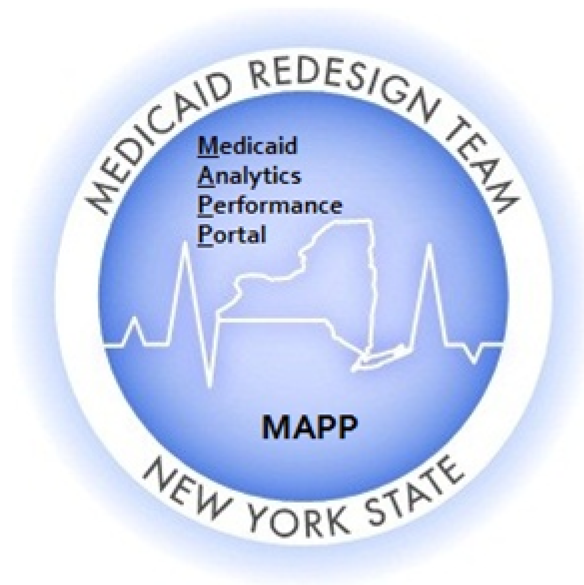
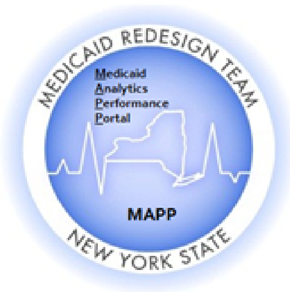
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Bronx-Lebanon Hospital Center



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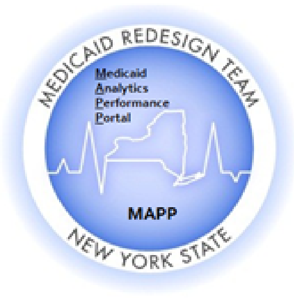

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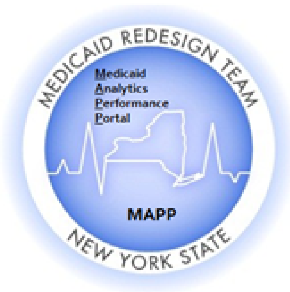

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Bronx-Lebanon Hospital Center (PPS ID:27)

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: **27_SEC000_PPS Lead Financial Viability Doc.xls**

Description of File

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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: vg467992
Last Updated On: 12/22/2014 03:28 PM

Certified By: vg467992
Certified On: 12/22/2014 03:29 PM
Lead Representative: Virgilina Gonzalez

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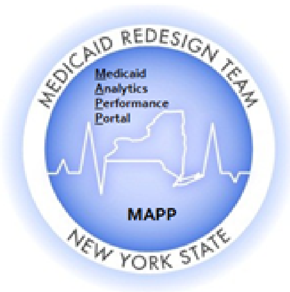

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

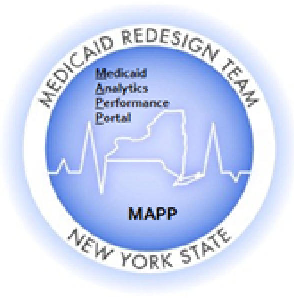
***Goals:**
Succinctly explain the identified goals and objectives of the PPS. Goals and objectives should match the overall goals of the NY DSRIP waiver and should be measurable.

#	Goal	Reason For Goal
1	Create a network of care that improves access, quality and efficiency for the safety net population	The Bronx Lebanon Hospital Center (BLHC) Performing Provider System (PPS) includes a wide range of health & social service providers, such as physicians, nursing homes, Federally Qualified Health Centers (FQHCs), IPA, community-based organizations, hospitals, & behavioral health providers. The objectives are: • Reduce unnecessary beds in the PPS (acute and possibly LTC). • Create a highly efficient Integrated Delivery System in collaboration with providers across the care continuum using IT interoperability & care coordination to improve the beneficiary's experience & outcomes; • Develop integrated value-based contracts & payment that brings all providers closer to the premium dollar; • Retrain & redeploy the health care workforce to provide services & supports that improve outcomes; • Create & implement multidisciplinary approaches to care that address issues identified in the CNA; and, • Reduce unnecessary ER utilization through primary care & social services integration.

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

BLHC PPS will begin implementation with a Collaborative Contracting Model and pivot operations to a Delegated Model no later than January 2016. The BLHC PPS Steering Committee has decided on this course to allow rapid implementation of the PPS under the Contracting Model to have an expeditious beginning, but the PPS is interested in a more formal, collaborative and inclusive governance that the Delegated Model offers. The Steering Committee will be an initial Board of the LLC of the Delegated Model and that Committee includes BLHC leadership as well as representatives of an FQHC (Urban Health Plan), labor (SEIU), a behavioral health provider and health homes among others. Through the PAC and regular town hall meetings along with newsletter, a website and a robust provider and beneficiary outreach program, the PPS seeks community engagement. The PPS will continue this strong engagement through regular town hall meetings, and an active PAC and a transparent governing process during implementation and beyond. We believe that the fundamental principles of creating broad, transparent governance is the best possible means of ensuring that community needs are met.

***Steps:**
Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.



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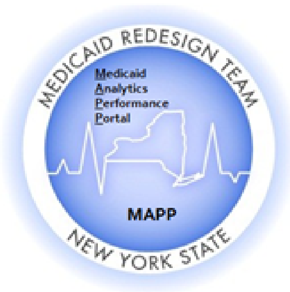
DSRIP is going to evolve the system into a more highly Integrated Care Delivery System that focuses on patient-centered care coordination. This transformation will be a profound shift in the cultural and structural approach in how care is delivered, which will require additional years of planning followed by implementation and then perfecting the new approach. The objective will be to prepare for value-based payment, with the goal of moving closer to global risk. In fact, the BLHC PPS is already in a much stronger position than most PPSs to work on capitation because BLHC is a partial owner of HealthFirst, a large Medicaid managed care plan; BLHC has almost 100,000 capitated lives from the health plan. This existing health plan experience will be invaluable in preparing for the next five years. It will certainly be the case that the institutional care footprint will be smaller in lieu of a larger outpatient footprint delivered by community partners, such as Urban Health Plan. This will mean a reconfiguration of the workforce with a focus on outpatient services, more community workers focused on care coordination and fewer hospital-inpatient workers than today.

***Regulatory Relief:**

Is the PPS applying for regulatory relief as part of this application? No



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.

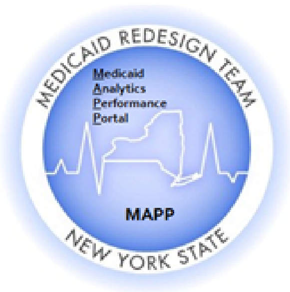
☑ Section 2.1 - Organizational Structure:

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 BLHC PPS intends to begin operations initially as a Collaborative Contracting Model in 2015 and then evolve into operating a Delegated Model by January 2016. This decision was reached by the Steering Committee with input from the Project Advisory Committee (PAC) and in consultation with its other Committees. The Steering Committee has decided on this course of action to allow rapid implementation of the PPS under the contracting model, but the PPS is interested in a more formal, collaborative, inclusive and transparent governance that the Delegated Model offers for the long-term.

The PPS began planning in May 2014 using a consultant very knowledgeable about PPS and DSRIP. In August, 2014 the consultant withdrew because of a potential conflict. The PPS was able to engage a new consultant in early October 2014. This delay has compressed the timeframe for governance for the organization, as a result, the Steering Committee with the PAC, has decided that the most prudent course is to contract directly with the more than 200 participating partners in Year 1. This timeframe provides an opportunity for the PPS partners to thoughtfully develop a Limited Liability Corporation (LLC) and to plan and implement the Delegated Model no later



than January 2016. The Lead Entity, Bronx Lebanon Hospital Center (BLHC), will serve as the contracting entity and finalize the PPS network of providers. The Steering Committee is comprised of 11 members representing BLHC, FQHCs, home health agencies, subacute/nursing facility providers, behavioral health providers, health homes, housing and other community agencies. The Steering Committee, along with the sub-committee chairs and input from the PAC, will provide project oversight in 2015 and will transition to the governing board of managers (Board) of the LLC in 2016.

