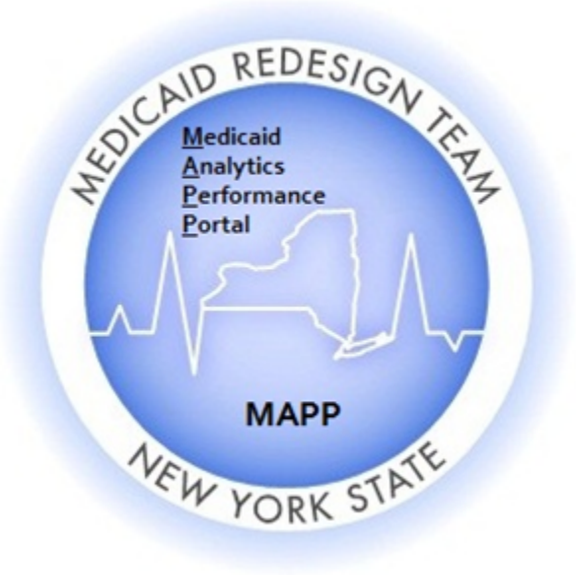
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



The New York and Presbyterian Hospital

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

DSRIP PPS Organizational Application

The New York and Presbyterian Hospital (PPS ID:39)

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

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

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

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

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

Currently Uploaded File: **39_SEC000_NewYorkPresbyterian_DSRIP_PPS_Financial_Stability_Test.pdf**

Description of File

NYP PPS Lead Financial Stability Test Application

File Uploaded By: debcg
File Uploaded On: 12/22/2014 07:27 AM

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: debcg
Last Updated On: 12/22/2014 04:52 PM

Certified By: phl9002
Certified On: 12/22/2014 04:58 PM
Lead Representative: Phyllis Lantos

Unlocked By:
Unlocked On:

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

DSRIP PPS Organizational Application

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Develop an integrated, collaborative and accountable delivery system	The fragmentation of the care delivery system creates an environment where a lack of coordinated care and aligned incentives negatively affects quality, cost and outcomes. An integrated delivery system will support a sustainable Medicaid program for present and future beneficiaries as measured by better quality care and Medicaid expenditures per patient. The PPS service area has a wide array of health services, yet gaps remain. The PPS will address structural gaps by expanding capacity in existing facilities (primary and specialty care), enhancing coordination and adding culturally competent human resources through our projects, rather than by adding facilities.
2	Reduce potentially preventable admissions, readmissions and emergency department use	Reducing potentially preventable admissions, readmissions and emergency department use allows limited Medicaid resources to be deployed in the most cost-effective way. NYP's Regional Health Collaborative has demonstrated success with reduced ED and inpatient utilization across a similar population (see Carrillo et al, "The NYP Regional Health Collaborative," Health Affairs, 33, No. 11 [2014] 1985-1992); that success can be replicated, expanded and measured.
3	Enhance primary care capability and capacity	The foundation of any integrated delivery system is accessible, high-quality primary care. In particular, the PPS is committed to employing capital to expand capacity—space, hours and provider availability—in NYP's Ambulatory Care Network (ACN) as well as develop capacity—information technology and culturally competent human resources—in other organizations in the network. Effective expansion can be measured through utilization of primary and preventive care and decreased incidence of hospitalization for ambulatory sensitive conditions.
4	Enhance data sharing and two-way communication across the care continuum	Lack of information integration results in duplication of services, gaps in service, and sub-optimization of resources. Care coordination and care management can mitigate this but only with enhanced data-sharing, workflow support, analytic capabilities and IT connectivity across the care continuum. Enhanced information integration will be demonstrated through the breadth and depth of Collaborator use of the common care management platform and of the RHIO in support of patient care.
5	Integrate behavioral health capability, capacity and awareness throughout the care continuum	Mental illness and substance abuse are both major standalone health issues in the community, as well as conditions which exacerbate and complicate the underlying medical conditions of the population. Mitigating the disconnect between behavioral and medical care through service co-location, and deployment and retraining of clinic and community resources

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#	Goal	Reason For Goal
		will result in lower incidence of ED utilization for non-urgent issues and better outcomes for mentally ill patients with comorbid medical issues.
6	Develop an integrated, collaborative and accountable delivery system	The fragmentation of the care delivery system creates an environment where a lack of coordinated care and aligned incentives negatively affects quality, cost and outcomes. An integrated delivery system will support a sustainable Medicaid program for present and future beneficiaries as measured by better quality care and Medicaid expenditures per patient. The PPS service area has a wide array of health services, yet gaps remain. The PPS will address structural gaps by expanding capacity in existing facilities (primary and specialty care), enhancing coordination and adding culturally competent human resources through our projects, rather than by adding facilities.
7	Reduce potentially preventable admissions, readmissions and emergency department use	Reducing potentially preventable admissions, readmissions and emergency department use allows limited Medicaid resources to be deployed in the most cost-effective way. NYP's Regional Health Collaborative has demonstrated success with reduced ED and inpatient utilization across a similar population (see Carrillo et al, "The NYP Regional Health Collaborative," Health Affairs, 33, No. 11 [2014] 1985-1992); that success can be replicated, expanded and measured.
8	Enhance primary care capability and capacity	The foundation of any integrated delivery system is accessible, high-quality primary care. In particular, the PPS is committed to employing capital to expand capacity—space, hours and provider availability—in NYP's Ambulatory Care Network (ACN) as well as develop capacity—information technology and culturally competent human resources—in other organizations in the network. Effective expansion can be measured through utilization of primary and preventive care and decreased incidence of hospitalization for ambulatory sensitive conditions.
9	Enhance data sharing and two-way communication across the care continuum	Lack of information integration results in duplication of services, gaps in service, and sub-optimization of resources. Care coordination and care management can mitigate this but only with enhanced data-sharing, workflow support, analytic capabilities and IT connectivity across the care continuum. Enhanced information integration will be demonstrated through the breadth and depth of Collaborator use of the common care management platform and of the RHIO in support of patient care.
10	Integrate behavioral health capability, capacity and awareness throughout the care continuum	Mental illness and substance abuse are both major standalone health issues in the community, as well as conditions which exacerbate and complicate the underlying medical conditions of the population. Mitigating the disconnect between behavioral and medical care through service co-location, and deployment and retraining of clinic and community resources will result in lower incidence of ED utilization for non-urgent issues and better outcomes for mentally ill patients with comorbid medical issues.

***Formulation:**

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

The PPS is fully representative of the community makeup and brings breadth and depth of experience to design projects and oversee implementation. Collaborators include Community Health Worker programs, housing organizations, OASES Article 32 providers, OMH Article 31 providers, skilled nursing facilities, FQHCs, HIV agencies, pharmacies and physicians among others. Physician representatives include behavioral health, pediatrics, primary & specialty care, dentistry and others.

Healthcare disparities identified by the CNA are driven by healthcare access barriers grounded in cultural and social determinants of health. The PPS is well positioned to address such barriers because the organizations are so experienced with their communities. Culturally diverse providers of care, such as those employed and trained by the NYP PPS, understand the reservations of particular populations and can target their needs. Moreover, NYP brings evidence-based expertise and experience in cultural competency and implementing successful population management programs (e.g., PCMHs, Hospital-Medical Homes, Health Homes & the Regional Health Collaborative, which significantly decreased hospital utilization).

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***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.

The NYP PPS has a strong commitment to achieving an integrated, collaborative and accountable delivery system (IDS). The strategic vision for the PPS is multi-pronged with a focus on developing a comprehensive and sustainable set of Collaborators in order to meet the community's needs, aligning with and leveraging existing population health resources, enhancing IT capability and connectivity, bolstering primary care and care management capacity and transitioning to a value-based reimbursement methodology capable of sustaining the PPS's projects and goals.

We believe that under the IDS umbrella, our specific DSRIP projects will contribute to improved health and impact rates of potentially preventable admissions and readmissions and emergency department use. The system savings associated with these reductions needs to be reinvested in the PPS and its Collaborators. A value-based alignment of the State, the MMCOs and the PPS that allows all three entities to share in the savings offers the means to fund the system's reinvestment in the integrated delivery system that DSRIP is focused on creating.

***Regulatory Relief:**

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

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

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

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

#	Regulatory Relief(RR)	RR Response
1	APG Payment Methodology	Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 86-8 (10 NYCRR 8.6-8). Waiver is requested to the extent that discounting, packaging, combining or other reduction or denial of payment is required for multiple procedures and/or medical services provided to patients on the same date of service. The current DOH policy as stated in the NYS Medicaid Update (Mar 2014, Vol 30, No 3) is "…providers that submit multiple fee-for-service claims on the same date of service (DOS) or within the same visit/episode of care will no longer be paid for the second claim." Project 2.b.i – Ambulatory ICU This project targets adults with at least two comorbid chronic conditions and children with complex medical conditions that require co-management by multiple subspecialists and primary care. One goal is to employ a multi-disciplinary care team to treat a patient for multiple medical and/or behavioral conditions during a single visit to the project site. This request is made so that claims for multiple services provided to a

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#	Regulatory Relief(RR)	RR Response
		patient on the same day will be paid at the full fee-for-service amount. Given the severely compromised health condition of the targeted patient population, the intensity of the necessary care and the need for care coordination, the project needs adequate funding to achieve financial sustainability. Without full payment for services provided, this project is not likely to be financially feasible. Project 3.a.i—Behavioral Health Integration with Primary Care This project targets patients with a primary psychiatric diagnosis of chronic mental illness and comorbid medical illness. The goal is to employ a multi-disciplinary team of providers to treat a patient for mental illness and medical conditions during a single visit to a provider site. This request is made so that each claim for multiple services provided to a patient on the same day will be paid at the full fee-for-service amount. Given the severely compromised mental and physical health condition of the targeted patient population, the intensity of the necessary care and the need for care coordination, the project needs adequate funding to achieve financial sustainability. The PPS believes that the services provided will deliver better care and decrease ED utilization. But without full payment for services provided, this project is not likely to be financially feasible. Both Projects The PPS believes that full payment for each service provided is the preferable alternative for secure funding of this much needed care. We don't believe that the patients' safety will in any way be jeopardized by the implementation of these projects. Participating patients are medically challenged and will receive multiple services to treat health concerns on one day in one place, with the benefit of care coordination personnel supporting education, medication reconciliation and social needs. This will enhance the patient's overall health and safety.
2	Behavioral Health Integration with Primary Care	While there are technically no waivers needed, other than the above, there are regulatory relief needs and guidance required. See Challenges section of Project 3.b.i.
3	Behavioral Health Crisis Stabilization	While there are technically no waivers needed, other than the above, there are regulatory relief needs and guidance required. See Challenges section of Project 3.b.ii.
4	APG Payment Methodology	Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 86-8 (10 NYCRR 8.6-8). Waiver is requested to the extent that discounting, packaging, combining or other reduction or denial of payment is required for multiple procedures and/or medical services provided to patients on the same date of service. The current DOH policy as stated in the NYS Medicaid Update (Mar 2014, Vol 30, No 3) is "…providers that submit multiple fee-for-service claims on the same date of service (DOS) or within the same visit/episode of care will no longer be paid for the second claim." Project 2.b.i – Ambulatory ICU This project targets adults with at least two comorbid chronic conditions and children with complex medical conditions that require co-management by multiple subspecialists and primary care. One goal is to employ a multi-disciplinary care team to treat a patient for multiple medical and/or behavioral conditions during a single visit to the project site. This request is made so that claims for multiple services provided to a patient on the same day will be paid at the full fee-for-service amount. Given the severely compromised health condition of the targeted patient population, the intensity of the necessary care and the need for care

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#	Regulatory Relief(RR)	RR Response
		coordination, the project needs adequate funding to achieve financial sustainability. Without full payment for services provided, this project is not likely to be financially feasible. Project 3.a.i—Behavioral Health Integration with Primary Care This project targets patients with a primary psychiatric diagnosis of chronic mental illness and comorbid medical illness. The goal is to employ a multi-disciplinary team of providers to treat a patient for mental illness and medical conditions during a single visit to a provider site. This request is made so that each claim for multiple services provided to a patient on the same day will be paid at the full fee-for-service amount. Given the severely compromised mental and physical health condition of the targeted patient population, the intensity of the necessary care and the need for care coordination, the project needs adequate funding to achieve financial sustainability. The PPS believes that the services provided will deliver better care and decrease ED utilization. But without full payment for services provided, this project is not likely to be financially feasible. Both Projects The PPS believes that full payment for each service provided is the preferable alternative for secure funding of this much needed care. We don't believe that the patients' safety will in any way be jeopardized by the implementation of these projects. Participating patients are medically challenged and will receive multiple services to treat health concerns on one day in one place, with the benefit of care coordination personnel supporting education, medication reconciliation and social needs. This will enhance the patient's overall health and safety.
5	Behavioral Health Integration with Primary Care	While there are technically no waivers needed, other than the above, there are regulatory relief needs and guidance required. See Challenges section of Project 3.b.i.
6	Behavioral Health Crisis Stabilization	While there are technically no waivers needed, other than the above, there are regulatory relief needs and guidance required. See Challenges section of Project 3.b.ii.

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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 and Presbyterian Hospital Performing Provider System (NYP PPS), formed under the NYS DSRIP opportunity, includes five of NewYork-Presbyterian Hospital's (NYP's) six campuses and its ambulatory clinics, Federally Qualified Health Centers, community-based physicians, nursing homes, home care providers, behavioral health providers, as well as social services and community based organizations providing services such as supportive housing, transportation, and specialized meal programs.

Given the relatively smaller size of the NYP PPS, the PPS Lead Applicant's overarching financial responsibility for DSRIP funds and performance, the varying degrees of the PPS participants' preparedness for a more population health-focused approach to healthcare delivery, and the rapidly evolving nature of the healthcare environment, the PPS selected the Collaborative Contracting Model organizational structure. This decision was made after numerous meetings with internal and external stakeholders, including our interim projects committee; community-based organizations (CBOs) and community physicians in the NYP PPS network (collectively, "Collaborators"); the Project Advisory Committee; the PPS Steering Committee; and NYP's legal counsel. Through PAC meetings, an

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open community webinar and consultations with community Collaborators, the NYP PPS leadership sought feedback on the Collaborative Contracting Model. The participating PAC members and Collaborators were supportive and understood the need to be flexible and nimble in responding to the initial Community Needs Assessment (CNA) and the attributed community's evolving needs.

The Collaborative Contracting Model allows the PPS Collaborators to retain their corporate independence while clearly and consistently defining the performance expectations of each Collaborator. Given the newness of the DSRIP program and the PPS concept, there was no desire to move to the Fully Incorporated Model this early in the DSRIP journey and NYP PPS thought it made sense to select an organizational model that allowed the NYP PPS to develop quick and flexible relationships. NewYork-Presbyterian Hospital (NYP) has successfully leveraged the Collaborative Contracting Model in its NYS Health Home and Medicare Shared Savings Program work. The NYP PPS and its Collaborators view the Collaborative Contracting model as the first step toward a more integrated network that will evolve as the NYP PPS attributed population's needs are more fully understood and our operations are solidified.

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

File Upload: (PDF or Microsoft Office only)

Currently Uploaded File: **39_SEC021_NYP_GovernanceStructure_v2.pdf**

Description of File

The attached file is a graphical layout of the NYP PPS governance structure.

File Uploaded By: ink9012

File Uploaded On: 12/12/2014 10:17 AM

***Structure 2:**

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

The PPS has elected to implement a five-committee governance structure made up of the following committees: Executive Committee, Finance, IT/Data Governance, Clinical/Operations and Audit/Corporate Compliance. To ensure the PPS operates as a single, well-aligned network that is responsive to the community and the goals of DSRIP, the Executive Committee will have the following responsibilities: establishing a single PPS vision and related guiding principles; approving committee charters, policies, and procedures; approving contracts and agreements for the PPS; monitoring PPS performance across Collaborators, vendors and committees; reviewing/approving the addition/removal of any Collaborators; reviewing/approving any submissions/reports to NYS DOH and CMS; addressing issues of non-compliance across the network; developing and approving a dispute resolution process; and, liaising with NYS DOH to adjust project selection, if appropriate.

