of DSRIP and its projects. Incentive-based bonus payments will be distributed to partners to reflect performance against DSRIP goals. Our PPS bonus payment allocation decisions will take into account that HHC is a public hospital system that provided Inter-Governmental Transfer (IGT) payment as local match for the DSRIP program. Revenue loss mitigation funds, as well as funding to cover costs not otherwise paid for under Medicaid, will be distributed to partners to compensate for DSRIP's impact on revenue. Implementation funds will be based on project/task-specific budgets, and flow of funds may include upfront payments for early activities and/or milestone payments for completing required project milestones. Bonus payments will be linked to performance metrics and reflect providers' level of participation in the PPS' overall performance. Revenue loss funds will cover a defined period of time to assist partner organizations in their transformation. Funding for uncovered services will be significantly tied to the level of services provided to the uninsured. We expect that implementation expenses will be front-loaded, and that more significant bonus payments will be paid in the later years.

The Executive Committee will provide appropriate guidance to shape the flow of funds across clinical and social service sub-categories. We expect the flow of bonus payments to favor providers and organizations whose performance was critical to DSRIP results, with a focus on avoidable re-admissions and ED visits. Given the projects' emphases on coordinated care, patient engagement, care transitions and



integrated care, we expect PCPs, behavioral health providers, post-acute providers, and CBOs to be fairly and substantially represented in the eventual list of bonus recipients.

Initially, we expect to focus our contracts on meeting and exceeding goals through an incentive-based system. Over time, as our partners gain experience operating in an integrated fashion across the care continuum, and as our PPS gains experience managing the flow of funds across the care continuum, the Executive Committee will consider introducing symmetrical risk-sharing with some key partners. This could occur where certain partners may have the opportunity for significant bonus payments in exchange for sharing downside risk if goals are not met. Any such risk sharing arrangement shall be structured in a manner that complies will all applicable law and requirements imposed under DSRIP.

HHC will receive a fiduciary fee to reflect its role in accounting for and distributing DSRIP funds, subject to review and approval by the Executive Committee.

The HHC PPS governance structure is integral to the framework and oversight of the funds distribution process. Project/task-specific budgets, performance obligations, milestones, and funding associated with revenue loss and uncovered services will be drafted and proposed by the CSO, in consultation with Hub Steering Committees, for review and approval by the Executive Committee.

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):

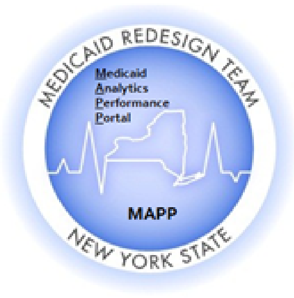
- Cost of Project Implementation: the PPS should consider all costs incurred by the PPS and its participating providers in implementing the DSRIP Project Plan.
- Revenue Loss: the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such 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	6.67%
2	Revenue Loss	6.67%
3	Internal PPS Provider Bonus Payments	0%
4	Cost for Services Not Covered	5%
5	Contingency Fund	3.33%
6	Public Hospital Bonus Pool	66.67%
7	General Bonus Pool	11.66%
	Total Percentage:	100%

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

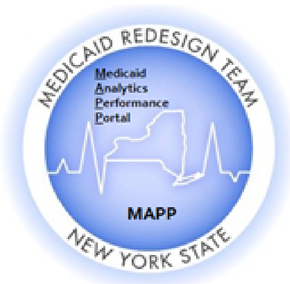
Description:
Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the



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.



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:

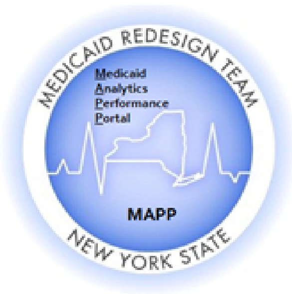
Description:
It is critical for the PPS to understand the overall financial health of the PPS. The PPS will need to understand the providers within the network that are financially fragile and whose financial future could be further impacted by the goals and objectives of DSRIP projects. In the narrative,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

To assess our potential partners, the HHC-led PPS grouped its members into 1) core safety-net providers likely to undergo significant shifts in utilization as a result of DSRIP; 2) other providers needed to add important services to ensure that the goals of DSRIP would be met; and, 3) CBOs to conduct outreach. The HHC-led PPS conducted an online survey of key partners in each category to determine their financial viability.

The public hospitals, nursing homes, and clinics that comprise the core safety-net providers are in many ways the most fragile. They serve a large number of Medicaid and uninsured patients, who represent the lion's share of their payer mix. In evaluating these providers, the PPS assessed the strength of the support that they currently receive from their government sponsors. Letters of support were provided for public providers. In the case of HHC, the City of New York provides substantial support through capital financing, supplemental Medicaid, and general support. One of our major partners – SUNY Downstate Medical Center – faces significant challenges. New York City and State have agreed that HHC cannot ensure the financial sustainability of this institution. That obligation rests with SUNY Downstate, in consultation with SUNY and the State.