The Steering Committee sees its goal as providing guidance to the entity and decision making based on recommendations from the Financial, Clinical (Project Development and Implementation Committee), Workforce, and IT Committees. Each of these sub-committees is co-chaired by a BLHC representative and a community provider as are each of the project committees. Those Committee chairs report weekly to the Steering Committee on their progress, with the Steering Committee offering important guidance and feedback. This is done in a transparent and democratic fashion on the Steering Committee—based on the premise that collaborative decision making is critical to success.

A primary consideration of the Steering Committee in adopting this two phase approach to governance is the number of organizations that have submitted attestations and participation Memoranda of Understanding (MOU), those that have confirmed their status as exclusive partners or vendors and others that have not. After the PPS establishes a Collaborative Contracting Model in 2015, it will move to developing the LLC that will provide organizational support to the Project Management Office for the duration of the DSRIP through overall program governance, management direction, monitoring and oversight of the PMO contract.

The Delegated Model provides for collaborative control with BLHC holding at least a 51% share in the LLC, depending upon capital requirements and capital funding by other members of the LLC. The LLC Board will be comprised of the current Steering Committee as well as the chairs of each of the Project Committees.

The PPS has also worked closely with the Mount Sinai Health System PPS, sharing consulting expertise, accepting a letter of support, coordinating projects in the South Bronx that address issues raised in both CNAs, and meeting regularly to share information about implementation. As a result, the BLHC PPS and the Mount Sinai PPS have worked to develop organizational structures that are similar and can continue to work collaboratively.

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: **27_SEC021_Org Structure of PPS.pdf**

Description of File

BLHC PPS Organizational Structure

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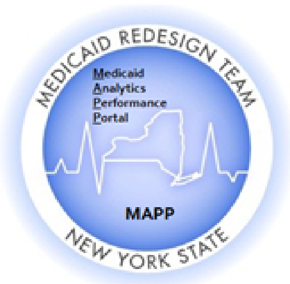
***Structure 2:**

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

The Steering Committee, with input from the PAC, leads the development of the Contracting Model and its evolution to the Delegated Model. When the LLC is developed, its Board will include the Steering Committee members, as well as representatives of clinical projects. The total composition of the Board is still to be determined. In 2014, the Steering Committee met two hours every week to provide oversight and direction to the Finance, Workforce, IT and Project Development and Implementation Committees. The Steering Committee will also create a Quality Committee to establish and monitor performance metrics and a Compliance Committee before April 2015.

The Steering Committee is responsible for:

- The performance of the PPS and all of its committees, projects, partners and vendors
- Approval of all contracts, agreements, charters, organizational documents and policies and procedures;



- The development of a collaborative contract for providers to participate in the PPS during the first year;
- The development of the LLC;
- The development of a provider dispute resolution process and a participant grievance and appeal process;
- Fulfillment of all state requirements; and,
- Submission of DOH reports.

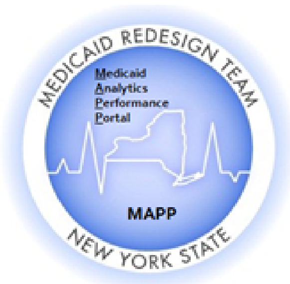
In support of the Steering Committee, there are many supporting committees that have been operating during 2014 in preparation for the PPS. Each Committee has been designed to have leadership from BLHC and community providers, and they report directly to the Steering Committee.
- The Finance Committee will play a key role to ensure success of the PPS by establishing a clear methodology for the flow of funds as well as requisite project based performance metrics. This committee is comprised of members representing hospitals, FQHCs, a home health/managed care agency, behavioral health entity, a care coordination agency, and other community based organization including representatives from BLHC, Dominican Sisters Family Service, Urban Health Plan, American Dental, All Med Medical, NADAP , Community Health Network, Harlem United, Comunilife, Special Care Center, Argus, BoomHealth, VSNY, and Bailey House, and Dennelisse Corp. This Committee is responsible for assessing the financial stability of participating partners as well as the PPS.
- The IT Committee, led by Urban Health Plan, conducted an IT readiness assessment of potential PPS partners and will develop a comprehensive IT plan based on those finding. The IT Committee meets weekly, and includes representation from participating providers including, Urban Health Plan, BLHC, BronxWorks, SelfHelp, VNSNY, American Dental, Bronx RHIO, Harlem United and Dennelisse Corp.
- The Project Design and Implementation Committee (PDI), with membership from the Lead Entity clinical staff and participating providers including BronxWorks, St. Vincent de Paul Residence, VNSNY, BLISS, CCMP, Terrace Healthcare Center, University Consultation Center, Archcare, Urban health Plan, Hudson Heights IPA, Catholic Charities, Comunilife, VIP, Narco Freedom, Harlem United, MHA-NYC, CHN, Unique People Services, God's Love We Deliver, and Dominican Sisters, meets weekly to provide oversight and guidance to the clinical projects under development in response to community needs identified in the CNAs.
- The Workforce Committee is comprised of the Lead Entity, union representation (1199SEIU, and NYSNA) and community providers (FEGS, Conifer Park, PAC Program, VIP, Argus, University Consultation, PCDC, SelfHelp, Urban Health Plan, and Dennelisse) meets regularly to develop a strategic plan for the retraining, redeployment and redesign of the healthcare workforce in the South Bronx.
- The CNA Committee led by Help PSI, is responsible for ensuring the projects selected align with the results from the CNAs and works closely with the PDI committee. It is comprised of the lead entity and 17 community based organization

***Structure 3:**

Specify how the selected structure and processes will ensure adequate clinical governance at the PPS level, including the establishment of quality standards and measurements and clinical care management processes, and the ability to be held accountable for realizing clinical outcomes.

The Steering Committee will establish a Quality Committee that will report directly to them and will be charged with quality oversight and management as well as oversight of any rapid cycle quality improvement projects. The Project Development and Implementation Committee (PDI) provides structure to the 10 clinical projects identified by the PPS in response to the enormous needs cited in both the quantitative and qualitative CNA and will work collaboratively with the Quality Committee. Each clinical project team is developing clinical pathways, quality standards and measurements as well as milestones that will improve access to health care and social services and improve the health of the South Bronx community. The Clinical teams will report quality measures to the Quality Committee and clinical activities to the PDI Committee. The PDI Committee, in collaboration with the Quality Committee, will develop monthly performance dashboards for review by the Steering Committee, as well as working with the Finance on developing a pay-for-performance initiatives.

The Quality Committee and the PDI Committee will work collaboratively to assess the impact of clinical interventions and will develop strategies to make adjustments to attain rapid cycle quality improvement. The PDI may identify quality issues among providers and will refer those providers to the Quality Committee and the Compliance Committee both of which are described later in the application of oversight and follow up. If the Quality or Compliance Committees are unable to resolve quality issues with a poor performing provider, that provider will go through the progressive discipline process described below of corrective action up to removal from the PPS. Both the Quality and Compliance Committees will be staffed by qualified individuals who will have direct access to the Steering Committee to raise issues of material concern to fulfilling state requirements.



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***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.