The Executive Committee is the entity from which all PPS functions receive their guidance/vision and to which they ultimately report. The Executive Committee will include NYP members as the majority (considering NYP's financial risk) with the remaining members coming from Collaborators, with a focus on primary care and post-acute care, which were identified as essential components in the CNA. The Executive Committee oversees the other four committees, with each of those committees led jointly by NYP and Collaborators. These committees will be responsible for executing the Executive Committee's vision and implementing/monitoring the projects and infrastructure identified through the CNA. Beyond oversight of the operations of the 10 selected projects, these committees will also be responsive to DOH's regulatory requirements, including finance and compliance operations.

Starting in January 2015, the NYP PPS will launch the Executive Committee; which will be responsible for developing operational, regulatory and compliance guidelines. These guidelines will be the basis for the organizational charters of the Audit/Corporate Compliance, Clinical/Operations, Finance, and IT/Data Governance committees and will ensure responsiveness to DSRIP and NYS policies and laws. The remaining four Committees will be formed and populated by April 1, 2015. NYP PPS is actively seeking committee participants. As a requirement of participating in the NYP PPS, we have asked that all Collaborators assign senior-level leaders to committees to ensure that the PPS can respond swiftly to programmatic changes and community needs.

NYP PPS will establish a Project Management Office (PMO) in order to support the committee and to provide the operational and project management aimed at ensuring all milestones and metrics are met. The PMO will report to the Executive Committee and hosted at NYP. The PMO will work across the NYP PPS to provide alignment necessary to meet the PPS's DSRIP goals.

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***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.

We expect to launch the Clinical/Operations committee in March 2015 and finalize membership by April 1. The committee will work on establishing the necessary strategies to succeed in the performance period, including defining: Standard care protocols for transitions of care, standards for information exchange within/across PPS, communication plans to Collaborators, community stakeholders and Medicaid beneficiaries, and, standard performance measures and feedback mechanisms.

The Clinical/Operations committee is responsible for implementation and management of the 10 projects. This committee will be jointly led by an NYP Vice President and a rotating Collaborator Executive. This committee will set guiding principles for the 10 projects; however, NYP project leads will be directing each projects' implementation. These project leads will be supported by individual managers, sitting inside the PMO, who will be responsible for the day-to-day project operations. The project managers will report regularly to these committees on implementation metrics (e.g., number of staff hired/trained, outreach efforts, encounters) and relevant quality and outcome metrics (e.g., HIV viral load suppression). The project managers, working with the project leads and project Collaborators, will develop the dashboards and other performance management tools necessary to support this process.

The Clinical/Operations committee will form ad-hoc sub-committees to address specific projects, geographies or functions (housing, nutrition, etc.). The Clinical/Operations committee will also be responsible for coordinating the PPS's efforts with existing ACO, Health Home and other population health initiatives across the network. Ultimately, the Committee will be responsible for ensuring Collaborator and project accountability and defining care protocols to succeed under future pay-for-performance mechanisms.

***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 NYP PPS has developed its governance structure to be flexible and responsive to evolving DSRIP guidelines and community needs. We do, however, anticipate that the structure will evolve throughout the performance period as we become more efficient and plan for future payment reform initiatives and environmental changes. As such, the Executive Committee will be responsible for monitoring the network's performance and any changes in the marketplace; this will include coordination with DOH and the Medicaid managed care organizations. If the Executive Committee determines that a change in governance structure or programmatic operations is necessary to maintain the gains achieved through the DSRIP initiative, it will make adjustments as necessary.

Once the infrastructure, clinical guidelines, workflows, and most importantly, cross-network trust, are established, we believe that the NYP-led PPS might begin to formally align with other population health initiatives and programs such as the recently-created New York Quality Care, a Medicare Shared Savings Program ACO formed by NYP, Columbia University and Weill Cornel Medical College.

Proposed course corrections will be communicated to the other committees and all Collaborators; the PAC will also have the opportunity to review and provide additional recommendations. Ultimately, NYS DOH will be notified 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.

We anticipate launching our 11-member PPS Executive Committee in January 2015. Collaborator members will be expected to keep other providers apprised of Executive Committee decisions. We anticipate this committee will be representative of the key stakeholder populations, similar to:

Organization	Function	Role
NYP	VP, Integrated Delivery System	PPS Executive Lead

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NYP VP, Ambulatory Care Operational Oversight
NYP VP, External Affairs Gov't/Community Relations
NYP VP, Community Health Clinical Oversight
NYP VP, Financial Planning Financial Oversight
NYP Corporate Director, IT Data/IT Oversight
MD Group/FQHC CMO/CQO/CEO Program Oversight
SNF CMO/CQO/CEO Program Oversight
Home Health CMO/CQO/CNO/CEO Program Oversight
CBO CEO/ED Program Oversight
CBO II CEO/ED Program Oversight

While not a having a formal voting membership on the Executive Committee, we intend to provide ample opportunity for the PAC to provide input on the work of the Committee.

***Process 2:**

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

Our governance model supports and will be reflective of an integrated, collaborative and accountable delivery system. Throughout the project planning period the NYP PPS operated with three interim committees: NYP Steering Committee (Hospital senior leaders and PMO staff); Project Advisory Committee (Collaborator representatives); and Project Committee (clinical leaders and PMO staff with active, bidirectional communication with all Collaborators). The NYP PPS also convened one ad hoc committee, the Primary Care Working Group, for project-specific guidance. We anticipate dissolving the Steering and Project Committees and launching our 11-member PPS Executive Committee in January 2015.

Considering NYP is the fiduciary for the PPS, the Steering Committee believed it important that NYP maintain majority control and the composition of the Executive Committee membership reflects that fact. The six NYP senior leaders selected by the steering Committee to serve on the Executive Committee have been actively participating in the DSRIP planning process since NYP submitted the design grant letter of intent. When considering the non-NYP members of the Executive Committee we looked to represent the key provider types, such as nursing homes, FQHCs, primary care physicians, and home care, we believe instrumental in achieving the PPS's DSRIP goals.

The five non-NYP members of the Executive Committee will be rotating positions throughout the four-year performance period, with 10 to 12-month, non-consecutive terms; we anticipate that this time period and membership will be enough to guarantee leadership continuity and ensure equal and fair representation of Collaborators with the potential to impact preventable inpatient and ED utilization. As the initial 10-month term draws to an end, the Executive Committee will work to recruit and seamlessly transition to the next members of the committee. Initial members of the Executive Committee will be selected by NYP and presented to the PAC in January 2015.

We surveyed Collaborators' interest in participating on the Executive and operational committees: Finance, Clinical/Operations, IT/Data Governance and Audit/Corporate Compliance. The membership and leaders of these committees will be selected by the Executive Committee and presented to the PAC by the end of March 2015. The operational committees will be co-chaired by a NYP member of the Executive Committee and a Collaborator that brings significant attribution and/or that has significant potential to impact preventable inpatient and ED utilization. Each committee will be staffed by a PMO representative.

***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.

All Collaborators will be required to serve on an operational committee over the four-year period as a requirement of participating in the NYP PPS. Collaborators have been given the opportunity to select committee roles. The initial size of the operational committees will be detailed in the committee's charter with the aim of ensuring that key provider types (behavioral health, nursing homes, FQHCs, PCPs, home care) and community-based and social services organizations are represented.

Additional Collaborators can be added to the committees and will receive formal invitations from the Executive Committee upon recommendation from existing committee members. The PAC will be notified of changes to the network. As the project evolves, we will ensure that the committees evolve to remain representative. While we anticipate being flexible, we must also ensure that committees do

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not grow to a size that limits our ability to be responsive to evolving needs.

***Process 4:**

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

PPS Collaborators/partners have been included in two key ways. During the initial planning phase, partners and community based organizations (CBOs) have been included as members of the PAC with slightly less than half of the PAC members coming from the community. Moving forward the PPS has elected to implement a five-committee governance structure and all partners will need to serve on an operational committee over the four-year period as a requirement of participating in the NYP PPS. As we move into DSRIP implementation phase our strategy is to contract with CBOs for a defined set of services, on a project-by-project basis, looking to work with those CBOs necessary to achieve the individual projects' goals as well as the overall goals of DSRIP. Over time we foresee an expansion of CBO services within managed care contracts as they demonstrate their value by helping to improve health outcomes and lower overall avoidable utilization.

***Process 5:**

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

The Executive Committee as well as the operational committees will have a committee charter that sets out the decision making/voting processes for the committee. The goal is to have a consensus-driven decision-making process informed by the views of all committee members.

The PPS will adhere to the following decision-making guiding principles for each committee: all committees, workgroups, and ad-hoc entities will have an odd number of representatives; a quorum consists of a simple majority of the groups' members; a decision is confirmed when a simple majority of those in attendance is reached. The Executive Committee will have ultimate authority over all decisions, but specifically, the management of funds, the approval of annual and ad-hoc budgets, and the disciplining of Collaborators for poor performance or non-compliance. As the Lead Applicant and fiduciary to the State, NYP will retain the ultimate responsibility and oversight for overall outcomes and be the final decision-maker on issues not resolved through PPS's consensus-based governance model.

***Process 6:**

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

We anticipate that the preceding guidelines will minimize conflicts/issues that arise in the Executive Committee or other committees. If a committee has an unresolved issue, the decision will be escalated to the Executive Committee. If a resolution cannot be identified or the impasse occurs at the Executive Committee, NYP as the PPS Lead Applicant and working with its legal counsel, will be ultimately responsible for the decision. NYS DOH and CMS leadership will be consulted, if necessary and when appropriate. Assuming the disclosure of information regarding the conflict will not negatively impact the PPS's ability to perform under the DSRIP initiative, the PAC may be consulted.

***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.

To ensure a transparent governing process, the NYP PPS will adhere to the following guiding principles:
1. There will be written notice (posted to the website) of meetings with agendas.
2. The minutes and attendance of all committee meetings will be posted to a PPS intranet within 10 working days.
3. A conference line number will always be provided for all meetings; to the extent relevant, webinar-technology will also be employed.
4. Committee meetings, when held in-person, will be rotated across NYP and Collaborator sites.
5. The PMO will release a monthly newsletter with links to relevant programmatic materials, performance data (as allowed), and details on upcoming 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

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program.

The PPS is committed to open communication among Collaborators and with its attributed Medicaid population. The PPS will employ its quarterly PAC meetings to engage stakeholders and provide recommendations on changes to projects and PPS governance. Slightly less than half of the PAC members are from the community, drawn from local government, public health agencies, educational facilities, senior centers, housing organizations, youth programs and churches.

This year, PPS staff attended public meetings convened by community boards and other organizations to educate the community on DSRIP. We agreed to regularly attend these public forums over the next five years to provide updates and answer questions of families, patients, the media, providers, local elected officials and other community members. The PPS will post all relevant materials to our PPS intranet and ensure that our external-facing website keeps Medicaid beneficiaries abreast of opportunities for providing feedback.

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.

The PAC's initial composition was conceived of during the design grant application period, and upon award of the grant in September 2014, the PAC began monthly meetings. As permitted by its size, the PPS opted for an alternative PAC structure, consisting of 57 members. Slightly less than half of the PAC – 23 members – was invited from the community, drawn from organizations such as community health worker programs, local government, public health agencies, educational facilities, senior centers, housing organizations, youth programs and churches. The community representatives are joined by members from two labor unions, invited based on the union representation of PPS members with more than 50 employees, and 31 representatives from PPS providers. Provider representatives on the PAC cover all PPS provider types and include: behavioral health, substance abuse and disability agencies (14); pediatric institutions (2); primary care (sole and clinic providers) (5); post-acute and long-term care providers (8); state psychiatric providers (2). Membership is flexible and open to change, based on the PPS's network, patient attribution, and Collaborators. The PAC has met monthly since September. Minutes are kept for each meeting, approved by the PAC membership and circulated widely. Participation in PAC meetings is conducted both in-person and via conference line. The PPS will maintain a website that will make publicly available all PAC materials, including minutes, presentations, calendars and attendance records.

***Committee 2:**
Outline the role the PAC will serve within the PPS organization.

As the first standing committee, the PAC has been an integral building block in the PPS's formation. It has served as a forum for education, dialogue and community feedback on the PPS's DSRIP projects, the CNA and on the overall needs of covered communities. In the future, the PAC will transition to an advisory body, providing direct advice and feedback to the Executive Committee. Currently, PAC meetings are quarterly, but it may decide to meet more frequently, convene topical subgroup meetings and reach out to other stakeholders as needed. NYP PPS staff will update the PAC on project activities, progress on quality and outcomes, changes in PPS membership and potential hurdles. Feedback from the PAC also will be solicited in areas such as: ensuring DSRIP projects continue to meet the needs of the community and our Medicaid members; maintaining a high level of cultural competency in all NYP PPS DSRIP activities; unmet service needs; and any other gaps identified in DSRIP projects.

***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).

To date, the PAC has advised the PPS on its formation through surveys and meetings on the proposed PPS governance structure, DSRIP project progress, and community needs. At the suggestion of PAC members, the PPS established a Primary Care Working Group to discuss the role of primary care in DSRIP project development. A Data and Analytics Working Group also will be convened during the project implementation phase at the PAC's recommendation.

A key PAC duty has been providing information for the CNA. A qualitative survey on the needs and health of the community was circulated

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multiple times to PAC members, and responses were incorporated into the final CNA. PAC members were utilized as "grasstops" representatives in this process and collected responses to the survey from their own grassroots employees, neighbors and patients. Preliminary findings from the CNA also were shared with the PAC for feedback and discussion on DSRIP project selection.

***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.

As explained in the first question in this section, we cast a broad net in forming the PAC. Half of its members are from the community, from government to churches. We included NYP's two major unions, SEIU 1199 and NYSNA, because they also represent other PPS members with more than 50 employees. Recently, we have invited the New York City Department of Health and Mental Hygiene to our PAC meetings, since we are working with them on a number of projects, including Tobacco Use Cessation (Project 4.b.i). Finally, our 31 provider-members represent the needs and challenges of all PPS provider types with whom we have developed our projects, from behavioral health to disability agencies.

Section 2.4 – Compliance:

Description:

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

***Compliance 1:**

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

The PPS has appointed the NewYork-Presbyterian Hospital Compliance Officer (Debora Marsden, VP of Compliance and Privacy) as the PPS Compliance Officer to oversee and offer guidance to the PPS on the establishment of an effective Compliance Program. Ms. Marsden, who will report to the Executive Committee, is not legal counsel to the PPS. The Compliance Officer will chair the Audit/Corporate Compliance Committee and attend all meetings of the Executive Committee (as a non-voting member) where there will be joint agreement upon the DSRIP, State and Federal rules and regulations that will be included in the oversight role. Ms. Marsden is also the Compliance Officer for the NYP-led Medicare ACO and, as such, is experienced the applicable, federal, state, and local laws and regulations that govern population health initiatives.

***Compliance 2:**

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

The PPS aspires to the highest levels of personal and professional ethics and to create a culture that promotes understanding of and adherence to applicable federal, state and local laws and regulations. The PPS will establish a Compliance Hotline, posting the number on the PPS website and providing it to all PPS Collaborators and at the regularly scheduled PAC meetings. It is the responsibility of the Compliance Officer to review the PPS Compliance Hotline, assure a thorough and appropriate response to calls or concerns and report the contents and actions taken to the Executive Committee.

The Compliance Officer will also be responsible for reviewing all PPS contract templates prior to their use with Collaborators. Finally, in addition to reviewing the output from the Finance, Clinical/Operations and IT/Data Governance Committees, the Audit/Corporate Compliance Committee will receive independent updates from the PPS PMO.