The survey of other providers assessed financial stability reviewing several criteria that might indicate fragility including declaration of bankruptcy and debt/asset ratio. Potential partners that seemed unlikely to be able to complete their role in DSRIP were not included.



***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.

We expect that DSRIP projects will result in three basic changes—expansion of ambulatory care (particularly primary care); contraction of inpatient services; and greater need for community-based and care management services. Providers in the HHC-led PPS have very high Medicaid and uninsured utilization and will continue to be extremely important to the safety net. Capturing savings will take some time for these providers, and for a number of our partners, DSRIP will likely result in increased costs and loss of revenue. Providers will need to adjust staffing to adapt to these changes, and the PPS will need to help these critical providers navigate these challenges successfully.

The PPS currently has the majority of its Medicaid Managed Care lives in global risk contracts that reward performance consistent with DSRIP. However, a significant portion of PPS inpatient stays originate from ED visits and are covered by non-participating plans which must pay fee-for-service. Also, importantly, the uninsured become eligible for Emergency Medicaid upon admission, which is also by default a fee-for-service arrangement. As we engage in DSRIP, other Medicaid reform changes may also negatively impact PPS providers including implementation of Fully Integrated Duals Advantage (FIDA) and Health and Recovery Plans (HARP). While some PPS providers have already received (Interim Access Assurance Fund) IAAF funding, additional stop-gap resources will likely be needed throughout the span of the DSRIP program.

The DSRIP projects taken in context with other MRT changes will financially impact providers in the following ways:

(1) Reduction in admissions and ED visits will reduce revenue. There will be some offset because of the PPS's global risk contracts, and because PPS patient outreach and engagement activities will result in additional utilization for the under- and non-utilizers. Taken together, we do not believe that these offsets will be sufficient to compensate for lost revenue. There is no offset when PPS patients utilize out-of-network services. Also, there is no offset on loss of Emergency Medicaid revenue for the uninsured.

(2) The successful reduction of preventable (often shorter-stay) admissions will result in remaining admissions having a higher average cost due to their increased complexity and fixed costs being spread over fewer stays. Rates based on average costs from base years that included the less complex admissions will not cover the cost of the remaining inpatient stays.

(3) Reduction in supplemental Medicaid revenue will follow this reduced utilization and the deeper penetration of Medicaid managed care.

(4) Increases in use of care management and primary care will result in increased revenue for insured patients; however, capital and staff investments will be needed to achieve these expansions.

(5) Increases in the investment in care management and information technology also carry financial risk should activities fail to achieve DSRIP performance goals in the allotted time frames.

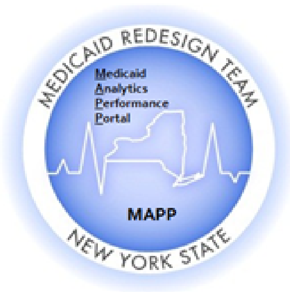
(6) Provider failure or downsizing may result in a shortage of a critical service or set of services needed to meet the needs of the projects.

(7) Cash flow challenges may result from timing mismatch between DSRIP and current revenue funds flow. Also, as a public-led PPS, unique cash-flow issues exist.

To address these concerns, the PPS will need to develop appropriate contractual arrangements to distribute DSRIP payments and will need to work closely with NYS on the timing of other supplemental Medicaid payments. Also, the PPS will need to maintain some level of reserves for provider failure. As discussed in other sections, including in our description of Project 2.a.i., the PPS will work with those partners that are not currently in value-based payment arrangements to assist them with transition.

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 PPS will develop a Financial Stability Plan (FSP) during start up and initial implementation. As HHC is such a large part of the PPS, the FSP will include but not be limited to the existing HHC Financial Plan. The PPS Executive Committee will review the financial and business plans of each of the core partners in January/February of 2015 and again in April/May, and will develop the FSP based on these reviews.

We expect the plan to address the long-term sustainability of our PPS, including the shift to increased reliance on value-based payments, and the need for managed care contracts that reward efficiency, value, and managing across the care continuum.

HHC's Financial Plan will be updated in January/February as part of NYC's Preliminary Budget process. HHC is required to perform a second update in time for the Mayor's Executive Budget in April/May. The HHC Financial Plan is approved by the Mayor and presented to all of NYC's financial monitors. The expected impacts of the DSRIP projects will be reflected in each of these updates. The January/February HHC plan will be presented to the HHC Board in March, 2015.