BLHC PPS will begin as a Collaborative Contracting governance model and move to Delegated Model operations in January 2016. The Steering Committee will be responsible for deciding the exact timing of the move to the Delegated Model and will work collaboratively with DOH to assure a smooth transition, with a Milestone Date set of October 2015 for LLC creation. The PPS Committees that are developing the PPS will evolve into the Board and Committees of the LLC. As the PPS gains experience with the changing environment, the LLC will continue to reassess the performance of the PPS through its Committees, including the Quality and Compliance Committees, to assure that goals and risks are being addressed. The governance structure will be assessed periodically to ensure that it functions well, recommendations are implemented and goals reached. The PPS Steering Committee believes that the LLC will offer a stronger platform for the PPS implementation and will provide a more equal footing for community partners to participate as members of the LLC board. The LLC board will take responsibility to managing the growth and evolution of the PPS over time and the best means of ensuring that success is to have broad, open, transparent board operations.

It will be up to each member of the governing body to help provide leadership through difficult transition periods by both offering leadership to the PPS and also taking responsibility for making sure their organization is participating in the best interest of PPS. This approach will help facilitate the transformation process of the PPS such that all of the most difficult DSRIP goals can eventually be met: 1) bed reduction; and, 2) moving PPS providers closer to the premium dollar.

☑ 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.

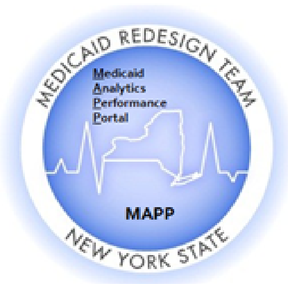
The PPS has a Steering Committee with representation from a broad range of PPS partners:
Dr. Isaac Dapkins- Director of Ambulatory Care, BLHC
Rosa Gil - President & Chief Executive Officer, Comunilife
Paloma Hernandez- President & CEO Urban Health Plan
Dr. Jeffrey Levine - Medical Director, Bronx Health Home
Octavio Marin- Bronx Lebanon Special Care Center
Aida Morales- 1199SEIU
Ramon Moquete – Hudson Heights IPA
Neil Pessin - President, Community Care Management Partners Health Home
Samuel Shutman - Vice President of Managed Care & Business Development, BLHC
Brent Stackhouse- Mount Sinai Hospital System
Kristin Woodlock - Chief Executive Officer, FEGS

The Steering Committee is ultimately responsible for the overall direction and execution of PPS operations. Steering has delegated key management roles to Committee Chairs:

- Finance Committee Chair: Vic Demarco, CFO, BLHC
- Project Committee Chair: Dr. John Coffey, ED Dir., BLHC; Dr. Abayomi Salako, BLHC
- IT Committee: Alison Connelly-Flores; Dan Figueras (Urban Health Plan)
- CNA Committee: Jessica Diamond, ProjectSamaritan.org
- Workforce Committee: Selena Griffin-Mahon, HR Dir. BLHC; Ellen Stoller, FEGS

***Process 2:**

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



In forming the Steering Committee, the Lead Entity sought to collaborate with providers in the South Bronx that have worked closely with BLHC, are deeply rooted in the community and have a deep understanding of the critical health, social, educational & economic issues that are faced by the residents of the South Bronx. This included organizations that have been leaders in providing health and social services, contributing to the health and well-being of the South Bronx community. Many PPS leaders on both the PAC and the Steering Committee emerged through relationships built on the success of the BLHC Health Home and working with care coordination and social services agencies, and its alliance with CCMP. BLHC's close partnership with Urban Health Plan and VNSNY, two large community providers, together with Comunilife, FEGS and other community based organizations, also helped in the identification of members. BLHC's clinical leadership and other influential and committed community providers also helped identify potential members who were then invited to join the BLHC PPS. Invitations to attend the PPS's first Town Hall in May 2014 were sent and more than 200 organizations attended. Through this process, the interest of more than 40 organizations to actively participate in the BLHC PPS grew into the identification of PAC members. Through a democratic process, the PAC members agreed that the PPS required a governing body that would have oversight and decision making power on behalf of the PPS. The PAC nominated the candidates for the governing body or steering committee. Votes were cast and the PAC approved the individuals that are now the members of the Steering Committee. As such the Steering committee elicits advice from the PAC. In addition, BLHC is an investor in and part of the governance of Healthfirst, the largest Medicaid & Medicare managed care organization in the New York Downstate market serving residents of the South Bronx and elsewhere. Throughout this process, BLHC PPS has invited guidance & advice from the Mount Sinai PPS, in part, because it is further along in the process of establishing a governance model.

***Process 3:**

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

The Steering Committee contains at least one representative of every major provider class in the PPS, including social service providers. The majority of seats are held by community providers—not institutional providers. With town hall meetings open to any interested provider, community organization and Bronx resident, the PPS has encouraged participation and open debate about topics including IT solutions, clinical projects, and membership on the PPS Committees. As the LLC develops, the Steering Committee will continue to ensure there is sufficient representation of all provider types within the PPS, including community members. The PPS recognizes the critical importance of primary care and community providers to PPS success and will continue the longstanding community relationships, with Steering Committee members including Urban Health Plan, Comunilife, Hudson Heights and Bronx United IPAs, CCMP and others.

***Process 4:**

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

The PPS has developed a model that includes a BLHC representative and a community provider representative as co-chairs of each of the administrative and project committees. The community provider representatives vary but include health homes, home care agencies, nursing facility representatives, social services groups, IPA representatives, and a Medicaid managed care organization. These committees have outreached to community partners to encourage participation in the PPS. During year 1, the Steering Committee will work with its community partners to develop their respective roles in PPS governance so that when the LLC is formed, it will include a broad community representation. The PPS has already begun outreach to community based organization and has gathered MOUs/attestations from more than 200 providers who will be invited to contract with the PPS. The PAC and Town Halls are other important means of keeping partners connected.

***Process 5:**

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

The Steering Committee will continue to develop principles that will guide its decision making moving towards the establishment of the LLC. The PPS Steering Committee has already agreed to certain principles that will carry over into the LLC, including:

• Minutes of meetings will be available online.

• A quorum, for most decisions, consists of a simple majority;

• Each member of the Steering Committee has one vote;

• Decisions are made by a majority vote of the members present unless the decisions involve a reallocation of the distribution of funds, the addition or deletion of a participating partner, the initiation of disciplinary procedures of a partner, or the change of a clinical project, or other significant issues. Those decisions will require a majority or other super majority vote of the entire Steering Committee or Board. The specific approvals will be detailed in organizational documents being prepared.

Steering Committee votes are communicated to other Committees by Sam Shutman, a vice-president at BLHC, or his consultants—though generally speaking Committee chairs attend the Steering Committee meetings and hear the discussion/decisions directly. This helps ensure clear communication and strong governance control.

***Process 6:**
Explain how conflicts and/or issues will be resolved by the governing team.

The BLHC PPS committee structure is comprised of odd numbered membership and its guiding principles are designed to avoid conflict escalation. However, if a Committee is unable to reach resolution, any issue may be referred to the Steering Committee, as well as referred to the PAC for broader discussion. A majority or super majority vote of the Steering Committee members will be necessary to decide such issues. As the Steering Committee develops the LLCs by-laws it will address which issues require a major or a super majority vote for resolution.

***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.

It is critical that the BLHC PPS Steering Committee act in an open and transparent manner so that issues are discussed openly and decisions are made openly. Public comment will be solicited at select meetings. Minutes of all Steering Committee meetings will be posted on the PPS webpage or other open source. The Steering Committee will have the ability to act in executive session on select critical and sensitive issues, as defined by its by-laws. Members of the Steering Committee will attend the monthly PAC meeting to allow bidirectional communication. The Steering Committee will continue to conduct town hall-type events at least monthly, open to all partners and to the public. The town halls will provide project updates, a forum for open discussion, and a venue for advocates to raise concerns, make recommendations and raise questions.

***Process 8:**
Describe how the PPS governing body will engage stakeholders on key and critical topics pertaining to the PPS over the life of the DSRIP program.