***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.

Each participating provider has an existing compliance program that is required to comply with the New York State Social Services Law inclusive of mechanisms for identifying and addressing compliance problems and the training of their workforce. The PPS Compliance Plan dictates that the Compliance Officer is responsible for assuring that education and training includes a PPS-wide HIPAA program and establishes audit procedures and that any existing education programs are tailored to DSRIP and includes both the definition of compliance and how compliance irregularities can be reported. Collaborators that are not subject to Social Security law (e.g., non-

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Medicaid billers) will be provided educational materials by NYP.

***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 PPS Audit/Corporate Compliance Committee will require Collaborators to communicate their existing processes (e.g., code of conduct policies, conflict of interest policies, hotlines, etc.) for filing compliance complaints to their members and beneficiaries that must include an anonymous process. Collaborators must also have a policy describing their process for responding to such complaints. These policies will be reviewed and jointly approved by the Audit/Corporate Compliance Committee and Executive Committee. Information on this process will be made available to the PAC and on the NYP PPS website as well.

The PAC will also remain as a method to receive and respond to community members', Medicaid beneficiaries' and uninsured community members' compliance complaints. PAC members will be responsible for making themselves available to receive feedback from the community and fairly representing the complaints to the greater PAC body (while respecting the identity of the original community member).

Section 2.5 - PPS Financial Organizational Structure:

Description:

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

***Organization 1:**

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

The Finance Committee, reporting to the PPS Executive Committee, will have the principal oversight responsibilities for PPS financial matters and will be responsible for developing the following:

- The PPS's financial accountability, oversight and performance monitoring processes
- The budget approval process for DSRIP-related functions (prior to Executive Committee approval)
- The policies and procedures related to funds flow including the financial approval process, with signatory requirements and approval limits, for the general management of DSRIP funds
- The functions and processes to define the financial and performance metrics used to assess Collaborator performance and determine qualification for DSRIP fund payments
- The process and thresholds for escalating budgetary and performance issues to the Executive Committee
- Process for working with the Clinical/Operations Committee and area Medicaid Managed Care Organizations to develop recommendations for specific pay-for-performance initiatives.

Starting in late January 2015 the Finance Committee will begin working with the Executive Committee to finalize the PPS's financial policies and procedures.

***Organization 2:**

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

As stated earlier, the Finance Committee reports to the Executive Committee and has the primary oversight and policy-making responsibilities for all of the financial matters of the PPS. While the PPS will draw upon NYP's resources to operationalize many of its financial functions, DSRIP project funding will be maintained and managed in segregated, specific cost centers and the PPS Finance Committee will maintain responsibility for the following key financial functions:

- Budget development and approval for DSRIP related functions, at both the PPS and project-specific levels.
- Assessment of Collaborator performance and determination of qualification for DSRIP fund payments; oversight of the financial approval process, including signatory requirements and approval limits, for the distribution of DSRIP funds.
- Working closely with the PPS Audit/Corporate Compliance Committee and NYP's internal and external audit functions to oversee the performance of reviews and tests related to the control, oversight and administration of the DSRIP funds as needed and address any issues that might be identified.

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***Organization 3:**

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

NYP has a financial controls department comprised of a Director and five staff who report to the SVP of Finance, CFO and Audit/Corporate Compliance Committee. Most elements of the Sarbanes-Oxley act are embedded within the NYP program, such as narratives, process flows, procedures, controls, control certification, testing and remediation. The financial controls department works with internal and external auditors to mitigate risk throughout the institution. An annual review of internal control processes is conducted to identify areas of potential exposure with necessary plans of correction incorporated into the annual internal audit plans. The PPS Audit/Corporate Compliance Committee and Compliance Officer will draw upon NYP's resources requesting internal audit support as needed and work with the PPS Finance and Executive Committees to determine what external audit needs are required given that no separate legal entity is being formed. When complete, the financial compliance program will meet all requirements of New York State Social Services Law 363-d.

***Organization 4:**

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

As no separate legal entity is being formed, the PPS Audit/Corporate Compliance Committee will work closely with NYP's internal and external audit functions to oversee the performance of reviews and tests related to the control, oversight and administration of the DSRIP funds as needed. Any reports resulting from these reviews will be presented, along with any required plans of corrective action, to the Finance Committee and Executive Committee of the PPS. NYP's compliance program is in accordance with New York State Social Services Law 363-d.

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 NYP PPS will leverage data from the local RHIOs/SHI-NY, the cross-Collaborator Allscripts Care Director care management platform and the NYS Performance Measurement Portal (available via MAPP) to monitor the performance of the PPS overall, as well as the performance of individual Collaborators. This will allow the PPS to look across claims, clinical outcomes, CAHPS and population health metrics. These data will be integrated into an internal PPS dashboard system, including the annual targets that are set by NYS throughout the performance period. We will also use Microsoft SharePoint (or another web platform) to monitor implementation milestones.

To ensure that all Collaborators are focused on achieving the relevant performance metrics, we will build these metrics into contracts with all Collaborators, dictating the minimum level of performance required and thresholds to receive performance rewards.

***Oversight 2:**

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

Once every two months, the Project Management Office will present low-performing providers to the Executive Committee, including specific reports on their meeting attendance, performance measures and implementation reports. Any discussion of poorly performing Collaborators will be conducted in executive session at the Executive Committee and will not be referenced on the meeting minutes distributed to the PPS. If a Collaborator is found to be below the minimum performances measure set in their contract, they will be notified and subject to an intensive review process (by the Executive Committee or its delegate), which may include remediation up to including removal.

***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.

Once a low-performing provider is identified, the Executive Committee will schedule a private meeting within 15 business days of the notice; the identified Collaborator(s) will be notified and invited to attend and present at the meeting. If the Collaborator is non-responsive,

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they will be given a notice that the issue will be escalated to CMS and their release from the PPS will be sought if they do not respond within 30 days of the initial notification.
Following the private meeting, they will be given the opportunity to submit an Improvement Plan.
1. The Improvement Plan must be submitted within 30 days of the initial meeting.
2. The Executive Committee will provide feedback within 15 days of receipt of the plan.
3. The Collaborator will then submit a progress report (as defined by the Executive Committee) within 45 days after acceptance of the Improvement Plan.
4. The collaborator will then submit a final progress report (as defined by the Executive Committee) at 90 days after acceptance of the Improvement Plan.
5. The Governance Board will have 15 days to review/respond to the final progress report.

At any time after 90 days of objective below-minimum performance, the Executive Committee reserves the right to prepare a formal statement to be forwarded to CMS for its approval, requiring the collaborator to leave the network. Those Collaborators that have been dismissed from the PPS will be allowed re-entry once a 365-day period has passed from their original dismissal.

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

Medicaid beneficiaries will be encouraged to provide feedback on the addition/removal of Collaborators through two methods: (1) submitting feedback through a regularly scheduled PAC meeting directly or through a representative; or (2) submitting feedback through the NYP PPS public website. All comments will be reviewed by the PMO and presented to the Executive Committee every other month.

The NYP PPS also will leverage "grasstops" representatives—e.g., local elected officials, community boards, patient advisory boards, and PAC members—to gather feedback from grassroots Medicaid members. The NYP PPS has encouraged its PAC to recommend additional members for inclusion in the group, including individuals from patient advocacy organizations and any underrepresented or vulnerable communities.

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

All additions and removals from the NYP PPS will be distributed via the PAC and will be posted to the NYP PPS public website. In addition and where applicable, we will notify the Medicaid Managed Care Organizations so that the MCOs, as per regulations, can notify affected patients. In those instances were a provider is being removed from the PPS, a detailed plan will be presented at the PAC highlighting how service continuity will be maintained through the addition of a new provider or the expansion or enhancement of programs offered by other PPS providers.

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.

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☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

- 3.1 Overview on the Completion of the CNA
- 3.2 Healthcare Provider Infrastructure
- 3.3 Community Resources Supporting PPS Approach
- 3.4 Community Demographics
- 3.5 Community Population Health & Identified Health Challenges

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

***Overview 1:**
Describe the process and methodology used to complete the CNA.

The Community Needs Assessment represents a collaboration led by NYP with participation from multiple departments across the Columbia Mailman School of Public Health and the Department of Healthcare Policy and Research at Weill Cornell Medical College. This team met on a regular basis to review progress, address barriers and coordinate development of the assessment, which included both qualitative and quantitative data collection and analysis. The NYP PPS solicited community participation and involvement in the needs assessment process. The CNA team fostered community participation and input, through meetings with community leaders, stakeholders, CBO members of the PAC, representatives of Community Districts and groups of community physicians from the PPS regions. NYP's efforts in population health are grounded in community needs assessments and healthcare gap analyses that inform interventions driven by Collaborators. Process and outcome indicators for these efforts are tracked closely to determine collective impact. This CNA represents the foundation of the next generation of population health management for NYP.

The NYP PPS serves patients from New York City, New York State and individuals traveling from elsewhere in the U.S. and internationally. Because NYP is the sole tertiary care provider in the PPS, we oriented the CNA around the core zip codes of Medicaid patients served by NYP's three New York City campuses: Lower Manhattan Hospital (NYP/LM), whose service area includes Downtown Manhattan; Weill Cornell Medical Center (NYP/WC), whose service area includes the Upper East Side of Manhattan, East Harlem and Western Queens; and Columbia University Medical Center (NYP/CU), whose service area includes Northern Manhattan (Washington Heights and Inwood) and the Southwest Bronx. Based on geography, socio-economic conditions and clear identification with hospital campuses, the CNA provides information by hospital campus.

***Overview 2:**
Outline the information and data sources that were leveraged to conduct the CNA, citing specific resources that informed the CNA process.

Broadly, our sources included web sites, internal billing data, Medicaid claims data, journal articles and qualitative feedback and survey data from community leaders. On the web, we reviewed hundreds of sites to collect information about healthcare and community resources, which we gathered and described. We also used several data sources available online, including the DSRIP website, as well as other local, state and national sources of health statistics. Specific examples include: mortality data from the CDC, NYC DOHMH Community Health Surveys, OMH PSYCKES, NYC DOHMH Epiquery and NYS's Prevention Agenda Dashboard. Internally, several queries of NYP billing data provided important information. Our research partners provided several important analyses of claims data.

We created a series of maps to illustrate the distribution of home zip codes for individuals that will be potentially attributed to the NYP PPS. Each set of maps includes a "heat map" which highlights the zip codes with the largest number of the specified patients, and a "percentage map" which highlights the zip codes containing 50%, 75% and 90% of the specified patients.

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Our Collaborators provided invaluable insight via emails, one-on-one discussions, group meetings and a detailed online survey. These data were collected, put into tables and figures, described with narration and organized into reports. The quantitative and qualitative findings of this analysis were shared with stakeholders in a variety of forums such as weekly DSRIP project lead meetings, PAC meetings and individual project team meetings with NYP and community collaborators. In addition, the various CNA components and focused reports derived from this needs assessment were made available to all DSRIP members by means of a shared electronic team site.

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	18	3
2	Ambulatory surgical centers	21	1
3	Urgent care centers	17	2
4	Health Homes	10	10
5	Federally qualified health centers	20	3
6	Primary care providers including private, clinics, hospital based including residency programs	109	21
7	Specialty medical providers including private, clinics, hospital based including residency programs	37	18
8	Dental providers including public and private	47	8
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	48	2
10	Behavioral health resources (including future 1915i providers)	137	35
11	Specialty medical programs such as eating disorders program, autism spectrum early	13	6
12	diagnosis/early intervention	9	4
13	Skilled nursing homes, assisted living facilities	15	15
14	Home care services	65	18
15	Laboratory and radiology services including home care and community access	49	3
16	Specialty developmental disability services	20	3
17	Specialty services providers such as vision care and DME	27	3
18	Pharmacies	62	11
19	Local Health Departments	1	1
20	Managed care organizations	13	3
21	Foster Children Agencies	12	2
22	Area Health Education Centers (AHECs)	12	2

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

***Infrastructure 2:**
Outline how the composition of available providers needs to be modified to meet the needs of the community.

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The PPS service area has a wide array of health services, yet gaps remain. The PPS will address structural gaps through expanding capacity in existing facilities (primary and specialty care), enhancing coordination and the adding culturally competent human resources through our projects, rather than by adding facilities.

The rates of potentially preventable ED visits (PPV) were larger than expected based on risk-adjusted State averages for six out of eight communities we serve. Rates of unplanned readmissions (PPR) were also higher than the State average at all but two local hospitals. The PPS will implement an ED Care Triage program to address the high PPV rate. This program will leverage the existing Patient Navigator Program associated with reduced ED utilization amongst participants, to create teams of Patient Navigators in five EDs across the PPS to decrease preventable ED visits and connect high-risk patients with primary care and specialty providers after ED discharge (Project 2.b.iii). The PPS will strengthen continuity of care between the hospital and outpatient settings to address PPR rates. Project plans include modifying the Transitions of Care protocol among PPS collaborators, implementing RN Transitions Care Managers for the highest risk cases and integrating Community Health Workers into the transition phase (Project 2.b.iv).

The CNA found that each of the PPS regions had a wide representation of primary and specialty providers; however, none of the providers in these communities are recognized PCMH Level 3 clinics under the NCQA 2014 standards. In addition, many of these providers have no or limited ties to care management and hospital resources. To address this gap the NYP PPS plans on developing an Integrated Delivery System (IDS) that will help all participating providers reach NCQA Level 3 2014 designation (Project 2.a.i). The IDS will facilitate coordination of primary care among the PPS collaborators through IT linkages, coordinated care management across the continuum of care and culturally competent communication. The IDS will also create a network of culturally competent Patient Navigators and Community Health Workers who will help coordinate care and reduce service gaps.

Finally, the CNA found that the communities surrounding the NYP PPS have larger percentages of patients with two or more chronic health conditions. This phenomenon was seen in both the adult and pediatric populations and is a contributing factor to the burden of potentially preventable hospitalizations. Further complicating this problem is the lack of access to and availability of health providers. For example, in the NYP/WC service area only 43% of pediatric providers accept Medicaid. Additionally, across the PPS, the majority of providers do not offer primary care after 5 p.m. or on weekends. To address these findings, the NYP PPS will develop an Ambulatory ICU for adults and pediatric populations, focusing on patient-centric care by hiring additional RN Care Managers, Social Workers, Psychiatric NPs and CHWs, and maximizing relationships with CBOs. The program will also extend weekday hours and offer weekend hours to improve access (2.b.i).

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	91	13
2	Food banks, community gardens, farmer's markets	77	8
3	Clothing, furniture banks	19	6
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	13	5
5	Community outreach agencies	19	19
6	Transportation services	11	10
7	Religious service organizations	34	0

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
8	Not for profit health and welfare agencies	27	14
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	21	21
10	Peer and Family Mental Health Advocacy Organizations	9	9
11	Self-advocacy and family support organizations and programs for individuals with disabilities	18	18
12	Youth development programs	19	7
13	Libraries with open access computers	40	3
14	Community service organizations	29	12
15	Education	200	16
16	Local public health programs	3	2
17	Local governmental social service programs	4	2
18	Community based health education programs including for health professions/students	10	10
19	Family Support and training	24	22
20	NAMI	2	2
21	Individual Employment Support Services	48	4
22	Peer Supports (Recovery Coaches)	7	7
23	Alternatives to Incarceration	9	1
24	Ryan White Programs	25	6
25	HIV Prevention/Outreach and Social Service Programs	50	14

***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.

Residents of NYP PPS regions have access to a wide array of community-based resources. Nonetheless, gaps exist, particularly for the targeted population. For example, on the Upper East Side there are no peer and family mental health advocacy organizations or alternatives to incarceration programs. There are no recovery coach services in the Upper Manhattan area. Finally, the Lower Manhattan communities have only one peer support services organization. In order to address these gaps in community resources, the NYP PPS plans to modify the resources available to these communities through the work of our chosen projects.