HHC's Financial Plan will be amended to reflect staffing changes, costs related to project implementation, expenses related to needed information technology investments, and other new costs. The Plan will forecast changes including offsets for successful furtherance of value based purchasing. The Plan will present budget gaps throughout the five years along with a corrective action plan. This corrective action plan will include changes in the current business models such as reductions in staff. It will also include Federal and State actions related to high level payment reform.

HHC costs related to flow funds to other partners will also be part of the HHC financial plan as will DSRIP payments. The PPS will need to consolidate the HHC Financial Plan with the information from the other partners to prepare the FSP for the Executive Committee.

***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.

The PPS will create a contractual structure to flow funds to partners as metrics are achieved. Some services may shift among PPS providers throughout the period. The providers may need to adapt their business models and staffing as their service mix shifts. The PPS will need to maintain some level of reserves. Key financial metrics will be required of each provider as a condition of participation.

Our Executive Committee - relying on information provided by its subcommittees, by the CSO, and by Hub Steering Committees - will monitor the financial viability of our key partners and provide appropriate technical assistance to partners facing financial challenges.

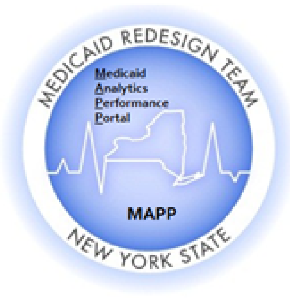
HHC's financial stability will continue to be monitored and supported by its government sponsor and relevant fiscal monitors. The PPS does not intend to take on the management of its providers. In the event that a provider is unable to provide services, the PPS will contract with other providers to meet the needs of DSRIP projects.

***Path 3:**

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

The PPS will work with all its partners to adapt their payer relationships away from fee-for-service toward value-based contracting. While the majority of HHC's current contractual relationships are risk-based, HHC will need to adjust its internal system for measuring and rewarding performance to align with DSRIP. HHC will work with MetroPlus and the HHC ACO to expand their network of community providers aligned with DSRIP goals. Taken together with the changes implemented within the provider business models, this should accelerate the achievement of the DSRIP goals.

However, we note that our PPS consists of providers that have a very high proportion of Medicaid and uninsured patients. Many changes are needed for these providers to succeed including expansion and enhancement of the health home program and reforms in Emergency Medicaid and Indigent Care programs.



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.

Most HHC Medicaid managed care patients are in MetroPlus or Healthfirst; HHC assumes global risk for medical services that members receive. As PPS sponsor, and with these MCOs as partners in our PPS, HHC expects to leverage its considerable experience in managing value-based payment models and extend value-based arrangements to other PPS partners. We expect to work with these partners to accept value-based payments from plans or be assigned to an HHC risk-taking entity. In the first instance, PPS primary care partners may be assigned members and receive an allocated percentage of premiums. Claims would be paid against that allocation, with reconciliation resulting in either an over-utilization penalty or a surplus pool payment. In the latter, PPS partners could become affiliated with existing HHC risk-assuming entities and the providers' claims would be charged against an HHC risk pool.

Once aligned to value-based payment models, the PPS intends to work with plan partners to support DSRIP goals through data sharing and incentive programs based on achieving DSRIP metrics. Currently, both plans achieve Quality Assurance Reporting Requirements (QARR) goals and Medicare Star status through these methods.

Also critical are shared savings approaches that provide incentives at the clinical department level. The PPS can partially address the challenge of rebalancing resources while not all payers are aligned with DSRIP by bringing its providers into HHC's Medicare Shared Savings Program (MSSP). Misalignment of Emergency Medicaid is not as easy to solve.

***Strategy 2:**
Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers

The PPS will evaluate each payer and realign incentives to support DSRIP. In some cases this can be done by contract; in others real reimbursement reform is needed.

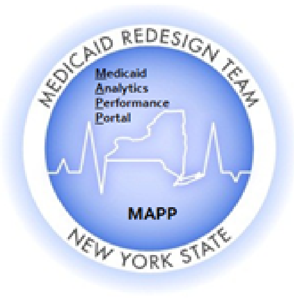
By contract the PPS can align its Medicaid and Medicare managed care relationships to reward providers for successful DSRIP outcomes. The PPS will collaborate with MetroPlus and Healthfirst to adjust incentives to reach the relevant clinical departments. To do so, the existing premium needs to be further enhanced for Health Home and for PCMH, and these funding streams need to be sustained.

For Medicaid fee-for-service the transformation vehicle is the DSRIP payments themselves. For Medicare fee-for-service the PPS will rely on HHC's ACO.

However, given the nature of this public PPS, much of its funding is specifically designed to cover shortfalls in reimbursement for Medicaid and uninsured patients. Currently, these providers are sustained through supplemental Medicaid which comes in two forms—Upper Payment Limit (UPL) and Disproportionate Share (DSH) Payments.