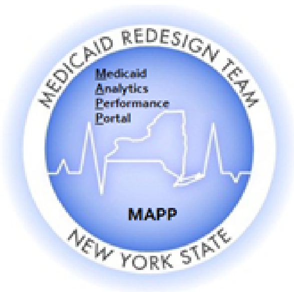
The PPS Steering Committee has begun the process of stakeholder engagement through town hall meetings, webinars, a website, and a weekly newsletter. As the PPS matures during the DSRIP program, the BLHC PPS will continue to hold stakeholder Project Advisory Committee (PAC) meetings comprised of key community members, advocates and Medicaid members. The PAC will meet at least quarterly to review PPS activities and make recommendations, including outreach to the community. In addition, the PPS will develop materials that describe its activities and make these materials and presentations available throughout the community in appropriate languages and formats. The PPS has begun to design a provider and beneficiary outreach and education program built on a successful community engagement model used in California to implement new programs that will train outreach workers to go to providers and public gatherings and explain the activities of the PPS.

☑ Section 2.3 - Project Advisory Committee:

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

***Committee 1:**
Describe how the Project Advisory Committee (PAC) was formed, the timing of when it was formed and its membership.

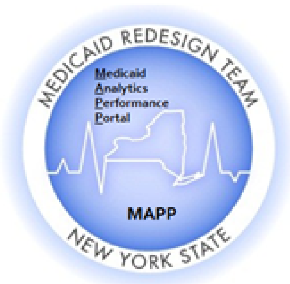
The PAC was formed initially in March 2014 and by the lead organizations of two Health Homes in the Bronx – CCMP and the Bronx Lebanon Health Home. Over the past 7 months, the PAC has grown in size to include organizations representative of the community. Currently, the PAC is comprised of 40 organizations and is represented largely by the senior executives associated with those organizations. The broad membership of the BLHC PPS PAC reflects the provider and stakeholder community in the South Bronx and



provides representation of a majority of community interests and services provided to the community. The PAC currently meets monthly to review the activities of the PPS and make recommendations to the Steering Committee. Since March 2014 the PAC has met eight times during which updates and discussion of key DSRIP processes took place. As the CNA revealed, the South Bronx is a highly at-risk community. Its population ranks as the lowest income in the State and the area has a very high number of uninsured/ Medicaid participants. In addition, there is a wide variety of new immigrant communities. The CNA identified housing security, personal safety, food security and transportation as primary issues that impact health in the South Bronx community. With this in mind, the Steering Committee has included community providers who focus on these important social needs so that the Steering Committee can work collaboratively to address community needs across the health, welfare and social services spectrum.

Project Advisory Committee
1199 SEIU
Affinity
AllMed Medical and Rehabilitation
American Dental
AmidaCare
Arch Care
Argus Community
ASCNYC/iHealth
Boom! Health
Bronx Health Home
Bronx Lebanon Hospital Center
Bronx Lebanon Integrated Service System
Bronx Lebanon Special Care Center
BronxRHIO
BronxWorks
Care For the Homeless
Community Care Management Partners Health Home/VNSNY
Community Health Network
Comunilife, Inc.
Corbin Hill Food Program
Dennelisse Corporation
Dominican Sisters Family Health Services
FEGS
God's Love We Deliver
Health People Community Preventive Health Institute
Healthfirst
HELP/PSI
Hemant Patel Medical Group
HITS
Hudson Heights IPA
Morris Heights Health Center
NADAP/iHealth
Narco Freedom
NYSNA
Salvation Army/iHealth
Selfhelp Community Services, Inc
Unique Peoples Services
Uptown Healthcare Management Inc
Urban Health Plan
VNSNY

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



The PAC will play a critical advisory role through the life of the DSRIP program. Currently, the PAC advises the Steering Committee by providing guidance during the Collaborative Contracting phase of the PPS development. During this period, the Lead Entity will be the contractor for the PPS, with the Steering Committee being responsible for leadership and governance. The PAC also serves a critical advisory function to the smaller Steering Committee by being able to offer a wider set of voices to the Steering Committee. The PAC shares information with the Steering Committee through formal reports, minutes, and shared members who sit on both Committees. In to 2015, The PPS will continue to rely on the PAC to advise the Steering Committee when the LLC is created and the PPS moves to the Delegated Model. The PAC will be requested to comment on all topics of interest to the Steering Committee, including financial, IT, project-specific, stakeholder relations, and clinical issues.

***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).

The PAC has been the lead in reviewing and providing comments on the development of the PPS. At the June 2014 meeting, the PAC agreed to create a Steering Committee which would serve as the governing body and whose membership would come from PAC members. While the PAC and the Steering Committee have separate roles and responsibilities, the overlapping membership facilitates good information flow. In the Bronx, New York Academy of Medicine (NYAM) conducted a comprehensive community needs assessment using quantitative research techniques. This public document included all of the South Bronx service area and statistically described the health and social needs of the Bronx. The Steering Committee and PAC decided to conduct a focus group based qualitative CNA to confirm the findings of the NYAM CNA. This study's findings, conducted by Researcher's Resource, mirrored the broader quantitative study and confirmed the service gaps and needs of the community.

***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.

More than 200 providers and community organizations have expressed an interest in participating in the BLHC PPS. Those providers include physicians, hospitals, health homes, mental health and substance use disorders providers, FQHCs, IPAs, housing, meals providers, Medicaid managed care, rehabilitation and sub-acute providers, the Bronx RHIO and a PACE provider, to name a few. As a result, the Steering Committee/PAC had to select representatives from several provider types to give the Committee the broad representation. Membership represents the lead entity, physicians, home health providers, FQHCs, hospice, social services, managed care, substance use providers, behavioral health providers, and shelters. The membership of the PAC is listed in a previous section.

☑ 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.

During the first quarter of 2015, and with the advice of counsel, the BLHC PPS will begin to staff the PPS through a management services organization (MSO) arrangement with the Mount Sinai PPS. It is anticipated that these services will include the provision of a Compliance Officer who will have independent accountability to the Steering Committee. It is expected that the Compliance Officer will have no previous recent experience with BLHC PPS providers to help ensure impartiality and will begin work no later than March 15, 2015. While the Compliance Officer will be an employee of the MSO, he or she will function under the direction of the Compliance Committee, the Steering Committee and the regulations developed by the DOH.

***Compliance 2:**

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

The Steering Committee will develop a compliance program that includes:

• A Compliance Officer designated to oversee compliance related activities and attend Steering Committee meetings.

• Safeguards will protect the Officer, PPS patients and other PPS participants from retaliation or retribution if he/she provides information of compliance concerns.
• The Compliance Committee will meet monthly, report to the Steering Committee which will adopt the Compliance Plan that will identify DSRIP, State and Federal rules and regulations affecting compliance activities.
• The Compliance program will describe the duties of the Compliance Officer, including review of complaints and grievances.
• The Compliance program will work with the Quality Committee on the Clinical projects and with Finance for financial compliance and oversight and provide assistance on any contractual issues.
• The Compliance Committee will review and recommend approval to the Steering Committee of contracts and protocols.

***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.

The Compliance Committee will review all of the compliance programs and training that are needed by PPS participants and develop a PPS wide training program that supplements those activities with PPS specific compliance training. The Compliance Officer will also review audit procedures and develop a PPS specific audit policy and procedure for implementation with PPS partners and vendors. Compliance training will include information about reporting any compliance issues across key functional areas, including: 1) data reporting; 2) IT protocol compliance; 3) funds flow; and, 4) clinical benchmarks. This will include information on audit procedures to be used. As well as a mechanism for reporting irregularities. Safeguards/whistle-blower protections will be developed to protect those making such reports. PPS Compliance training will be distinct from existing provider based compliance training and focus on PPS specific issues. HIPAA training will be mandatory for PPS partners and providers.