Behavioral health community resources were identified in the PPS communities; however, a similar access issue occurs with these resources as do with the primary care providers. Numerous programs across these communities report long waiting lists, and there is a critical lack of access to behavioral health resources. To address these gaps, the NYP PPS will embark on two behavioral health initiatives at NYP/CU that will work to create better access for services in the community. First, Project 3.a.i will integrate primary care into behavioral health clinics. Second, Project 3.a.ii will foster greater linkage for community resources through a community-based Critical Time Intervention (CTI) team as well as an ED-based psychiatric triage team. These crisis programs will bring behavioral health services to crisis populations and create more robust linkages among all providers, through IT and other resources.

Yet another community resource gap identified was the lack of Ryan White programs in Western Queens or the Upper East Side, though there are several in East Harlem. Additionally, the CNA found that the Northern Manhattan/South Bronx service area experiences shortages in clinical and care coordination services for people living with and at risk for HIV. Gaps in services include delayed HIV diagnosis and entry to care, homelessness/housing instability and insufficient chemical dependency treatment services. In order to address these gaps, the NYP PPS plans to develop two programs in close collaboration with community organizations that implement NYS's End of the Epidemic Task Force recommendations. The first is an HIV Center of Excellence (Project 3.e.i) that encompasses the NYP/CU and NYP/WC campuses and will focus upon care management and coordination though 1) expanding immediate, low-threshold access to poorly engaged and newly diagnosed people living with HIV (PLWH); 2) integrated behavioral health and chemical dependency services; and 3) a transformed, bundled HIV/HCV/STI testing service that incorporates CBO-sourced CHWs to extend services beyond

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the clinics, deep into surrounding neighborhoods. The second program will work closely with CBOs to target communities throughout the five boroughs to decrease HIV and STD morbidity (Project 4.c.i). The project will forge a new prevention partnership, leverage cutting-edge IT and knit together regional providers to help identify and engage the nearly 40% of HIV-positive New Yorkers who have fallen out of care or are lost to follow-up care.

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 total number of lives covered in the NYP PPS is approximately 1,730,000. This population consists of 47% males and 53% females. The NYP PPS population age groups distribution is broken down as follows: 23% are 19 years of age or younger; 19% are between 20-29 years of age; 16% are between 30- 39 years of age; 13% are between 40-49 years of age; 12% are between 50-59 years of age; 8% are between 60-69 years of age; and 8% are 70 years of age or older. This age distribution prompted us to consider the pediatric and geriatric populations, both of which are often overlooked, when choosing our projects. For the nearly quarter of the population that is 19 or younger, we have developed the Pediatric Ambulatory ICU (Project 2.b.i). For the geriatric population, in part, we have developed a program to integrate palliative care services into our PCMHs (Project 3.g.i).

***Demographics 2:**
Race/ethnicity/language statistics of the population, including identified literacy and health literacy limitations:

The NYP PPS is 45% white, 20% Black, 10% Asian and 24% other; 41% is Hispanic, 26% is foreign-born and 61% speak a primary language other than English. However, there are significant differences among service areas. In the NYP/LM service area, the population is 60% white, 25% Asian, 6% Black and 5% other. The majority of Asians (75%) are of Chinese origin. In the NYP/CU service area, the population is 28% white, 31% Black and 40% other; 61% is Hispanic. Within the Hispanic community, 66% are Dominican, 23% are Puerto Rican. Similar to the ethnic distribution, there are differences between areas in languages. In the NYP/LM service area, 60% speak English as the primary language, 20% speak an Asian language. In the NYP/CU service area, English is the primary language for 35%, Spanish for 55%. Half of the Spanish-speaking public speaks English less than "very well." These differences have profound effects on program design, especially with regard to cultural competency.

***Demographics 3:**
Income levels:

The 2012 American Community Survey describes 699,000 households in the area. Of these, 12% have an annual income of under $10,000, 7% have an annual income between $10,000 and $14,999, 11% have an annual income between $15,000 and $24,999, 9% have an annual income between $25,000 and $34,999, 11% have an annual income between $35,000 and $49,999, 15% have an annual income between $50,000 and $74,999, 9% have an annual income between $75,000 and $99,999 and 25% have an annual income of $100,000 or more. This distribution informed our analyses as well, since almost a third of the PPS population was living at or under the federal poverty line of $23,050 for a family of four (2012 figures). Poverty is a significant social determinant of health and plays a role in how we have designed our projects, e.g., with Community Health Workers who understand and relate to the everyday challenges faced by our patients.

***Demographics 4:**
Poverty levels:

In addition to a third of the population living at or below the federal poverty line, out of 699,000 households, 22% reach their listed earnings at least partially using social security income, 5% do so using cash public assistance income and nearly 22% do so after including food stamp benefits over the 12 months prior to data collection. However, there are some regional differences. For example, in the NYP/CU service area, 17% of the population has an annual income of less than $10,000, compared to 10% in NYP/LM and 8.5% in NYP/WC. The disparities only grow between the areas: 41.5% of NYP/CU service area residents have an annual income of less than $25,000, compared to 24% in NYP/LM and 22.25% in NYP/WC. These disparities informed our decision to place more of our projects at the NYP/CU

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campuses, where the socioeconomic determinants of health were more prevalent.

***Demographics 5:**

Disability levels:

Eleven percent of the total population has a disability, of which 7% is under the age of 18, 55% is between the ages of 18 and 64 and 38% is 65 or older. Again, regional differences can be seen across the PPS. In the NYP/CU service area, 10% of the population under the age of 18 has a disability compared to only 4% in the NYP/LM service area and 5% in the NYP/WC service area. Similarly, there are higher rates of disabled among community residents between the ages of 18 and 64 in the Upper Manhattan/Southwest Bronx regions than in Lower Manhattan and the NYP/WC service area: 59% as compared to 44% and 45%, respectively.

***Demographics 6:**

Education levels:

In the NYP PPS, 425,000 people (25%) are currently enrolled in school. This includes 190,100 nursery school, kindergarten or elementary school students; 82,000 high school students; and 153,000 college or graduate students. The overall education statistics, however, are not encouraging. Among the 1,189,000 people aged 25 years or over who live in the NYP PPS region, approximately 13% have attained less than a ninth-grade education, 10% have completed some high school but received no diploma, 19% have completed high school and received a diploma, 26% have attended some college and 32% have received a college or graduate degree. Again the NYP/CU service area fares the worst, with 17.5% of those 25+ years having attained less than a ninth-grade education, compared to 11% in the NYP/LM service area and 7% in the NYP/WC service area.

***Demographics 7:**

Employment levels:

The NYP PPS population 16 years or older is 1,429,000. Of this group, 926,000 people are in the potential labor force, including 89% who work as civilians, 730 (<1%) who work for the US Armed Forces and 11% unemployed. Of the 823,000 employed as civilians, 34% work in management, business, science and arts occupations; 21% work in sales and office occupations; 33% work in service occupations; and 12% are employed in a range of areas including production, transportation, construction and maintenance. Again differences between the service areas point to the NYP/CU service area as more socioeconomically disadvantaged. In Northern Manhattan and the Southwest Bronx, the unemployment rate is 15%, more than double the U.S. rate of about 6%, compared to an unemployment rate of about 8% (half that of the NYP/CU area) in both the NYP/LM and NYP/WC service areas.

***Demographics 8:**

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

A report from the NYC Mayor's Office, published in December 2013, found that between 2001 and 2012, the number of incarcerated NYC residents in jails and prisons fell 36% (669 to 448 per 100,000). Over the same period of time, the national incarceration rate grew by 3% (622 to 641 per 100,000). In 2012 the incarceration rate in NYC was 30% below the national average. The number of inmates from NYC courts also saw a 34% drop, from 56,370 in 2001 to 37,142 in 2012. The report also found that the number of inmates sentenced in NYC who were housed in NYS prisons at year's end fell 40% (41,880 to 25,316) between 2001 and 2012. Finally, the number of inmates in NYC jails fell 18% (14,490 to 11,827).

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

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

File Name	Upload Date	Description

No records found.

Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

NYS Confidentiality – High

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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:

The top 10 leading causes of death in NYC are: (1) Heart Disease, 16,730 people [age adjusted rate per 100,000: 188.2]; (2) Malignant Neoplasms, 13,399 people [155.1]; (3) Influenza & Pneumonia, 2,244 people [25.2]; (4) Diabetes Mellitus, 1,813 people [20.8]; (5) Chronic Lower Respiratory Diseases, 1,651 people [19]; (6) Cerebrovascular Disease, 1,646 people [18.6]; (7) Accidents Except Drug Poisoning, 1,032 people [12]; (8) Essential Hypertension & Renal Diseases, 980 people [11.1]; (9) Mental & Behavioral Disorders due to Accidental Poisoning and Other Psychoactive Substance Use, 812 people [9.2]; (10) Alzheimer's Disease, 696 people [7.6].

The top 5 causes are the same for men and women. Men are more likely to die from accidental poisoning and HIV, women from septicemia. Diseases of the heart are the top cause of mortality of three race/ethnicity groups: Hispanic, White Non-Hispanic and Black Non-Hispanic. Looking at the boroughs, HIV was in the top 10 for Brooklyn and the Bronx. Though diseases of the heart were the leading cause of death across all five boroughs, it was second to malignant neoplasms for non-residents, reinforcing anecdotally our issue with heart disease.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

Across the PPS the top chronic conditions that lead to hospitalizations include: substance abuse, diseases of the respiratory system, mental health disorders, diseases of the cardiovascular system, Diabetes Mellitus and HIV. For the pediatric population, the largest burden of preventable hospitalizations is asthma. The largest potential gap in pediatric asthma care is in the Bronx, though there are notable gaps in Manhattan and Queens. Among adults, the five conditions with the largest burden of potentially preventable hospitalizations (PQI) are: COPD/Asthma, Heart Failure, Diabetes, Urinary Tract Infections and Bacterial Pneumonia. The communities of the Southwest Bronx and East Harlem have the largest gaps. Though many of the neighborhood rates of PQI are lower than the risk-adjusted State average, there are several opportunities to lower rates to NYS's goal of a 25% reduction below the current average. Our projects--including Ambulatory ICU (adult and peds), HIV (two projects) and Tobacco Cessation--address these chronic conditions and their causes. In addition, behavioral health is a component of all projects as it is both a common primary diagnosis and a prevalent comorbidity.

***Challenges 3:**

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

PDIs and PQIs are measures of ambulatory care sensitive conditions. Using data published by New York State, we found:

PDIs. In pediatrics, the largest number of preventable hospitalizations (PDIs) are for asthma, with notable room for improvement in the Bronx (42% higher than state average).

PQIs. Among adults, the five conditions with the most potentially preventable hospitalizations (PQIs) are for COPD/Asthma in older adults, Heart Failure, Diabetes (Long Term Complications), Urinary Tract Infections and Bacterial Pneumonia. The Southwest Bronx and East Harlem have the largest potential gaps in care.

PPRs. NYP has fewer potentially preventable readmissions (PPRs) compared to the state average, but more than the state goal of a 25% reduction.

PPVs. The largest number of potentially preventable emergency department visits (PPVs) are among residents of the Southwest Bronx and Northern Manhattan. In six out of eight neighborhoods the PPS serves, the observed rate of preventable emergency room visits rate was larger than expected (Southwest Bronx, Lower East Side, Lower Manhattan, Greenwich Village and Soho, East Harlem, Upper East Side).

***Challenges 4:**

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

The five most common diseases among children in our PPS are Asthma (16%), Developmental Delay (9%), Vision Problems (6%), ADD (4%) and Hearing Problems (2%). One in eight children has chronic diseases with medical complexity. Utilization of health services is highest among young children and children with chronic disease and medical complexity. Based on Simon's Medical Complexity

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Algorithm, the majority of children did not have chronic diseases (13,883 children; 63%). A quarter of the children had chronic diseases that were not medically complex (5,445 children; 25%). But one in eight children had chronic diseases that were medically complex (2,796 children; 13%), which informed our development of the Pediatric Ambulatory ICU (Project 2.b.i).

The five most common diseases among adults are Hypertension (37%), High Cholesterol (30%), Low Back Pain (21%), Diabetes (19%) and Depression (18%). In 2013, there were about 130,000 persons living with HIV/AIDS in NYC, accounting for more than 10% of national cases. HIV incidence remains high in NYC: 38.4 cases per 100,000 person years, highest in Manhattan (48.5), compared to 18.0 nationally. NYC has higher rates of gonorrhea, chlamydia and syphilis than the rest of NYS. (All rates cited here are per 100,000 individuals aged 15-44.) For gonorrhea, the rate in NYC is 444.9 for men, 283.1 for women (vs. 284.1 and 235.8 statewide); for chlamydia, the rate is 2,047.6 for women, vs. 1,625.1 for NYS. For primary and secondary syphilis, the NYC rate is 24.3 vs. NYS's 12.4. Bronx and Manhattan have higher rates than other NYC boroughs.

To assist planning, we categorized adults into mutually exclusive categories. We chose eight diseases of interest (sickle cell, COPD, seizures/epilepsy, CHF, renal failure, diabetes, stroke, and asthma). We then counted the number of individuals with only one of these diseases, with and without serious mental illness or substance abuse. We looked also at individuals with exactly two of these diseases, and with three or more of these diseases. In addition, we examined patients with none of these eight, but with at least one other "Major DRG" (Diagnosis Related Group), i.e., one significant medical condition as defined by Johns Hopkins' ACG software. This analysis uncovered that 20% of the PPS population has one or two of the most common chronic conditions: sickle cell, COPD, seizure, CHF, renal failure, diabetes and asthma. Adding individuals with substance abuse and/or serious mental illness along with the chronic conditions, that figure rises to a full 32% of the population.

***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:

Infant mortality rates in NYC have been declining. In 2003, the infant mortality rate was 6.5 per 1,000 live births. By 2012, the infant mortality rate had dropped 28% to 4.7 per 1,000 live births. The leading causes of infant death in 2012 were birth defects, prematurity and cardiovascular disease deaths in the perinatal period.

The number of live births with low birth weight (less than 2500 grams) in NYC in 2012 was 10,336 (8% of all live births). Bronx County had the highest percentage of mothers on Medicaid for live births at 80%. The percentage of preterm births was 10.8% in NYC and NYS, which is lower than in the U.S. (11.6%).

Of the live births in New York City in 2012, few (0.7%) had no prenatal care. Of all mothers with no prenatal care, 77% were Medicaid beneficiaries. Prenatal care that began in the first trimester was provided to 54% of mothers who were on Medicaid. Prenatal care in the second trimester was provided to 72% of mothers who were on Medicaid. Prenatal care in the third trimester was provided to 82% who were on Medicaid.

Adherence to well-child visit schedules needed improvement in four out of six areas of New York City served by the NYP PPS.

***Challenges 6:**

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

The percentage of obese indvidiuals in NYC has increased from 17.8% in 2002 to 24.1% in 2012. Furthermore, in 2012, 31.8% of people were overweight but not obese. Among the boroughs served by the NYP PPS, the obesity rates are: Bronx 32%, Brooklyn 27%, Manhattan 15%, and Queens 22%. Among youth, 20.7% of NYC children and adolescents are obese compared with 17.6% for NYS.

According to EpiQuery, in 2012, 65.4% of people in New York City never smoked, an improvement from 58.1% in 2002. According to the CDC, NYC has a lower rate of smoking than the U.S. as a whole (18.1%) and NYS (16.2%). But smoking in the Bronx was at 18.1% in 2009, making that borough (served by NYP/CU) a prime target for smoking cessation. NYC's 2012 Community Health Survey estimated smoking rates in Lower Manhattan, East Harlem and Southwest Bronx at 17.6-23.0% and Western Queens at 14.2-17.1%.

In NYC, the percentage of adults that self-reported as heavy drinkers was 5.9%, which has been stable since 2002. The rates of heavy drinking in high-risk neighborhoods (highest rate of morbidity and mortality in NYC) are as follows: South Bronx 5.1%; North and Central

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Brooklyn 4.8%; and East and Central Harlem 8.2%.