We expect UPL payments to decline with the further implementation of Medicaid reforms as more and more services are provided through managed care. This essential funding stream needs to be preserved through one or more of the following: 1) a payment add-on for safety net providers; 2) a premium add-on for safety-net providers; or 3) a special DSRIP type UPL payment.

DSH payments will decline as ACA payment reductions are passed down to states. To address this, we urge the State to direct remaining DSH payments to PPS providers serving the uninsured. With changes brought about by the ACA, we expect that the remaining uninsured will concentrate within the public system. It is important that as the Federal government reduces DSH, the DSH funding go to the PPS providers that care for the uninsured.



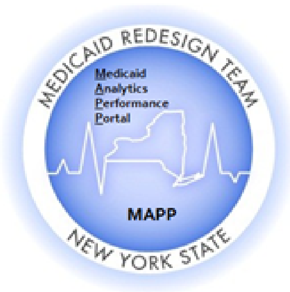
Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

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.



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.

Across our PPS service area, we have 12 inpatient hospitals, six large Diagnostic Treatment Centers (each with NCQA 2011 Level 3 PCMH recognition), four Health Homes, and a robust provider network. We have experience working with a diverse set of partners to deliver population health-based care under innovative value-based payment arrangements, including under several risk-sharing models with Medicaid MCOs. Our PPS lead, HHC, derives nearly 30% of its overall inpatient and outpatient revenues from value-based payments made by MCOs. We expect to leverage HHC's ownership of one MCO (MetroPlus) that has approximately 400,000 Medicaid members, as well as the PPS's contracting experience with other MCOs. We will build upon our experience with our ACO and PCMH recognition to strengthen our capabilities in data analytics and risk stratification, care management and coordination, and patient engagement.

HHC's Medicare Shared Savings Program Accountable Care Organization (ACO) was one of only four NYS ACOs to meet quality and cost targets, demonstrating our population health management skills. The ACO delivers coordinated, high-quality care to beneficiaries through an organized group of physicians, hospitals and other providers who have agreed to work together to treat a defined population of patients across care settings–including primary and specialty care, hospitalizations and long-term care–and become accountable for the quality, cost and overall care delivered.

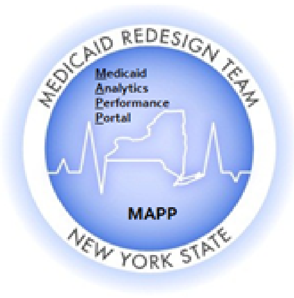
HHC has successfully transformed its clinics in order to achieve 2011 NCQA PCMH Level 3 recognition. PCMH is predicated upon the successful use of a range of population health tools in order to improve management of those with chronic diseases and to provide whole-person care.

In addition, PPS-partner SUNY Downstate has a long-standing commitment to and expertise in medical education, including equipping physicians and other health professionals with population health tools and strategies.

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.

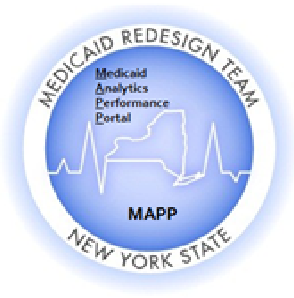
Our PPS intends to contract with one or more proven entities to help carry out our workforce strategy to retrain, redeploy, and recruit employees. We expect it will take a minimum of six months to undertake a comprehensive assessment of the training and development needs of our PPS participants, including identifying vendors to help us meet those needs. We will select our vendors on the basis of successful prior experience in large-scale workforce training initiatives; depth of expertise in the required skillsets; ability to train at scale for required skillsets; and other relevant selection criteria. We will ensure that any qualified vendor has sufficient experience and scalability to serve the diverse needs of our PPS partners. Our Stakeholder and Patient Engagement Subcommittee, whose membership includes representation from organized labor, will evaluate our workforce needs and then make vendor recommendations to the Executive Committee.

Among other possible qualified entities, we expect to engage 1199SEIU League Training & Employment Funds (TEF). We understand that 1199SEIU TEF also intends to collaborate with the State University of New York, City University of New York and other designated



workforce vendors to ensure the PPS has access to required resources and programming. According to 1199 SEIU material and a presentation given at the PPS's first PAC meeting, 1199SEIU TEF is the largest joint labor management workforce planning organization in the U.S. The Training & Upgrading Fund (TUF) has a vast network of educational providers and offers a broad range of programs, including those focused on Health Home, ACO and PCMH care models, to help the workforce adapt to meet the needs of healthcare transformation efforts. The Job Security Fund (JSF) and Employment Center (EC) counsel, train, and place laid-off, at-risk, and/or members of the general public in jobs in the healthcare industry, ranging from entry level to professional and technical staff.

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



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 New York City Health and Hospitals-led PPS that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

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

Lead Representative:	Ross Wilson
Submission Date:	12/22/2014 02:09 PM

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