***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.

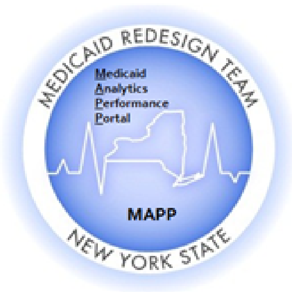
The Compliance Officer, with guidance from the Compliance Committee, will be responsible for developing procedures for community members and beneficiaries to report compliance concerns. PPS participant education about a wide range of PPS related activities and programs will be an integral part of the roll out of the PPS. The BLHC PPS will have a member services compliance phone number and email response available in several languages that will be broadly promoted through BLHC PPS providers. This phone number will receive all participant questions, concerns, complaints and grievances and will identify the appropriate PPS office or department to address the concerns. The Compliance Officer will be responsible for compiling and resolving those concerns where possible, or referring them to the Compliance Committee or Steering Committee, when necessary. Beneficiaries will also be able to complain about PPS activities directly to any provider who will relay that complaint to Compliance or by mail to the PPS.

☑ 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, which reports to the Steering Committee, is comprised of a Lead and 15 community agencies, such as nursing facilities, home health agencies, health homes, IPAs and others. It has the following tasks:
• Develop and approve policies and procedures for the flow of funds;
• Review and approve the MSO's financial management policies and procedures;
• Monitor the budget and escalate issues that exceed the budget by more than 5%;
• Monitor the financial performance of the PPS monthly and report to the Steering Committee;
• Work with health plans to develop new pay for performance initiatives;
• Attend clinical committees and monitor their financial activity.



***Organization 2:**

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

The Finance Committee will manage its activities and report to the Steering Committee and the Lead Entity. The PPS will contract with the Mount Sinai MSO for certain financial and other services beginning in 2015. When the PPS moves to a delegated LLC model in 2016, the LLC will assume responsibility for all financial matters and maintain the MSO contract. The Finance Committee will recommend policies to the Steering Committee concerning spending authority limits for all Committees and the MSO; the annual budget process; the financial milestones for each partner; and the finance component of the Compliance Plan. The Committee will be responsible for developing evaluating and recommending new financial models such as value based contracts, risk pools etc. to the Steering Committee.

***Organization 3:**

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

The PPS will use internal and external auditors to oversee the performance of the PPS, including the services contract with the Mount Sinai MSO. The Finance Committee will make recommendations to the Steering Committee regarding internal and external auditors to monitor finance components. The Finance and Compliance Programs will define whether an internal or external auditor will be used for a specific task. All work in these area will meet requirements of New York State Social Service law 363-D. The milestone for retaining external auditors is June 30, 2015.

***Organization 4:**

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

The MSO will be responsible for hiring a Compliance Officer during the first quarter of 2015. The Compliance Officer will convene the Compliance Committee and write the Compliance Plan for implementation prior to April, 2015. Working with the finance Committee, the Compliance officer will participate in provider audits that will be designed to uncover potential fraud as well as other compliance issues.

☑ 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 BLHC PPS will monitor performance through data driven metrics that are developed by each clinical project, the Finance, IT, Workforce and the Compliance Committee. The IT Committee will implement metrics and reports developed by the clinical project and quality program. The Quality Committee will provide oversight to the performance of the clinical projects, again using data made available through the MAPP as well as PPS-wide developed metrics. The target performance goals will be included in all of the Partner and vendor contracts and will describe the expected minimum level of performance of each Partner or vendor that is required to meet overall PPS targets. Finance and Compliance will also receive regular IT dashboards and other generated reports for their use in monitoring performance.

***Oversight 2:**

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

The Steering Committee, with the assistance of the MSO, will be responsible for monitoring the performance of PPS members. The Steering Committee will refer specific concerns to the Clinical Project Committee. The MSO will initially work with low performing members. If informal interventions are not successful, a corrective action plan (CAP) will be prepared in consultation with the poor performing member, and monitored by the Steering Committee, or delegated to another PPS Committee. Milestones within the CAP will be monitored by the Committee, with the assistance of the MSO. If the provider fails to meet a milestone, the issue will be raised with the Steering Committee or other delegated Committee. Consistent poor performance in meeting CAP milestones may require other corrective actions, which may include placing a PPS representative at the poor performing provider list or initiating action to remove a poor performer. If the removal of a provider creates a potential gap in the provider network by provider type, the Steering Committee will seek a new provider to fill that gap.

***Oversight 3:**

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

When objective measures of clinical performance or financial viability indicate that a PPS member is performing poorly, the Steering Committee will direct the Compliance Officer and other MSO personnel to develop a Corrective Action Plan (CAP) and schedule to bring the member into compliance. If performance issues are financial, quality or regulatory, the Finance, Quality or Compliance Committees will each provide oversight to activities to improve the provider's performance, as appropriate. If the member fails to comply within 90 days to the plan and schedule, the Steering Committee will first consult with the member and with DOH to seek resolution.

Generally speaking, the CAP will have core elements including: 1) a clear statement of the action to be corrected; 2) options for the correction; 3) time frame for achieving a corrected state; 4) risks for achieving the corrected state; and, 5) role of stakeholders, if any, in achieving correction.

If those consultations do not provide resolution, the Steering Committee may take action to remove that member from the BLHC PPS. A 2/3 vote of the steering committee membership is required to approve an action to remove a PPS member. If the removal of a partner causes PPS service gaps, a process to add new members will established. Organizations seeking to join will be subject to review and approval of the Steering Committee. Removal of a member will generally be considered a final step. The goal will be to work collaboratively with partners to help them understand their requirements and achieve them. It is vastly preferably to keep the community nature of the providers, rather than dismissing them at the first sign of trouble.

Once the LLC is formed, new members may join the BLHC PPS through a formal application and review process. The Steering Committee will accept new members through a majority vote of the Steering Committee membership. This process will be in place throughout the 5 year DSRIP period and beyond.

***Oversight 4:**

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

The BLHC PPS has an active Town Hall process that brings together all project participants, community members and advocates to discuss issues confronting the PPS. The Town Hall provides a venue to provide feedback about providers. In addition, BLHC PPS call center and the BLHC PPS website will receive comments, complaints, and grievances about providers. The data from the call center will be reviewed by the Compliance Officer on a monthly basis and issues reported to the Compliance Committee and Steering Committee for further action, if necessary. The PPS is still developing other outlets for participant input including social media, as well as navigators and other advocates.

***Oversight 5:**

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

The BLHC PPS informs Medicaid beneficiaries and their advocates, as well as all interested parties, about all activities of the PPS through a website, newsletters, town halls, and a listserv all of which are designed to provide transparency to all of the PPS activities including the removal of a provider. If a provider no longer participates in the PPS and has assigned members, those members will be informed by mail and other available means of the change in the provider's status and will be offered options within the PPS for his/her care. In addition, the call center will make 3 attempts to reach those members by telephone to advise them of the change and to discuss their options within the BLHC PPS.

☑ Section 2.7 - Domain 1 – Governance Milestones:

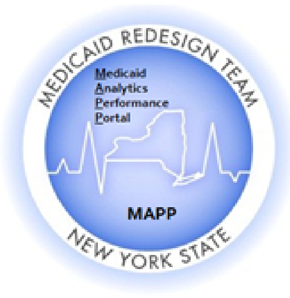
Description:

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

to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

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

Please Check here to acknowledge the milestones information above



SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

Description:

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

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

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

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

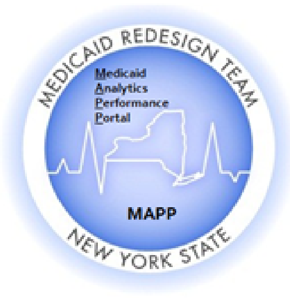
Additionally, the New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention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

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

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

This section is broken into the following subsections:

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



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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

Description:

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

***Overview 1:**

Describe the process and methodology used to complete the CNA.