***Challenges 7:**

Any other challenges:

Community leaders identified these health and health services gaps, via a survey:

Affordability. High costs of living, healthcare, and social services in NYC are burdensome for the elderly, disabled, and chronically ill.

Access. Limited availability of key services, such as appointments with specialty physicians, mental health services, education programs, adult day centers and social services.

Culture. Language barriers and cultural factors that may prevent some individuals from seeking appropriate care.

Education. Several populations would benefit from education about (1) healthier living choices, (2) how to best use the US healthcare system, and (3) how to obtain sufficient health insurance. Such education would be particularly helpful for elderly patients, newcomers to the health system, and individuals with multiple appointments and complex care.

Accessibility. People with disabilities need improved accessibility to transportation, support programs, and information technology.

Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

Description:

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

***Gaps 1:**

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

The CNA identified the following service gaps in the PPS community.

Access to primary/specialty care: Limited hours in evenings/weekends and appointment availability at primary care clinics; significant delays for new patients seeking primary and specialty care; no urgent care center in East Harlem; no FQHCs or safety net pharmacies on the Upper East Side; and less than half of general physicians, pediatricians and OB/GYNs in the NYP/WC service area accept Medicaid.

Access to behavioral healthcare: Despite a roster of 62 behavioral health centers in Northern Manhattan and the South Bronx, the number who provide timely access for Medicaid patients is less than 20. Among these, Palladia, Inwood Community Services and Morris Heights Center provide reasonably timely availability, but are unable to meet ambulatory crisis management and psychopharmacological care most urgently needed. In addition, although 80 Medicaid credentialed physicians attest they prescribe basic psychiatry medications, only Board Certified Psychiatrists may prescribe for complex seriously and persistently mentally ill (SMI) patients. New SMI patient appointments are limited with these providers; access is insufficient to serve a high utilizing population with a primary psychiatric diagnosis. In addition, there are gaps in timely access to pediatric behavioral providers.

Challenges in navigating the healthcare system: A survey of our Collaborators highlighted just how complex and difficult to navigate the U.S. healthcare system is for the elderly, immigrants and people with multiple chronic/complex conditions in our community. Providers typically do not address the insurance, language, culture and socio-economic barriers to good health. Clinical interventions alone are an inadequate response to the health issues of this community without an understanding of insurance coverage, linguistically appropriate discussions of disease progression/prevention, culturally-sensitive recommendations for disease management and close attention to the socio-economic issues that compound health (housing, nutritional support, education, employment). In addition, medical services are focused on addressing only a specific disease state. As a result, it becomes incumbent upon the patient to assume responsibility for integrating his or her own care. This is an enormous challenge for an educated, native patient of means; it can be insurmountable for an elderly person or non-native speaker with multiple chronic conditions. Creating a system of support and integration—through resources like culturally competent Patient Navigators/Community Health Workers; community-based clinic, social support and advocacy sites; and

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an investment in connecting patients to their providers and to agencies that best advocate for them—is essential to improving quality and creating a sustainable system.

The DSRIP application was released in the fall after the NYP PPS had already completed its CNA based on June 2014 guidance, which did not include any reference to bed reductions. Given the original guidance, no efforts were made to capture the information necessary to make detailed estimates of bed reductions.

***Gaps 2:**

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

The identified gaps in access and navigation are not structural but the result of healthcare access barriers grounded in cultural and social determinants of health. These barriers affect patients' use of the system and ultimately their health outcomes. Dr. Emilio Carrillo, NYP's VP-Community Health, has done extensive research into these barriers, resulting in a comprehensive, evidence-based understanding of how they prevent access for minority and poor communities. The three types of barriers are reciprocally reinforcing and affect healthcare access individually or in concert. Each barrier is associated with low preventive screening, late presentation to care, lack of treatment and often improper utilization of healthcare services, which in turn result in poor health outcomes and health disparities.(1)

Among the PPS communities, the CNA found evidence of significant social and cultural determinants of health which are associated with the aforementioned healthcare access barriers. Large percentages of foreign-born residents and low rates of English-speaking patients are present in the NYP PPS service area. For example, 40% in the NYP/CU service area are foreign born, 30% in NYP/LM and 31% in NYP/WC. Similarly, the PPS service area experiences high percentages of residents who do not report English as their primary language: 65% in the NYP/CU service area, 41% in NYP/LM and 45% in NYP/WC.

Poverty is yet another contributor to gaps in access, understanding and health outcomes for PPS communities. For example, residents of the PPS have low median household incomes: the NYP/CU communities report median incomes of $25,000-34,999/year, while those of the NYP/LM and NYP/WC service areas are between $50,000-74,999/year. Though patients in the NYP/WC service area may seem better-off, the statistics are skewed by wealthy neighborhoods of the Upper East Side, most of whom do not receive care in the PCMHs the PPS is targeting with its DSRIP initiative. Communities in the PPS have high unemployment (11% compared to 6% nationally) and high rates of uninsured residents: approximately 18% in NYP/CU, 9% in NYP/LM and 13% in NYP/WC.

{References available on last page of CNA.}

***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 the identified gaps includes strengthening care coordination among providers and community-based resources using the evidence-based and proven NYP RHC population health model, which integrates IT and population health tools, culturally competent interdisciplinary teams, risk stratification using targeted care management, and culturally competent Patient Navigators (PNs) and CHWs to optimize care of the PPS' poor and immigrant population.

For example, ED Care Triage (2.b.iii) creates teams of PNs (who are trained as CHWs and represent the communities served) in EDs across the PPS to decrease preventable ED visits by providing culturally relevant education and support, and by connecting high-risk patients with primary and specialty providers after discharge from the ED. Care Transitions (2.b.iv) strengthens continuity of care between the hospital and outpatient settings, reducing readmission rates. Ambulatory ICU for adults and children adds RN Care Managers, Social Workers, Psychiatric NPs and community-based CHWs to existing staff to manage patients with multiple comorbid chronic conditions.

These barriers will also be addressed through development of an Integrated Delivery System (IDS), through which the PPS will support achievement of NCQA Level 3 2014 designation for appropriate providers and facilitate coordination of care among Collaborators through common IT platforms, coordinated cross-continuum care management and culturally competent training and staff. IT tools include Allscripts and Epic-based provider dashboards; Microsoft's Amalga which creates/operates disease registries that enable care

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management across multiple providers; and Allscripts Care Director, customized by NYP to Health Homes and implemented in over a dozen collaborating health and human service agencies and providers across the NYP PPS.

Finally, the PPS will address gaps by linking patients to appropriate Collaborators, who span a wide breadth of medical services (e.g., behavioral, primary care, hospice and long-term care) and non-medical services (e.g., needle exchange, legal assistance and housing). We plan to strengthen the referral process, create greater coordination services and develop collaborative care plans that address the diverse needs of our patient population through greater inter-agency communication, IT linkages & increase data sharing

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).

The identification of public health priorities reflect quantitative and qualitative findings based on the CNA. Information from community stakeholders and leaders, as well as input collected during public participation through interviews and formal group meetings, served as the foundation for the final needs assessment. The PPS has engaged several key stakeholders, gathering expertise from clinical teams, hospital administration, health information technology specialists, public health and health services research and community leaders. The process included formal and informal meetings. For example, the CNA was a regular topic of discussion at weekly DSRIP meetings at NYP lead by hospital leadership and attended by clinical leaders, researchers and IT specialists. The CNA and gaps in care were also discussed and shared with members of the hospital's Provider Advisory Council (PAC). Preliminary findings were shared with PAC membership at the first meeting. NYP also surveyed community leaders to better understand gaps in health and health services in the neighborhoods they serve. (See next section.) Findings were shared with community leaders at the project advisory committee meeting.

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

NYP distributed an online survey to community leaders to better understand the gaps in health and health services in the neighborhoods they serve. The result is the last section of the CNA: C. Health and Health Services Challenges Facing the Community. There were 33 respondents representing 24 community organizations. The respondents were leaders within their organizations, including five CEOs/Presidents and seven VPs. Organizations that participated in the survey included private healthcare organizations, community outreach organizations, community board members and community physicians. The populations served by these organizations include: elderly individuals, people with a chronic condition or multiple chronic conditions, the homeless, people with a mental illness, people with disabilities, people of low socioeconomic status and the uninsured. All the organizations provide services to individuals served by the proposed NYP PPS. Half were most closely connected with NYP/CU, a quarter were most closely associated with the NYP/LM, and a quarter with NYP/WC. A thematic analysis of the free-text responses was conducted to determine similarities in challenges facing the community.

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

Affordability. High costs of living, healthcare & social services are burdensome for the elderly, disabled & chronically ill. Connections with low/no-cost social services providers can alleviate this burden.
Access. Limited access exists to specialty physicians, mental health services, transportation and technology. We must expand access and support new services.
Culture. Language and cultural barriers prevent individuals from seeking appropriate care. Integrating culturally diverse providers who understand the reservations of these populations helps target their needs.
Education. The elderly, newcomers & chronically ill are ill-prepared to manage their care. Education about healthier choices, navigating the healthcare system and obtaining insurance is critical.
Inappropriate healthcare use. Many patients wait until an emergency arises before seeking care. Poor adherence to treatment regimens worsens outcomes. Bringing services to patients in their communities can reduce these behaviors.

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High-risk behaviors. Tobacco/substance abuse, high-risk sexual behavior and poor nutrition are common. Culturally appropriate education and community-based social services can reduce such behavior.

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.

[The New York and Presbyterian Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Washington Heights/Inwood Regional Health Collaborative	A coalition of community based organizations, churches, local schools, mental health agencies, local providers, and public health experts formed to improve the population health of the predominantly low income, Hispanic population of the Washington Heights and Inwood communities in Manhattan.	Community-based, culturally competent, population-focused healthcare and social services is at the heart of both the Collaborative and DSRIP. Integrating the Collaborative and its members into the PPS was a critical building block.
2	Manhattan Community Boards 1 and 12 (CB 1 and CB 12) (PAC Member)	Washington Heights/Inwood and Lower Manhattan neighborhood advisory councils that engage local residents and stakeholders in assessing community needs and conducting long term planning in areas such as housing, human services, and health. These organizations provide a regular forum, open to the public and media, for discussion and education on important local issues.	DSRIP prioritizes transparency, community need, and open public engagement in PPS planning.
3	Community Physicians of NYP/Columbia University Leadership Group	The Community Physicians group is open to 25 local, independent primary and specialty care physicians serving a large population of Medicaid patients in the Washington Heights and Inwood communities in Manhattan. NYP has assisted many of these independent physicians in attaining Level III PCMH status.	Connecting hospital inpatient and emergency department patients with community-based primary care is a large part of many of the PPS's projects.
4	NYP/1199 Workforce Training Academy	A joint labor/management training fund at NYP/Columbia focused on retraining support staff for placement in new positions.	Workforce training is an important component of DSRIP.
5	Stanley Isaacs Neighborhood Center (PAC Member)	Multi-service community based organization serving low income and vulnerable residents in Manhattan's East Harlem and Yorkville communities in areas such as job training, youth programs, mental health, senior services, and nutrition.	Community-based mental health and nutrition services are an important part of the PPS's strategy.
6	Council of Senior Centers and Services (PAC Member)	New York City membership organization consisting of over 200 senior service agencies in the city.	Seniors with chronic conditions are a target population of PPS projects.
7	Broadway Housing Communities (PAC Member)	A non-profit supportive housing developer in New York City	Access to affordable housing is a priority in the PPS's communities and will be an underlying need in its DSRIP projects.
8	Jewish Community Center of Washington Heights-Inwood (PAC Member)	Community social services organization that provides crisis intervention, housing assistance, nutrition programs, and transportation services.	Increasing access to social and human services for at-risk populations is a critical component of PPS projects.
9	YM & YWHA of Washington Heights (PAC Member)	Northern Manhattan human services organization targeting children, adults, and seniors.	The PPS is undertaking projects targeting all age groups, which will necessitate multi-generational community services.

Section 3.8 - Summary of CNA Findings:

Description:

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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.

[The New York and Presbyterian Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Delivery system that integrates medical, behavioral & social services to improve population health	At the core of the PPS's projects is recognition that the community needs an integrated delivery system that provides both healthcare and services that address the social determinants of health across the continuum, from preventive to end-of-life care. The CNA found a wide array of primary and specialty providers and social service organizations. However, how these resources are knit together is still fragmented and incomplete. For example, few providers are recognized PCMH Level 3 clinics under the NCQA 2014 standards which represent one measure of integration. In addition, many of these providers have no or limited process and technology ties to care management and hospital resources, which results in fragmented care for patients returning to the community. Finally, the lay resources--Community Health Workers and Patient Navigators that support patients culturally and linguistically—remain insufficient and episodic in their interactions. The PPS is uniquely positioned to assess, prioritize and support this integration, investing in the technology, culturally competent human capital and service innovations required to achieve sustainable performance at a high level. For example, the PPS will help all participating providers reach NCQA Level 3 2014 designation; facilitate coordination of care among PPS collaborators through technology, coordinate care management across the continuum; and ensure culturally competent communication through embedded community resources.	Collaborator Survey
2	Care/community team that addresses cultural/language barriers to, and social determinants of health	The NYP PPS communities face structural, financial and cognitive challenges that affect their utilization of healthcare resources and ultimately their health outcomes. This community has known cultural and social barriers to health. These barriers manifest in low preventive screening, late presentation to care, lack of treatment and improper utilization of	U.S. Census; American Community Survey; Collaborator Survey; Data Resource Center; Primary Health Care Experiences of Hispanics w/ SMI, Adm Policy Ment Hlth 2013;

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[The New York and Presbyterian Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		healthcare services, which in turn exacerbate health disparities. The CNA, NYP experience and Collaborator survey feedback confirm this. The NYP PPS community is a study in these challenges. It includes large percentages of foreign-born and low rates of English-speaking patients who suffer from measurable health disparities. For example, Hispanic English-speaking families and Hispanic non-English speaking individuals have significantly lower outcomes for the six core Maternal and Child Health Bureau outcomes for CSHCN. Also, focus groups conducted with Hispanics with Serious Mental Illness in Northern Manhattan by the Center for Cultural Competence at the NYS Psychiatric Institute reveal that they will not seek primary care due to perceived stigma and discrimination, lack of culturally adapted care and language barriers. In addition, poorly aligned culture, religion and ethnicity may prevent physicians from offering this population palliative care. Our experience in the Regional Health Collaborative supports a model of culturally diverse providers actively engaging with patients to understand reservations & target needs.	Disparities In Access To Palliative Care, Health Affairs Blog 2014; Defining & Targeting Health Care Access Barriers, JHCPU, 2011
3	Full array of integrated and accessible primary, specialty, behavioral and palliative care	The community needs a less complex yet more complete healthcare system. In its current form, the system presents a barrier to access. Primary and specialty care are siloed. Lack of cultural and linguistic competence further exacerbate the disconnect: poorer healthcare for major medical illnesses such as hypertension and diabetes, poorer access to palliative care and racial disparities in disease prevalence are well-documented. Community outcomes reflect this failure of integration: Behavioral Health quality metrics were lower than the state average for 24 of the 53 metrics (with data) across neighborhoods served by the PPS. People with chronic mental illnesses lose 10-25 years of life expectancy due to medical illnesses. Supporting these findings, Collaborators highlighted the need for better access and coordination of mental health care. Palliative care referrals are infrequent & delayed. There is a lack of options for palliative care in our service area; few community providers have the capability of providing it. Integration of services within sites (e.g., bringing palliative care & tobacco cessation into PCMHs and primary care into behavioral health clinics) can	Collaborator Survey; HEDIS; Primary Healthcare Experiences of Hispanics w/ SMI, Adm Policy Ment Hlth 2013; SMI & risk of CVD, JAMA 2007; Low rates of treatment for hypertension, dyslipidemia & diabetes in schizophrenia, Schz Res 2006; Disparities In Access To Palliative Care, Health Aff Blog 2014