An extensive process was undertaken in the development of the CNA. A committee was formed to coordinate efforts, review results, and provide expertise. A quantitative and qualitative CNA were conducted. Both primary and secondary data collection were used to inform the CNA. The primary data collection included the following:

• The New York Academy of Medicine (NYAM) CNA was a joint effort involving all of the PPSs in the Bronx County. The focus was on gaining information on community conditions, primary health concerns, available programing and services, disparities in access and use, and recommendations for improvement.

o 600 surveys were conducted using street outreach, focusing on neighborhoods identified as having large numbers of Medicaid populations. The survey was translated into ten languages.

o 24 key informant interviews involved 30 individuals and was comprised of community members and other stakeholders. Local organizations helped recruit participants.

o 21 focus groups, focused on community members from low-income neighborhoods and residents identified as having unique health needs, including individuals with behavioral health issues and immigrants or other limited English proficient (LEP) individuals. Also, a small number of focus groups with providers and community leaders were conducted.

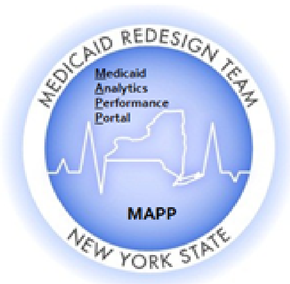
• In addition to the borough-wide CNA, Researchers Resource conducted a qualitative focus group based study. A total of 91 individuals were enlisted from the immediate BLHC PPS community to participate in 11 focus groups and 11 in-depth interviews. Participants were patients and clinicians of programs based in the South Bronx, as well as leaders of organizations.

• A ten question survey of physicians was conducted by Harbage Consulting to confirm the health care priorities of practicing providers in the community. The survey was sent to the PPS partners who forwarded it to any providers within their organizations that provided services to patients.

***Overview 2:**

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

The secondary data analyses followed the recommendations and guidelines set forth in the Guidance for Conducting Community Needs Assessment provided by the DOH. Overall, the analyses started with publicly available, de-identified data to assess health care and community resources, disease prevalence, demographic characteristics, and social determinants of health. The main goal of this component of study was to assess preventable emergency room visits and hospitalizations, as well as to develop a set of descriptive analyses on the rates of chronic conditions of the population at county and zip code levels. Additionally, Salient Dashboards and Data Workbooks were utilized to better understand the community and population to be served. The analyses of approximately 70 publicly available data sets was supplemented with a review of the literature, including reports prepared by the participating providers such as



hospital and community needs assessments and reports, NY DOH, and others.

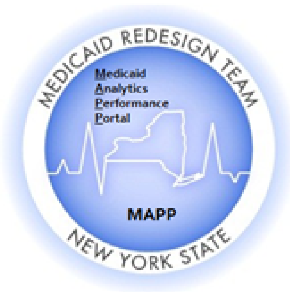
The data was collected, reviewed and analyzed by the consultants working on behalf of the PPS and was then shared with participating partners to help guide discussions on project selection. The data examined was both Bronx County-wide data as well as specific to the PPS, including data on chronic conditions and hospitalizations.
A partial list of the sources of data and reports utilized is below:
• NYS Community Health Indicator Reports
• Prevention Quality Indicators (PQI)
• Pediatric Quality Indicators (PDI)
• Potentially Preventable Emergency Visits (PPV)
• Medicaid hospital inpatient Potentially Preventable Readmission (PPR) Rates
• Hospital-specific profiles of quality of care for selected conditions
• Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits
• U.S. Census Data
• New York State Vital Health Statistics
• NYC DOHMH Community Health Survey
• Mental Health Services Utilization and Co-morbidities
• NYC Department of Corrections Jail admissions

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	10	8
2	Ambulatory surgical centers	14	2
3	Urgent care centers	10	5
4	Health Homes	5	2
5	Federally qualified health centers	39	37
6	Primary care providers including private, clinics, hospital based including residency programs	1132	409
7	Specialty medical providers including private, clinics, hospital based including residency programs	2535	1171
8	Dental providers including public and private	348	101
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	446	45
10	Behavioral health resources (including future 1915i providers)	300	189
11	Specialty medical programs such as eating disorders program, autism spectrum early	10	1
12	diagnosis/early intervention	255	60
13	Skilled nursing homes, assisted living facilities	46	27
14	Home care services	40	21



#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
15	Laboratory and radiology services including home care and community access	35	5
16	Specialty developmental disability services	316	13
17	Specialty services providers such as vision care and DME	90	39
18	Pharmacies	102	4
19	Local Health Departments	1	1
20	Managed care organizations	9	5
21	Foster Children Agencies	1	1
22	Area Health Education Centers (AHECs)	1	1

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.

While the BLHC PPS has many health care providers and community-based resources, Medicaid beneficiaries are not always able to easily access the services they need in their local communities. The provider mix is weighted towards primary care and institutional resources, particularly hospital beds and inpatient settings. There is a lack of specialty care services. Additionally, many resources are located in geographic areas with higher socioeconomic status so the hardest hit parts of the Bronx are lacking access to providers.

The goal of the BLHC PPS would be reallocate resources in the system towards more outpatient and ambulatory care for primary and specialty services that can help prevent admissions and readmissions. Behavioral health resources is a major areas that is in need of modification. There are not enough inpatient or outpatient services to meet the needs of the population. The provider mix needs to be modified to increase access to and use of mental health services at primary care and community settings for those with less severe mental health needs. Additionally, focusing more on patients with chronic health conditions should be an increased area of work. In particular, gaps in care for diabetes patients. This includes increasing the number of social workers and case managers who can help patients navigate the complicated health care system.

The BLHC PPS has a strong FQHC and clinic presence. Work will continue to integrate the clinics so that coordinated care is provided to patients across the service spectrum.

While the BLHC PPS has two major home health programs, more can be done to better integrate those services with the health care system to ensure that patients are supported through care transitions and adhere to treatment regimens following hospitalizations or stays in nursing facilities.

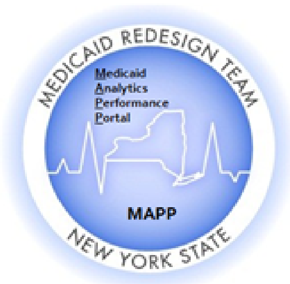
Overall, the BLHC PPS needs to continue to increase access to healthcare services in under-served areas, particularly those that also have lower socioeconomic status. It is not so much that services need to be realigned, but that services in general need to be increased. DSRIP will help do that by increasing the efficiency of services delivered to the community, thereby effectively creating additional services through greater operational efficiency. Resources should be reallocated to provide more access to specialty care in outpatient and ambulatory settings. Additionally, the system needs more support with care transitions and care management to ensure that beneficiaries can navigate the health care system and reach the providers that are available.

☑ Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

***Resources 1:**



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

DSRIP PPS Organizational Application

Bronx-Lebanon Hospital Center (PPS ID:27)

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.