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[The New York and Presbyterian Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		simplify the system and close gaps. One model to emulate is Designated AIDS Centers. People Living with HIV/AIDS obtain multidisciplinary care, including primary care, dentistry and behavioral health. While opportunities exist to enhance this model, it offers a basic model of integration lacking elsewhere.	
4	Sustainable connections to community-based primary care to promote appropriate healthcare use	The community needs to be better connected to primary care that is available in the right place at the right time. In the absence of accessible primary care, many people wait until an emergency arises before seeking care. The data reflects this: in six out of eight neighborhoods, the observed rate of preventable emergency room visits (PPV) was larger than expected. In addition to avoidable ED visits, the data shows rates of unplanned readmissions (PPR) were higher than the State average at all but two of the local hospitals. These rates suggest gaps in services or the coordination of such services. However, primary care availability is only one part of the solution. Our patients require education on using primary care for semi-urgent needs and rely heavily on Patient Navigators and Community Health Workers to help them secure warm handoffs and sustain the relationships to primary- and community-based-care. To promote appropriate utilization, the PPS needs to build integrated primary and behavioral care capacity in the community; deploy patient navigation resources that will connect patients seeking care in the ED to that care; employ care managers to oversee successful transitions post-discharge and manage the most chronically comorbid pediatric and adult patients in the ambulatory and home settings; and retain Community Health Workers who will work to sustain patients' connections to care when they return to their communities.	Collaborator Survey; 3M - Potentially preventable emergency department visits (PPV); 3M – Potentially preventable readmissions (PPR)
5	Intensive care management and community support for people with multiple comorbid conditions	The community demands better coordinated care for its sickest community-based residents. 20% of the PPS population has one or two of the most common chronic conditions: sickle cell, COPD, seizure, CHF, renal failure, diabetes and asthma. Adding individuals with substance abuse and/or serious mental illness along with the chronic conditions, that figure rises to a full 32% of the population. In addition, NYC continues to be the epicenter of the HIV/AIDS epidemic in the U.S. In 2013, there were an estimated 130,000 people living with HIV/AIDS in	2012 Medicaid Claims data; HCUP; AHRQ PQI; Hopkins ACG software; NYC DOHMH HIV Epidemiology and Field Services Program Semiannual Report, 2014; Centers for Disease Control and Preventions, NCHHSTP Atlas

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[The New York and Presbyterian Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		NYC, accounting for over 10% of national cases. Furthermore, HIV incidence remains high in NYC, with a reported rate of 38.4 cases per 100,000 population, more than double the incidence of 18.0 per 100,000 nationally. These patients all need intensive care management coordinated seamlessly as they move through the continuum. The best models attend to behavioral as well as medical care needs, delivering the right level of service based on how the patient's disease, support system and ability to self-manage evolves. NYP's successful Regional Health Collaborative, an effort that involved a broad array of NYP and community resources, demonstrated that this model is possible, achieving measureable outcomes for targeted populations with CHF and diabetes. Building upon this foundation across a broader array of conditions including COPD, HIV and renal disease will better meet this community's needs.	

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
39_SEC038_DSRIP NYP PPS Community Needs Assessment APPENDICES_FINAL.pdf	12/22/2014 02:40:42 PM	NYP PPS CNA Appendices
39_SEC038_DSRIP NYP PPS Community Needs Assessment_FINAL.pdf	12/22/2014 02:40:06 PM	NYP PPS CNA

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

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **NY Presby_Section4_Text_NYP PPS DSRIP Project Plan Application _ Section 4_FINAL.docx**

Description of File

NYP PPS Section 4: 2ai, 2bi, 2biii, 2biv, 3ai, 3aii, 3gi, 3ei, 4bi, 4ci

File Uploaded By: debcg

File Uploaded On: 12/22/2014 04:37 PM

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

Currently Uploaded File: **NY Presby_Section4_ScopeAndScale_NYP_DSRIP Project Plan Applications _ Scale & Speed only _ 20141221_DCG.xlsx**

Description of File

File Uploaded By: debcg

File Uploaded On: 12/22/2014 07:23 AM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

5.1 Detailed workforce strategy identifying all workplace implications of PPS
5.2 Retraining Existing Staff
5.3 Redeployment of Existing Staff
5.4 New Hires
5.5 Workforce Strategy Budget
5.6 State Program Collaboration Efforts
5.7 Stakeholder & Worker Engagement
5.8 Domain 1 Workforce Process Measures

Scoring Process:

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

5.1 is worth 20% of the total points available for Section 5.
5.2 is worth 15% of the total points available for Section 5.
5.3 is worth 15% of the total points available for Section 5.
5.4 is worth 15% of the total points available for Section 5.
5.5 is worth 20% of the total points available for Section 5.
5.6 is worth 5% of the total points available for Section 5.
5.7 is worth 10% of the total points available for Section 5.
5.8 is not valued in points but contains information about Domain 1 milestones related to Workforce Strategy which must be read and acknowledged before continuing.

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

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

***Strategy 1:**
In the response, please include

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

Understanding that a talented, patient and customer-focused workforce guarantees the best outcomes for patients and supports the goals of the DSRIP initiatives, the PPS is actively working to define an overall approach to workforce retraining, redeployment and hiring. Our program is designed to minimize or reduce any impacts to existing workforce.

Retraining and redeployment plans include an assessment, training and remediation for talented workers who need additional support. NYP is committed to retraining and redeploying existing talent within the organization to fit new roles as well as recruiting community talent.

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The PPS strategy will include retaining the 1199SEIU League Training and Employment Funds (TEF) as the lead workforce development provider. Using TEF's expertise (some of which is outlined in Section 10), the PPS will identify at-risk workers and retrain for new and emerging positions, provide training to incumbent workers who need additional skills to do existing jobs and develop training for new occupations. The scale and scope of TEF's efforts to provide education and training to a broad spectrum of workers has facilitated the establishment of several educational partnerships. These education professionals are experts in adult learning styles, training strategies, interdisciplinary teams and content for the new healthcare delivery environment. Additionally, these partnerships afford TEF staff the ability to establish programs quickly.

TEF will screen and contract with the most suitable educational vendors to deliver high-quality training conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where high-quality workforce and certificate programs meet industry needs. Working with TEF ensures access to services and expertise of all nine of its Funds—such as the Training and Upgrading Fund and the Job Security Fund—which have experience across the healthcare sector. Training will also be delivered by external resources from the community or by the NYP internal training department (Talent Development).

The extent to which existing workers will be redeployed and retrained or to which existing positions will be reduced is project dependent. We predict the following workforce categories of existing staff will be impacted:

- Administrative (Program Managers, Program Coordinators)
- MDs and Primary Care Physicians
- RNs
- NPs
- Social Workers
- Psychologists
- Patient Navigators
- Healthcare Navigators
- Community Health Workers
- Other Collaborator Positions (Health Educators, Translators, etc.)
- Other Corporate Services as needed (IT, Communications, etc.)

Our plan to address changes is to redeploy employees on a voluntary and "fit-for-role" basis, retrain employees identified to be displaced or redundant so that they have skills to accept new roles or positions, train staff in their current roles to accept new responsibilities or duties and train staff for reassignment.

***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.

Retraining and redeployment plans include an assessment strategy, a training approach and remediation for talented workers who need additional training and support. The NYP PPS is committed to retraining and redeploying existing talent within the organization to fit new roles identified as part of the DSRIP efforts in order to minimize the negative impact on existing workforce. We are also committed to recruiting community talent, as necessary, across the PPS.

Workforce shortages, such as those expected for providers of behavioral health and palliative care, will be addressed through the acquisition of new talent into the organization. NYP's comprehensive talent acquisition strategy includes utilizing its innovative and cost-effective recruitment strategies to generate interest and trust in NYP as the PPS lead, and create a diverse, community-focused talent pipeline for the DSRIP projects. Marketing of the DSRIP positions includes posting job openings on NYP's Careers Website and external online job boards, as well as using direct marketing outreach to share the postings with NYP's current candidate pipeline.

For hard-to-fill DSRIP positions, such as Psychiatric Nurse Practitioners and Palliative Care specialists, NYP's Talent Acquisition

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department will apply a search firm approach to source and recruit top talent. This approach entails dedicated Talent Acquisition staff that will rigorously identify qualified candidates through networking, research and constant pursuit of a pipeline matching the position specifications. NYP will also host career events, such as professional conferences and interview days, dedicated to the type of human capital needed.

For past projects in which NYP recruited hard-to-fill clinical positions, our sourcing strategy included:
• Mining NYP's candidate database and engaging potential candidates via cold-calling, emailing, and sending invitations for our career events. The candidate database consists of former employees who no longer work with the Hospital, previous NYP Continuing Education course attendees, prior cold-call leads, and candidate profiles on LinkedIn.
• Leveraging NYP's electronic candidate relationship management (eCRM) tool in which email messages are sent directly to potential prospects with information on the Hospital, department, and open position.
• Search engine marketing (SEM) and pay-per-click (PPC) job advertising on Google, Indeed, SimplyHired, LinkUp, and FindTheRightJob.com.
• Direct marketing, which send email blasts and postcards to potential candidates that belong to relevant professional networks, such as Nursing Spectrum and Advance for Nurses.
• Posting jobs online on external websites, such as Nurse.com, DiversityNursing.com, and American Hospital Association.
• Banner advertising targeting a job seeker audience by both geographic and professional experience standards.
• Print advertisements circulated in professional magazines and research journals.
• Hosting career events, such as professional conferences and interview days, dedicated to the type of human capital needed.

NYP will offer is vast expertise in this realm to other members of the PPS where needed. Appropriate training will be provided to all new hires. Various training formats will be made available and accessible to workers and their schedules in order to mitigate negative ramifications to the existing workforce and shorten the learning curves of the new hires.

***Strategy 3:**

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

Workforce Implication	Percent of Employees Impacted
Redeployment	10%
Retrain	10%
New Hire	80%

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.

Many incumbent workers will remain in their jobs but need new skills. New skill needs might include communication skills, working in teams or supporting care transitions. TEF will assist the PPS in partnership with NYP's internal training department (Talent Development) to assess redeployment skills needed and create development programs to adequately prepare staff for the new functions.

The scale and scope of the TEF's efforts to provide education and training to a broad spectrum of workers (both union and non-union) has

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facilitated the establishment of educational partnerships with providers that have the willingness, capacity, and expertise to provide programs that afford TEF the ability to retain and contract with education professionals who are experts in adult learning styles, training strategies for interdisciplinary teams, and content for the new healthcare delivery environment.

Additionally, these partnerships afford TEF staff the ability to establish and open programs quickly. For this DSRIP project, TEF in partnership with NYP will screen and contract with the most suitable educational vendors to deliver high quality training. Training will be conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. In addition, TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where high-quality workforce and certificate programs meet industry needs.

We will ensure that a multitude of training opportunities and varied delivery formats will be made available to allow training to be voluntary and accessible to workers and their schedules in order to mitigate negative ramifications to existing workforce. Training will be offered via a blended approach including face-to-face, instructional, and e-learning. Training will be broken out into the following areas:

- New Hire Orientation to acclimate the new hires to the PPS, its goals, culture, etc.
- Training on new skills and processes for those moving into new roles in the organization.
- Soft /interpersonal skills to build capabilities of those moving into more patient-facing roles.
- Mentorship/preceptorship where appropriate to provide ongoing support to the employee.

Retraining will be voluntary. We will ensure that a multitude of training opportunities in varied delivery formats will be made available to allow training to indeed be voluntary and accessible to all workers, and their schedules, in order to mitigate negative ramifications to existing workforce. Training will be offered via a blended approach including face to face, instructor-led and eLearning to meet different learning styles and address any generational learning issues.

***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.

As new skill sets and training needs are determined for existing jobs, HR – Compensation will partner on projects to update job descriptions and assist in identifying internal job opportunities of similar nature for identified at-risk workers. There will be no negative impact to salary or benefits of at-risk workers provided training to enhance additional skills needed to function in existing job and determined to be prepared upon completion of training.

We will analyze any necessary benchmarking of compensation salary bands and benefits and perform the necessary market research and adjustments as a result of up-skilling/retraining/redeployment.

Incumbents identified for new and emerging positions as well as new occupational training will be consulted on which opportunities offer minimal, if any, impact to salary to mitigate any negative outcomes. Where appropriate and deemed that additional training has prepared workers to function competently in higher level positions, the redeployment of staff may result in an increase to salary.

***Retraining 3:**

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

Employees who refuse redeployment will be consulted on additional opportunities elsewhere within the organization they are suited for based on individual's qualifications, prior experience and skill set, and allowed to apply for vacant positions. All efforts will be made to assist these employees in finding placement within the organization's open positions with the least possible impact to salary.

***Retraining 4:**

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

Where applicable (depending on campus and project), the PPS's internal Labor Management group will work with TEF as the lead workforce development provider. Both groups will communicate and partner with affected labor groups to ensure that the retraining is communicated to them and address any of their concerns.

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

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	90%
Partial Placement	10%

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:
Please outline expected workforce redeployments.

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

All redeployment options will be reviewed in-depth to determine the most beneficial arrangement for impacted staff and ensure the least possible impact. Options will be prioritized to mitigate any negative impact. For example, we will provide ongoing communication about and access to open positions so that they can express interest and pursue as needed. We will meet with individuals to provide them with an in-depth overview of the positions and how their skill sets and expertise potentially match to that position.

NYP will partner with TEF and other external training and community organizations to discuss redeployment options with employees and provide training support to fill gaps in skills for redeployed positions in order to minimize negative impact to these positions.

***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.

Additional skills, job duties and minimum qualifications outlined for internal jobs will be incorporated into job descriptions. The HR – Compensation department will assess and re-evaluate changes to impacted jobs to determine if any increases to salary would be warranted for current staff prepared to take on new functions.

Redeployment into established union roles will provide compensation at the contractual rate of pay for identified job based on the outlined grade and market value of the role; health and pension benefits will be provided in line with the offerings covered through the contract. Redeployment into non-union roles will involve salary assessments in comparison to the salary range of new job to minimize any negative salary impact for outlined transition; health and pension benefits for non-union roles will be provided by NYP and PPS Collaborators consistent with their respective offerings for all non-union positions.

Changes with impact to salary and/or benefit offerings will be outlined and reviewed in detail to ensure minimal impact, full understanding of affected employee and seamless transition.

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

Our workforce strategy intends that every individual who wants a role will be able to have a role. Staff with the same position titles may be asked to move to a different department or unit. If they choose not to accept this new position, they will have the opportunity to apply for other vacancies across the organization. If redeployment is refused, however, separation discussions may occur.

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

Where applicable (depending on campus and project), the PPS's internal Labor Management group will work affected labor groups to ensure that the redeployment is communicated to them and address any of their concerns as well as to facilitate the process in a way that

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has the least amount of impact to the employees.

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 PPS has identified a need to hire approx. 153 FTEs. We think of these new jobs as follows:

Primary Care Providers (see 7.8 FTE "Physicians" and 13.7 FTE "Nurse Practitioners" in the table below): New providers include physicians, NPs and possibly physician assistants. Providers will be located in the NYP ACN, behavioral health clinics and the community, and will deliver the much-needed primary care to Medicaid beneficiaries referred from the EDs; provide care for behavioral health patients lacking primary care; and support the HIV patient population.

Care Managers (see 18.25 FTEs of 22.1 "Mental Health Providers Case Managers" below): Care managers are RNs or Social Workers. They may be located in hospital-based clinics to support ongoing management of complex patients with ambulatory care sensitive conditions through phone contact, facilitation of inter-disciplinary rounding and in-person consultation, among other things. Some will be inpatient-based and assume responsibility for the patients at high-risk for readmission 30-days post-discharge. Others will work in and with community-based providers of care.

Behavioral Health Practitioners (see remaining 3.9 FTE "Mental Health Providers Case Managers" and 3.5 FTE "Social Workers" below): This cohort includes psychiatrists, psychologists, psychiatric NPs and social workers. Because of the priority placed on integrating behavioral health capacity, competency and awareness in all settings, behavioral health practitioners will be hired into community sites (e.g., to support tobacco cessation services), the ED (e.g., to facilitate triage/referral to CTI) and the HIV COE/Ambulatory Care ICUs (e.g., to address the mental health comorbidities of these populations).