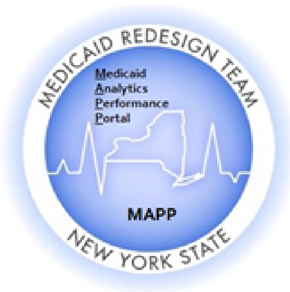
#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	78	33
2	Food banks, community gardens, farmer's markets	231	11
3	Clothing, furniture banks	16	2
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	34	8
5	Community outreach agencies	43	5
6	Transportation services	21	4
7	Religious service organizations	7	2
8	Not for profit health and welfare agencies	441	10
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	44	18
10	Peer and Family Mental Health Advocacy Organizations	4	2
11	Self-advocacy and family support organizations and programs for individuals with disabilities	86	11
12	Youth development programs	336	15
13	Libraries with open access computers	40	0
14	Community service organizations	21	9
15	Education	541	14
16	Local public health programs	40	3
17	Local governmental social service programs	53	2
18	Community based health education programs including for health professions/students	50	6
19	Family Support and training	13	13
20	NAMI	1	1
21	Individual Employment Support Services	66	20
22	Peer Supports (Recovery Coaches)	13	4
23	Alternatives to Incarceration	1	3
24	Ryan White Programs	82	17
25	HIV Prevention/Outreach and Social Service Programs	97	7

***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.

While BLHC PPS is home to many community resources, there are geographic areas mentioned in the CNA where community services and resources are lacking, such as food support, housing, and transportation including in Mott Haven. One way these community resources need to be modified is to make resources more widely available on a geographic basis. This could include expanding the geographic reach of organizations serving the Bronx so that all of the zips in the PPS have more equitable access to services.

Access to healthy, nutritious food is a key need in the PPS service area. While there are a number of food pantries and food banks, more could be done to increase not just access to healthy food but more awareness about the importance of good nutrition for good health and the skills to prepare healthy food on a budget. BLHC and Urban Health Plan collaborate with the Corbin Hill Food Program to address this need. The PPS will be working in the coming months to engage more food banks, farmers markets, and food programs in implementation. The Corbin Hill Food Program will also become more integrated into clinical programs to improve population nutrition as it relates to chronic diseases such as diabetes.



The PPS service area could also use increased access to safe, stable, and affordable housing. Poor living conditions, including exposure to mold, lead, and vermin, can contribute to poor health outcomes including asthma. DSRIP's asthma management program will help support the addition of legal aid intervention and remediation support

While education focused community based organizations are involved in the PPS, it currently does not have schools or libraries involved. The PPS will be working in the coming months to secure additional support from the education system as it is critical to include them in the discussions on implementation of DSRIP in the projects focused on school-aged children and their families.

With the need for increased access to mental health services discussed in the CNA, peer and family mental health advocacy is another area the PPS will look to integrate as a resource within the DSRIP projects.

A final community resource need is transportation. Current programs used for patient transportation are unpredictable and unreliable, creating timeliness issues. Lack of transportation means that patients cannot access needed care. The issue of transportation was referenced numerous times in the CNA as a reason why patients were not able to access health care. The PPS will expand a program developed by BLHC, in collaboration with Transcare Ambulance Company, to better integrate care for patients that have been transported by ambulance. Physicians of patients transported by ambulances are very often not aware that their patient has been hospitalized nor of the specific follow up care and drug regimen prescribed. The BLHC/Transcare program provides feedback to physicians who use the program, including emergency room or inpatient discharge summaries as well as consult reports. In so doing, this program allows the community based physician to better manage their patients who are at highest risk of readmission and readmission

✅ 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:

There are 369,168 children (age 0-17) living in the Bronx and 1,017,196 adults (17+). Seniors (65+) make up a smaller proportion of the population (147,030). According to U.S. Census data, approximately 7.6% of population is under the age of 5; 25% is under the age of 18; 36% is between 18-54; and, 11.1% over the age of 65. There is a greater number of females (735,636) compared to males (650,728). Adults between the ages of 18 and 65 account for the largest proportion of uninsured in the Bronx, with a rate of 20% versus approximately 2% among those aged 65 and older, and approximately 5% among children aged 0-17. Additionally, the population in the Bronx has grown by 2.4% since 2010 in comparison to NYC's growth of 1.4%.

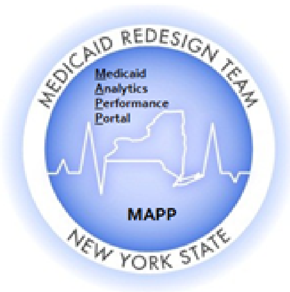
***Demographics 2:**
Race/ethnicity/language statistics of the population, including identified literacy and health literacy limitations:

The PPS is culturally and ethnically diverse. Only 16% of the total population is white. More than 66% of the population identifies as being Hispanic or Latino, and 33% as African American. Approximately 21% of PPS residents are not U.S. citizens, and 14,000 residents (1% of the total population) migrated from abroad less than a year ago.

According to US Census, there are 24 different languages spoken in homes in the Bronx, with the Spanish (46.4%) and English (43.2%) being the top two. African languages account for 3%, French 1% and Idic 1%, and 5.4% spread out amongst a variety of 19 other languages. For a quarter of the PPS, they speak English "not very well."

Health literacy is an issue specifically due to the borough's demographics. According to nationally averaged data, 41% of blacks and 24% of Hispanics score "Below Basic" when given a health literacy survey. Of those living below the FPL and on Medicaid, 30% scored "Below Basic" on the same survey.

***Demographics 3:**
Income levels:



The median household income in the Bronx is approximately $34,300 per year, significantly lower than NYC ($51,000) and NYS ($57,000). In several zip codes of the PPS, the annual salary is between $22,000-$24,000 annually.

***Demographics 4:**

Poverty levels:

On average, more than 38% of households in the BLHC PPS live below the federal poverty level, compared to just under one-fifth (19%) in NYC and approximately 14% in NYS. In some neighborhoods of the BLHC PPS, is it as high at 47% of households live below the federal poverty level. There are relatively high rates of poverty throughout the Bronx, with the highest rates of poverty in Hunts Point-Mott Haven, where nearly half of households have incomes
below the federal poverty level.

***Demographics 5:**

Disability levels:

Among Bronx households, 29.1% have a disabled household member. This includes a family member with a hearing, vision, cognitive, ambulatory, self-care, or independent living difficulty. The comparable percentage for NYC is 21.2% and for New York State is 22.5%. Approximately 44.2% (64,949) of Bronx residents aged 65 and older have an ambulatory difficulty, comparable to NYC (42.5%) and NYS (39.8%). Among Bronx residents aged 18-64, approximately 7%
(60,771) have an ambulatory difficulty, higher than the rate in NYC (4.3%) overall and NYS (4.4%).

***Demographics 6:**

Education levels:

The percent of the BLHC PPS that has graduated from High School is 61%, compared to 69% for the Bronx overall. This is much lower than NYC (79%) and NYS (85%). Additionally, only 11.5% of the BLHC PPS has a bachelor's degree compared to 18% for the Bronx overall. In general, the BLHC PPS has a population of residents who have obtained a lower level of education in comparison to the Bronx overall.

***Demographics 7:**

Employment levels:

The average unemployment rate in the BLHC PPS is 15.8% compared to 14.2% in the Bronx overall. In some areas of the PPS, the unemployment rate is as high as 21.5%. The unemployment rate for NYC is 10.2% and NYS is 8.7%. The BLHC PPS has an unemployment rate that is significantly higher than New York State as a whole (on average), NYC, and the larger Bronx community.

***Demographics 8:**

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

There are nine jails on Riker's Island. The PPS includes Riker's Island because the BLHC does extensive work with the Bureau of Correctional Health Services to improve the health of people transitioning out of incarceration and back into the community. Annually, over 53,000 individuals are released from the prison system, and more than 70% return to areas with great socioeconomic and health disparities, including Bronx County. One challenge with this population is that when they are in the corrections system, all health care is provided in-house so they lose Medicaid. Once released, they usually become Medicaid beneficiaries again looking to connect with providers in the Bronx community. This population suffers from a myriad of health conditions: 3.9% are self-report HIV infected; 5% have diabetes; 12% have hypertension; 23.7% have asthma; 23.4% have a mental health condition or needs; 46.8% report current drug use; and 58.3% use tobacco.