IT Staff (as below): A strong IT team is needed to develop the broad IT competency required. Developers and application managers are needed to support the care management platform and in-home/community applications, and develop the functionality needed to effectively deploy registries, order sets and interfaces in the inpatient and ambulatory EHRs. Analysts are needed to develop the robust data warehouses and performance metrics required to help the PPS understand performance. IT trainers are needed to support the deployment of new technologies to the PPS membership.

Administrative (as below): This group includes project/program management and supervisors for the major expansion in both the patient navigation and community health worker services.

"Lay" Health Workers (see 59.9 FTEs of the 66.3 "Other" below): This key group includes: 1) Patient Navigators who intervene in the ED with patients lacking connections to primary care, making the warm handoff, 2) Health Priority Specialists who partner with the care team in the ambulatory clinics to deliver coaching/education to patients with chronic conditions, 3) Community Health Workers who meet patients where they are in the community, building connections to care and assessing in-home the social determinants of health, 4) Outreach Coordinators who ensure HIV and behavioral health patients stay engaged in care, 5) Peer Educators that support better outcomes among the substance abuse/mental health populations, and 6) Translators engaged where the cultural competency of the healthcare worker is not matched with linguistic competency.

Other PPS Hires (see remaining 6.4 FTEs of "Other" below): These include pharmacists who deliver medication education and reconciliation to patients being discharged, troubleshoot medication adherence issues among patients with non-compliance history and poly-pharmacy and collaborate with hospital- and clinic-based providers when patients present in the community with formulary/coverage or adherence issues. Also included are patient representatives serving in clinic settings, quality improvement resources & project-based data coordinators.

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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	23
Physician	8
Mental Health Providers Case Managers	22
Social Workers	4
IT Staff	17
Nurse Practitioners	14
Other	66

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	121,200	121,200	80,800	40,400	40,400	404,000
Redeployment	23,400	23,400	15,600	7,800	7,800	78,000
Recruiting	111,000	111,000	74,000	37,000	37,000	370,000
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.

The PPS will build on the TEF's experience. Since 2002, TEF has used New York State HWRI funding to offer training to more than 75,000 workers, achieving a 97% completion rate. Over the last two years, TEF utilized HWRI funds to train over 2,500 workers in Care Coordination Fundamentals, an innovative 48-hour training created with the Primary Care Development Corporation (PCDC). Participants came from over 100 institutions, including acute care settings, long term care facilities, ACOs, Health Homes, FQHCs, and CBOs.

The training's success is evidenced by South Brooklyn (Maimonides) Health Home's adoption of Care Coordination Fundamentals as its core new employee training, and the additional occupational and interdisciplinary team curricula that were designed off this foundational program. In the CMMI-funded Maimonides project, surveys indicate that more than 90% of clients express satisfaction with their care management services and more than 60% a sense of improved health due to their care management services and training.

The Care Coordination Fundamentals Training was copyrighted in 2013 and TEF has been providing national Train-the-Trainer services with this curriculum as far as California and Washington State. Since 2012, an additional 3,000 workers were trained by TEF through HWRI funds in and Emerging Technology/Electronic Health Records (EHR) at over 25 facilities, including a large number of safety net institutions. Additional training efforts of TEF funded with HWRI resources (through June of 2016) include training in Managed Long Term Care, Medical Assistant, Patient Care Technician, Patient Centered Care, Certified Home Health Aide and LPN.

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.

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Stakeholders have been engaged regularly in developing the workforce strategy.

Aug: Surveyed the initial network regarding proposed projects, unique institutional capabilities and CBO staff strengths.
Sept: Met with 5 PPS-wide post-acute providers to understand workforce and training capabilities.
Sept/Oct: Met with key Collaborators (e.g., mental health, substance abuse, social service) with whom established relationships exist for services/referrals (e.g., needle exchange, transitional housing). This facilitated identification of the role best suited to the Collaborator.
Oct/Nov: Reconvened the PAC (Collaborators, community, labor) to review the CNA/projects and make recommendations regarding workforce issues, e.g., primary care. Met with the TEF (see next section).
Dec: Distributed a mandatory survey to PPS with dedicated workforce needs section, including impacts of DSRIP projects (retrain/redeploy/hire employee counts/roles). Results were compiled and informed planning efforts.

***Engagement 2:**

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

Both 1199 SEIU and NYSNA had representation on the PPS PAC. The PAC has met monthly since September with minutes kept for each meeting which are approved by the PAC membership and circulated widely. A summary of the Community Needs Assessment, the proposed PPS governance model and detailed descriptions of the PPS projects have all been presented at the PAC for input. To ensure that the needs and priorities of the non-unionized DSRIP workforce are not overlooked, the PPS also consulted directly with human resource representatives to identify programmatic avenues for conducting training and outreach.

In addition, the TEF, a key workforce strategy partner, was invited to collaboratively plan the final workforce strategy with key PPS Lead representatives from HR, labor relations and training. The TEF provided advice on training capabilities and provided the PPS with a detailed training budget. The PPS and TEF have already met five times to design the workforce strategy.

***Engagement 3:**

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

The PPS will engage frontline workers in planning and implementation through multiple means. There will be general written communications to all workers impacted by the change. There will also be in-person general information sessions with PPS leadership to explain the changes, answer workers' questions and discuss the impact on workers. Frontline workers will then meet in smaller groups on their work units with PPS leadership to discuss the impact on them. The PPS's HR group will also hold sessions and work with labor unions to discuss the changes, what supports will be available to them, etc.

TEF offers an ongoing development program where clients participate in workshops to develop facilitation, conflict resolution and leadership skills. There is also a research component where stakeholders are informed of emerging trends, innovations and best practices. They further develop the capacity of stakeholders to use and interpret data, research and evaluation.

***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.

The PPS will use TEF's experience as a consulting group specializing in labor-management collaboration. Staff will work with multiple stakeholders to enhance quality of care, improve patient/staff satisfaction, increase operational effectiveness and performance, and increase worker voice and involvement.

Specific services may include:

- Connect system strategic plan to front-line workers and managers
- Facilitate collaboration among stakeholders at multiple levels of organizations
- Support systemic culture change for effective implementation
- Increase operational effectiveness and performance
- Improve patient/staff satisfaction
- Engage frontline managers & workers
- Consult on process improvement

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- Train project leaders in organizational development, process improvement, leadership
- Research and evaluation

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.

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

DSRIP PPS Organizational Application

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

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

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

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

Scoring Process:

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

Section 6.1 – Data-Sharing & Confidentiality:

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

***Confidentiality 1:**
Provide a description of the PPS' plan for appropriate data sharing arrangements among its partner organizations.

There are two main technical approaches to assuring that PPS members will be able to share data and have knowledge of the condition of relevant patients: Allscripts Care Director (ACD), a care coordination platform supported by NYP, and Healthix, the RHIO. Each approach has an associated set of policies and activities that assure the privacy and security of patient data. Under DSRIP, PPS members involved in the care of a particular patient will implement ACD and become participants of Healthix if they have not already. Healthix is a "qualified entity" in the State Health Information Network for NY (SHIN-NY).

***Confidentiality 2:**
Describe how all PPS partners will act in unison to ensure data privacy and security, including upholding all HIPAA privacy provisions.

ACD's privacy and security framework includes Business Associates Agreements (BAA), which establish privacy obligations under HIPAA; formal processes for creation and termination of user accounts; training in privacy and security; and password management.

Healthix members sign a Participant Agreement, which obligates them to adhere to Healthix's Privacy and Security Policies, one key aspect of which is the obligation to obtain the patient's written affirmative consent before it can view the patient's data in Healthix. Participants must adhere to Healthix's privacy compliance program, under which participants must assure consent forms are current and contain proper language; demonstrate adequate user training; create processes for creating user accounts and roles-based access privileges; adhere to technical standards, e.g., password length; and conduct periodic audits.

***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.

Connectivity of the PPS members will be established through extending ACD to other PPS members and use of Healthix to support inter-institutional data views, notification about key events and the use of Direct messaging to support transfer of data between PPS members.

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PPS members will use ACD to document patient assessments and care plans and to see documents entered by others who are caring for the patient. ACD currently is being used by several CBOs as part of NYP's Medicaid Health Home program and will be extended under DSRIP. In addition, a discharge planning application in place at NYP, Allscripts Care Manager, will allow inpatient care managers to identify and communicate with follow-up providers to facilitate the continuum of care.

Through Healthix PPS members will be able to see data from multiple organizations—including those not part of the NYP PPS—and will thus have a better overall view of the patient. Healthix's messaging capabilities will also be leveraged to actively notify care managers about key events such as ED visits and admissions to other facilities.

NYP will develop a custom documentation application for Community Health Workers (CHWs), who will often be documenting while conducting home-based visits. The PPS will leverage lessons learned as part of a NYS eHealth Collaborative Digital Health Accelerator project in which NYP piloted electronic documentation for CHWs. We will create tailored documentation capabilities for the various projects' CHWs and address workflows to bring CHW-captured data to clinicians.

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 NYP PPS Clinical/Operations Committee will be responsible for reporting on PPS performance, both at an individual project level and at a network level. As described in the Governance sections, this Committee will be led by one NYP Hospital representative and one non-Hospital, community Collaborator, with membership including representation from all Collaborators. This group will report directly to the Executive Committee and receive analytical support from the IT/Data Governance Committee and the PMO. From NYP's population health experience, we understand that effective rapid-cycle evaluation requires: (1) clear definitions and benchmarks for performance measurements; (2) developing the appropriate data governance standards; (3) scheduling regular meetings to review performance data; and (4) focusing on both process and outcomes data. The Finance Committee will also monitor financial performance (revenue and expenses) of the PPS. Both committees will report on the "State of the PPS" at bi-monthly committee meetings and at Executive Committee meetings.

***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 NYP PPS will use a variety of analytics tools (Microsoft Amalga, Tableau, SAS, etc.) to develop reports that monitor process and outcome measures with data from the Hospital EHR, Allscripts Care Director (care management platform), the Healthix RHIO and implementation reports. These reports, including baseline, current and target performance metrics, will be available on the PPS's intranet website and open by the end of DY1 to any PPS members with permission. Performance data will be reviewed at weekly PMO meetings and bimonthly Clinical/Operations Committees; to achieve necessary targets, each group will develop a plan-do-study-act (PDSA) cycle for metrics that are not achieving their goals. Any major tweaks to project activities will be reviewed by the Executive Committee and the NYS DOH, when appropriate.

***RCE 3:**

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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).

NYP's IT/Analytics staff will make relevant monthly data available via the PPS intranet website for all committees to review on a regular basis. Individual Collaborators will receive bimonthly updates on project-specific process and outcomes data that can be specifically attributed to their efforts. The NYP PPS PMO will make itself available to walk through any data, including deeper-dives and root analyses, to support Collaborators' individual quality improvement efforts.

***RCE 4:**

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

Rapid Cycle Evaluation is a key driver to any clinical transformation and population health effort. Beyond having a shared vision across the PPS, collective monitoring and responding to data (PDSA cycles) can bring a group of disparate providers together around shared performance metrics. As we've shown through our other population health and clinical transformation work, we are confident that opening access to process and outcome measures (when appropriate) can lead to increased ownership of the results. As Collaborators become more comfortable and confident with the data, we anticipate that the identification of improvement opportunities will be a more grassroots effort (i.e., bottom-up) rather than the currently described (i.e., top-down) process.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

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

Scoring Process:

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

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

***Competency 1:**
Describe the identified and/or known cultural competency challenges which the PPS must address to ensure success.

Much the NYP PPS service area is comprised of linguistically isolated ethnic and racial minorities. Residents of the NYP/CU service area are 31% Black and 61% Hispanic, and Spanish is the primary language for 55%, of which half speaks English less than "very well" according to the 2012 American Community Survey. Forty percent are foreign-born. In the NYP/WC service area, East Harlem is 35% Black, 52% Hispanic and 26% foreign-born; Western Queens is 27% Hispanic, 17% Asian and 43% foreign-born. Spanish is the primary language for 22% of the service area overall and 44% in East Harlem, while in Western Queens, 60% of people speak a language other than English at home.

Though these statistics may seem daunting, NYP has extensive experience in providing cultural competent care among Black, Hispanic and Spanish-speaking populations. NYP has less experience with the Asian population that lives in Lower Manhattan, home to its newest hospital, NYP/LM. The service area is 6% African American, 16% Hispanic and 25% Asian. The majority of Asian people are of Chinese origin (75% of the Asian population; 18% of the total service area). Almost a third of the population is foreign-born, 60% of which originate from Asian countries. Twenty percent of the population speaks an Asian language, of which 65% speak English less than "very well."

To ensure success, the PPS will extend NYP's training to include Asian populations. We are fortunate to have Charles B. Wang Community Health Center in our network to assist in this regard.

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***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.

NYP has adopted a patient-centered approach to cultural competency aligned with the National Quality Forum's (NQF) framework. Dr. Emilio Carrillo, NYP's VP-Community Health, co-chaired the committee that designed this framework.(28) The 2009 NQF framework and seven domains of cultural competency have guided NYP's programmatic efforts in cultural competency, language services and health literacy, including extensive use of community-based bilingual and bicultural CHWs and PNs in its PCMHs, EDs and population health efforts.

The NYP PPS will train frontline staff and physicians involved in DSRIP projects to provide care that respects patients' "Culture of One." NYP's approach treats patients as individuals whose culture is unique and a result of multiple social, cultural and environmental factors and avoids racial or ethnic stereotyping. This approach stems from seminal research published by Dr. Carrillo in 1999 and is used internationally as the basis for cultural competency training.(29)

The curriculum includes such information as proper use of interpreters and the limitations of family interpreters; understanding one's own biases; recognizing and managing sensitive cross-cultural issues; developing health literacy of patients and families; and the underpinnings of institutionalized healthcare disparities. In addition, we will tailor training to project-specific competencies, such skills needed in working with behavioral health or pediatric populations.
{Refs available on last page of CNA.}

***Competency 3:**
Describe how the PPS will contract with community based organizations to achieve and maintain cultural competence throughout the DSRIP Program.

The PPS is contracting with a multitude of CBOs—such as Community League of the Heights, Center for Urban Community Services and VillageCare—to hire more than 20 Community Health Workers (CHWs) and other positions such as health educators and translators. CHWs are trained local community members who provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. They can also assess non-medical causes of hospital utilization, such as lack of transportation or food insecurity. All CHWs will be given the means to document their interventions in Allscripts Care Director, the electronic care coordination platform. Where necessary, trained translators will be hired to avoid the pitfall of "false fluency" and the pitfalls and limitations of using family interpreters or bilingual providers as ad hoc interpreters.

To ensure success with the Asian and Asian-American population in Lower Manhattan, the PPS will work with Charles B. Wang Community Health Center. For select projects, such as Project 4.b.i (Tobacco Cessation), we will also Collaborator with NYC Department of Health and Mental Hygiene, which has extensive experience with this population, for translated materials and training modules.
{References available on last page of CNA.}

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.

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- 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.

Patients and their families need to understand health information both consistently and completely to ensure full access to care, safe compliance of treatment directions, recognition of health situations that are emergencies and full compliance of all prescribed health tasks. Providers need to learn ways of improving patient's health literacy through the use of pictures, other visual aids and other communication mechanisms.

As part of the Culture of One, NYP realizes that the burden of clear communication and understanding is placed on the provider, not the patient. We intend to imbue all of our DSRIP project-related communications in language that is plain and clear and provide cultural competency training as described above. The "Culture of One" cultural competency curriculum also focuses on health literacy and helps providers understand the importance of health literacy in the care of patients and provides supportive skills such as the "Teachback" technique.

The Clinical/Operations Committee will be responsible for ensuring that all providers participating in DSRIP—including the NYP PPS and community-based organizations contracted to work with the PPS—are trained in cultural competency, inclusive of health literacy. We will tailor training to project-specific competencies, such skills needed in working with pediatric populations, palliative care or behavioral health services.

Specific initiatives include: (1) "Culture of One" training; (2) Teachback Training; and (3) Establishing a Cultural Competency/Health Literacy expert panel to review the health literacy level of DSRIP project educational material.

As with cultural competency, we will contract CBOs for CHWs who will be trained to provide diagnosis-specific education in a linguistically and culturally appropriate manner to patients and families. Translators will also aid in health literacy by enabling providers to cut through the medical jargon to often underlying traditional provider-patient communications.(30) In 2013, the New England Journal of Medicine cited NYP's approach to integrating CHWs into the healthcare team (specifically with its WIN for Asthma Program) as one of three sophisticated ways of achieving better outcomes and lower spending among culturally diverse and socio-economically challenged patients.(31) In addition, NYP's advanced model of integrating CHWs into the PCMH healthcare team as well as using them as extensions of hospital systems was recently recognized by NYC Department of Health and Mental Hygiene leadership engaged in the Harlem Community Health Worker Initiative as a replicable goal for the project.(32)
{Refs available at end of CNA}

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

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

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

Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

***Budget 1:**
In the response below, please address the following on the DSRIP budget and flow of funds:

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

The PPS Executive Committee has the full representation of provider groups and contributors responsible for the achievement of the PPS's DSRIP projects goals. With broad representation on the Executive, Clinical/Operations, IT/Data Governance and Finance Committees, all providers groups will have input into the DSRIP funds flow process and fully understand their responsibility for achieving the goals of each project as well as the overall DSRIP initiative.

The PPS's plan for distributing DSRIP funding establishes 5 budget categories through which funds are distributed. As directed, the expected budget revenue amounts are based upon the maximum funding amount available. Expenses are driven by project-specific implementation costs and overhead & IT investments necessary to ensure success. The plan is focused on supporting implementation costs with bonus funding contingent, and variable upon the PPS's performance & goal achievement, both overall & at the project level. The distribution plan allocates significant funds to support providers for costs related to project and redesign initiatives. The funding plan also provides measures to ensure that Safety Net Providers receive 95% or more of distributed DSRIP funds.

The PPS plans to distribute funds on a project basis with funding at the provider level based on the individual project goals and implementation costs for each of the participating providers. Within each category, the provider is assigned a budgeted amount of DSRIP funding that the provider is eligible to receive. This funding is driven by the overall valuation of the specific DSRIP project with consideration then given to project-related costs as well as any requirement for the provision of currently non-reimbursable services. In addition, bonus funding will be made available at the individual provider level, contingent upon their and the PPS's performance and goal achievement, both overall and at the project level.

The PPS's plan for distribution of DSRIP funds supports achievement of its DSRIP goals by focusing on the successful implementation of the PPS's 10 selected projects. Funding will be structured such that it rewards those providers who participate in, and most contribute to, the success of the projects and the achievement of the overall DSRIP goals and objectives. This same bonus pool will be used to offset

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revenue loss associated with reductions in potentially preventable admission, readmissions & ED visits. The logic behind this is that there will be no utilization reduction unless the projects achieve a certain level of performance.

In addition, the PPS's approach rewards providers who exceed the identified, project-specific performance metrics while at the same time providing for the removal of those providers who consistently fail to meet agreed-upon targets. The plan also provides a contingency funding mechanism to help offset any potential reductions in DSRIP funding due to poor statewide performance. This same contingency fund could be used in specifically designed instances to assist financially challenged providers develop an approach to financial viability.

Budget: Admin (Central PMO incl. support for governance structure & individual DSRIP projects; Common IT needs across projects); Project Implementation Costs (Implementation & transformation costs; Investments required to realize project goals, i.e., IT, training; Costs for services not reimbursed by Medicaid); Increased Program Capacity (Expansion of substitutional care delivery sites aimed at reducing I/P and ED use); Contingency (Reserve fun to set aside for unexpected costs; Allow for reductions due to Statewide missed DSRIP goals; Financially fragile providers needing support); Bonus payments (For achieving project goals/milestones; Recognition of high performance; Revenue loss due to volume reductions)

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	65%
2	Revenue Loss	5%
3	Internal PPS Provider Bonus Payments	10%
4	Administration & Overhead	10%
5	Increased Program Capacity	5%
6	Contingency Fund	5%
	Total Percentage:	100%

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

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

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

***Assessment 1:**
Describe the assessment the PPS has performed to identify the PPS partners that are currently financially challenged and are at risk for financial failure.

Given the application timeframes which the PPS has been operating under and the number of Collaborators in the NYP PPS, NYP is in the planning phase of assessing and identifying those PPS Collaborators that are financially challenged and at risk for financial failure. With most of our Collaborators participating in numerous PPSs, many of which are significantly larger than NYP PPS, we are also working through how to best integrate these efforts with the other PPSs. Through our PAC and PPS project-specific meetings we have gathered some qualitative knowledge of Collaborators and financial status.

Our intent is to work with the PPS Finance Committee to develop an initial survey to be completed by our PPS providers. The survey will request financial data and operational metrics and statistics. In addition the survey will include specific questions regarding the providers' level of dependency on sources of funding for uninsured or indigent services that might or will be impacted by DSRIP. We anticipate the distribution of the survey prior to April 1, 2015.

As a PPS with a single, financially stable hospital in the lead role, no assessment will be undertaken in that area. We will work with our key larger providers (nursing homes and FQHCs), whose absence or failure during the DSRIP period would be very disruptive, to provide additional financial and operational data. Then, working with the PPS Finance Committee, the PPS will develop a monitoring process for those providers identified as potentially vulnerable.

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***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.

There are two primary financial impacts resulting from DSRIP projects: volume reductions and the affect that has on providers in a fee-for-service reimbursement model; the actual costs of implementing the DSRIP projects themselves; and, the shift from fee-for-service to value-based reimbursement.

With DSRIP's overall goal being a 25% reduction in potentially preventable admissions and emergency room visits, hospitals and other (primarily) inpatient-focused providers stand to be negatively affected. The level of that impact will vary depending upon the provider's current business model, the portion of its business directly affect by the DSRIP initiative, its ability to increase appropriate inpatient business and how significant the current 'gap to DSRIP goal' is. Those providers who fail to implement the necessary changes in their business and operating models will be at particular risk, with the financial impact of the DSRIP changes being more acutely felt by those providers already at financial risk.

Reductions in inappropriate admissions and ED volume could impact hospitals depending upon their ability to reduce costs and/or "backfill" with appropriate volume. In addition it is likely that the DSRIP projects, while focused on the Medicaid patient population, will also impact the non-Medicaid volumes at facilities, reducing them as well. These reductions may be partially offset by volume increases in other, lower-cost settings. However, the costs associated with implementing that transition – new staff, training, capital requirements– could be a challenge during the initial phases. The cash flow implications of substituting DSRIP funding for direct payer payments could be significant, particularly for those financially fragile providers. Another potentially negative impact would be a provider's inability align operating expense reductions with planned service reductions could have a negative impact, particularly during the initial, "start-up" period as PPSs work to achieve DSRIP's goals.

The cost of implementing the DSRIP projects will also have a financial impact on providers. The projects all require investment by providers, be it capital investments, in the form of new ambulatory space or IT systems, or an increase in operating expenses in the form of adding new providers, staffing, and/or contracted vendors, non-capital IT upgrades, training, connectivity and implementation costs. The availability of capital funding under the Capital Restructuring Financing Program could provide some relief to providers but it is unlikely those funds will not require at least a 1-to-1 match from the provider.

With DSRIP award dollars not coming for months after a performance period and even further removed from the time period when investments will need to be made in order to generate a positive performance, cash pressures at providers could be exacerbated. In addition there also exists the potential for an operating margin decline if the projects do not achieve the intended performance levels and there is no revenue to cover the incremental expense.

In addition, providers who have traditionally received some level of support from the State may be negatively affected by a probable overall reduction in these funds, though that reduction may, or may not be, related to DSRIP. There are provisions in the DSRIP program for certain financially fragile providers to access assistance funding during the transition to DSRIP.

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.

Under the oversight of the PPS Finance Committee, a Financial Stability Plan (FSP) will be developed during the PPS's initial implementation and startup period. The intent is to present the FSP to the Executive Body for approval at its April 2015 meeting. In order for a provider to achieve financial stability, it must hit key operational and financial milestones represented in the PPS organization's plan, with these milestones represented by a set of key performance metrics such as volume, revenue growth, expense reduction, etc.

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The FSP will define the specific financial and operational metrics that must be achieved during each phase of the DSRIP project in order for the provider to be considered financially stable and for DSRIP goals to be met. It will also include a process to monitor and report actual results compared to the metrics. At this point in the DSRIP process, it is too early to report on any financial restructuring efforts that may be required though none are known of at any of the larger providers in the PPS. The PPS intends to monitor the status of the identified, financially fragile providers through reports to the PPS Financial 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.

As stated above, the PPS Finance Committee will develop a monitoring process for those providers identified as potentially vulnerable. This monitoring will include twice-per-year or quarterly reporting for those Collaborators identified as vulnerable. Particular attention will be paid to the safety net providers participating in the PPS so that their contributions to the achievement of the DSRIP goals can be maintained throughout the five-year period and beyond. The PPS budget and flow of funds plan provides the financial support necessary to support all providers as they work with the PPS on project-specific goals and deliverables. In those instances where the Executive and Finance Committees of the PPS think it an appropriate use of DSRIP funds, the PPS Project Management Office will work with a provider facing financial instability to develop a sustainability plan, assuming that provider is achieving the agreed-upon, project-specific performance metrics.

***Path 3:**

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

The PPS will initiate conversations with the Medicaid managed care organizations (MMCOs) aimed at establishing a common understanding of what performance-based programs could become part of an integrated healthcare delivery system and operating model. The PPS will be focused on working with the MMCOs to develop programs that put engaging the patient first while reinforcing the provider's role in delivering quality care at the individual and population level.

Our thought is that the DSRIP period, and the coordination of services occurring during that period coupled with a population health management perspective that will need to be developed in order for DSRIP to be successful, will contribute to a healthcare environment where providers will have matured as population and disease management organizations more fully capable of succeeding within a value-based rewards methodology.

This evolutionary growth will enable providers & their organizations to position themselves as financially sustainable organizations with the capabilities that would allow them to sustain the programs & services benefitting their organization and the patient population beyond the five-year DSRIP period.

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.

NYP enjoys professional and collegial relationships with contracted MMCOs serving our communities and will continue to engage them in this transformational process. We believe that our specific DSRIP projects will contribute to improved health and impact rates of potentially preventable admissions, readmissions and ED use. We have already demonstrated success in these areas through the work of our Regional Health Collaborative, recently featured for the second time in Health Affairs, which shows that such efforts can reduce the total amount of Medicaid expenditures per patient. From our perspective, a logical next step would be to introduce element(s) of value-based, pay-for-performance terms into our payment methodology. We recognize that MMCO contracting evolves over time and contemplate we would initially pursue negotiations with one plan, with the goal of perfecting the implementation and approach, before considering

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introducing the amended terms in other MMCO Agreements. Longer term, subject to negotiating acceptable terms and conditions, we could consider other alternative models, such as bundling and upside only, shared savings. Our primary goal for any value-based payment model we pursue with our Collaborators is that it puts the patient first. In support of that goal we want a payment system that is focused on increasing the quality of healthcare services to be fair and rewarding of high performance. We and many of our network providers are in the early stages of payment reform, so any process must be flexible and allow for multi-year phasing.

***Strategy 2:**

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

DSRIP funding is limited, both in terms of the annual amount provided as well as in the number of years for which it is available, necessitating the identification of an alternative funding source for the NYP PPS DSRIP projects. NYP PPS believes that these projects will be successful and contribute to improved health and help reduce the rates of potentially preventable admissions and readmissions and emergency department use for our attributed population. The system savings associated with these reductions needs to be reinvested in the PPS and its Collaborators, particularly those financially fragile safety net providers contributing to the projects' positive performance. Over the five-year DSRIP period, financially fragile safety net providers will have had the opportunity to further develop their competencies and partnerships positioning them for success in a more value-based market. Through their work and contributions to the PPS's DSRIP projects they will have ensured themselves of long term, viable role within the PPS and its integrated delivery system. A value-based alignment of the State, the MMCOs and the PPS that allows all three organizations to share in the savings, should yield the resources necessary to ensure that financially fragile safety net providers can achieve financial stability and that the Medicaid population has access to the services the safety provides. Payment transformation offers the means to fund the system's reinvestment in the integrated delivery system that DSRIP is focused on creating.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

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

Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

As we have seen, Northern Manhattan is a predominantly poor, Medicaid-dependent, Hispanic community with disproportionately high rates of chronic disease, including asthma, diabetes and congestive heart failure. In 2008, recognizing that the health needs of this population were going unmet, NYP embarked on a population health initiative. After conducting a formal health needs assessment of the community and reviewing the services the hospital offered residents, NYP joined forces with its physicians and community-based providers and organizations to reinvent its ambulatory care healthcare delivery model. The goal was to reduce health disparities at both the individual and population levels.

In October 2010, NYP launched the Regional Health Collaborative, an integrated network of patient-centered medical homes that were linked to other providers and community-based resources and formed a "medical village." Evidence-based strategies, information technology and cultural competency were used to reorganize care delivery around the needs of patients and families. NYP developed care protocols and information systems and conducted extensive training for physicians, nurses and other care team members before the formal launch.

Three years later, a study of 5,852 patients who had some combination of diabetes, asthma and congestive heart failure found that emergency department visits and hospitalizations had been reduced by 29.7% and 28.5%, respectively, compared to the year before implementation of the network. Thirty-day readmissions and average length-of-stay declined by 36.7% and 4.9%, respectively. Patient satisfaction scores, as measured by Press Ganey, improved an average of 2.25 points across all 28 measures.

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

The NYP PPS will contract with the 1199SEIU League Training & Employment Funds (TEF) as its lead Workforce Strategy Vendor. TEF is the largest joint labor-management workforce planning organization in the U.S., covering 250,000 workers & over 600 employers across all healthcare sectors. Throughout its 40+ year history, TEF has a track record of evaluating and selecting the most appropriate training vendors to meet employer and worker needs; collaborating with academic institutions such as the City University of New York; writing curricula; and working collaboratively with employers, unions & training providers to design and deliver high-quality programs.

Examples of TEF's extensive experience include:
• Since 2001, TEF has utilized Health Worker Retraining Initiative funding to successfully offer statewide training and education programs to over 76,000 workers with a 97% completion rate.
• TEF has created customized curricula to train professionals from allied health to MDs in new models of care, e.g., health homes, ACOs and PCHMs.
• In 2013, TEF's Employment Center received 5,000 job openings from employers and filled 40%.
• TEF implemented: 1) HCAHPS Immersion Project, where 95% of participants increased their understanding of HCAHPS survey, scores

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and the financial impact on their hospital; and 2) Patient Centered Care training in 12 hospitals with over 1,800 workers trained, where 96% reported they felt better prepared to provide patient-centered care.

• In 2013, TEF provided training services to nearly 16,000 homecare workers in contextualized ESL, basic adult education, college and nursing school preparation, tuition support, workplace skills and homecare certification training.

NYP & TEF have a history of collaboration. Dr. Carrillo presented the "Culture of One" model of patient-based, cross-cultural communication at TEF's Training Conference in 2013. TEF endorsed the model as a valuable strategy for cultural competency training for its workforce programs.

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.

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

DSRIP PPS Organizational Application

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

☑ ***I hereby attest as the Lead Representative of this PPS The New York and Presbyterian Hospital that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: PRESBYTERIAN HSP CITY OF NY
Secondary Lead Provider Name:

Lead Representative:	Phyllis Lantos
Submission Date:	12/22/2014 04:58 PM

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