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:
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:

Using the NY Vital Statistics Data, the leading causes of death in Bronx County is:

o Males: 1) Heart Disease; 2) Cancer; 3) Unintentional Injury; 4) Pneumonia and Influenza; and, 5) Diabetes.
o Females: 1) Heart Disease; 2) Cancer; 3) Pneumonia and Influenza; 4) Diabetes; and, 5) Stroke.

The Bronx leads New York State in the percentage of premature deaths in people aged less than 65. Using the NY Vital Statistics Data, the leading causes of premature death (death before age 75) in Bronx County is as follows: 1) Cancer 2) Heart Disease 3) Unintentional Injury 4) AIDS 5) Diabetes. These top five causes accounted for 63% of the 13,806 premature deaths recorded for the most recent three years.

o For Bronx County, males top 5 cause of premature death are: 1) heart disease; 2) cancer; 3) Unintentional injury; 4) AIDS; and, 5) Homicide and legal intervention.
o For Bronx County, females top 5 cause of premature death are: 1) cancer; 2) heart disease; 3) diabetes; 4) AIDS; and, 5) Chronic Lower Respiratory Diseases.

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

The Bronx ranks highest among all boroughs in the rate of potentially preventable Medicaid inpatient hospitalizations. It also ranks second among the boroughs in the rate of Medicaid preventable emergency room visits.

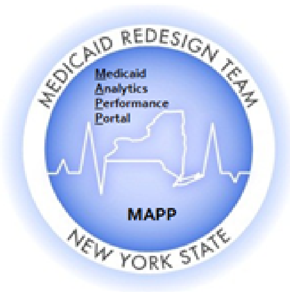
Leading causes of hospitalizations in the BLHC PPS:
• Chronic Obstructive Pulmonary Disease and Asthma: In adults, 1,147 admissions per 100,000 recipients.
• Asthma: In children, 701.47 visits per 100,000 recipients. Asthma is the leading cause of preventable ED visits for children, and is higher than the NYC (426.91 per 100,000) and NYS (210.39 per 100,000)
• Diabetes: Overall, 472 hospitalizations per 100,000 recipients.

NYS DOH data demonstrates that improvements could be made in the PPS to reduce unnecessary (preventable) Medicaid hospitalizations.
• For the Adult Overall Conditions Composite, Medicaid hospitalizations in the Bronx is 13,447 with 70% (9,535) attributed to the PPS.
• For the Acute Conditions Composite, Medicaid hospitalizations in the Bronx is 3,384, with 68% (2,333) attributed to the PPS.
• For the Adult Chronic Conditions Composite, the number of PQI Medicaid hospitalizations in the Bronx is 10,063, with 71% (7,202) attributed to the P

***Challenges 3:**
Rates of ambulatory care sensitive conditions and rates of risk factors that impact health status:

The CNA data demonstrates that the BLHC PPS is home to a significant number of Medicaid Potentially Preventable Emergency Visits (PPV) (253,636 cases) in comparison to the total number of cases (346,837) in the Bronx. This means that 73% of all PPV cases in the Bronx occur in the BLHC PPS. A number of factors contribute to non-emergent use of hospital emergency departments: wait times for appointments, wait times on the day of the visit, and the potential need for multiple visits in regular care. Even long waits in the ER are perceived to represent a more efficient use of time than waiting weeks for a doctor's appointment.

There are several risk factors that impact health status and use of health care resources including obesity, HIV/AIDS, tobacco use, and mental health and substance use. A number of these risk factors will be addressed by the BLHC PPS through the DSRIP projects with the goal that developed interventions will help decrease risk factors that negatively impact health status.



***Challenges 4:**

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

The prevalence of key disorders impacting the residents of the BLHC PPS includes:

- Approximately 10% of the total Medicaid population has diabetes.
- Approximately 2% of the total Medicaid population is HIV positive.
- Approximately 22% of the total Medicaid population has a mental health condition. However, in the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall
- Approximately 9% of the total Medicaid population has a substance abuse issue.

***Challenges 5:**

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

The BLHC PPS has a higher percentage of births between ages of 15-19 and 15-50 in comparison to the Bronx overall. Additionally 82% of the births are Medicaid or self-pay compared to 75% for the Bronx overall. Approximately 10.5% of the BLHC PPS births get late or no prenatal care and about 9.7% of births are low-birth weight. Racial disparities in the Bronx reflect that there are 1.4 times the number of preterm births for blacks and 1.2 times for Hispanics as compared to non-Hispanic whites.

***Challenges 6:**

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

Highlights of the risk factors affecting the BLHC PPS include:

- The prevalence of obesity in the Bronx is higher than in NYC or NYS, with nearly one in three (32%) of all adults in the Bronx obese, versus 24.2% in NYC and 23.6% in the state. In the focus groups, limited access & relatively high cost of healthy food were the reasons given by people for the high rates of obesity.

- Approximately 15.8% of adults in the Bronx smoke. The percentage of cigarette smoking among adults in the Bronx varies by neighborhood. Approximately one in five of adults in Pelham-Throgs Neck (21.2%) and the South Bronx (18.2%) report being a current smoker.

- Approximately 9.1% of adults in the Bronx had poor mental health for 14 or more days in the last month. Additionally, 7.1% of all people report experiencing serious psychological distress.

- Nearly one in five adults living in the Bronx participated in binge drinking in the last month, according to the CNA. In the Bronx, the age-adjusted percentage of adult binge drinking among the total population "during the past month" for the borough was nearly one-in-five (18%) in 2012, similar to the overall NYC rate (19.6%) for the same time period.

***Challenges 7:**

Any other challenges:

One of the leading challenges for the BLHC PPS is that its residents are dealing with a multitude of non-health specific issues that impact daily living, and, therefore, their ability to and the frequency with which they access health care services is impacted. The qualitative CNA brought many of these issues to the forefront. All participants in the qualitative CNA, including patients, providers and organizational leaders, described a number of structural and social challenges that affected patients' lives including housing, employment, and financial needs. In addition, the patients talked about transportation problems, neighborhood safety, racism, and social isolation. The overwhelming sense of facing multiple challenges was most succinctly stated by a patient who, when asked what stood out the most for him, said: "Trying to live." All of these non-health specific challenges that residents in the PPS face impact the timing of when they access services and help dictate the place (ED vs clinic) in which they will access health services when needed. It also has implications on their ability to participate in the necessary follow-up that may be prescribed by their physician.

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 health service gaps in the PPS are most prominent for chronic conditions such as diabetes and asthma and behavioral health. For behavioral health, the CNA points out a particularly serious gap in mental health services for children and adolescents, and, in general, the availability of residents being able to access behavioral health services. For all chronic conditions, the overall gap includes the ability to access to care management and case workers. Additionally, there is a gap in culturally and linguistically competent providers and weak links between care settings has caused gaps in patient transitions from inpatient care to community settings, and limits the ability of care coordinators to follow clients after discharge.
All patients who fall into these gaps account for the largest percent of PQIs in the PPS. For the Adult Chronic Conditions Composite (PQI 92), the number of PQI Medicaid hospitalizations in the Bronx is 10,063 compared to 7,202 (71%) in the PPS.

Immigrants face higher levels of acculturative stress which impacts long-term mental and physical health increasing poor health outcomes. This rich cultural diversity requires specially trained clinical care providers. According to the CNA, key informants and focus group participants report that gaps remain in culturally and linguistically competent providers, particularly for immigrant populations that are relatively new to the Bronx. Also, in the CNA, residents complain about the quality and reliability of language services offered, whether in person or by phone. This project will address this gap by providing training to providers on how to deliver culturally competent care throughout behavioral health system, public education about MEB resources in immigrant communities, the role of acculturative stress on mental and physical health and the role immigrant stress plays on poor health outcomes.

On the over bedding question, the CNA shows that PPS has profound behavioral health needs. The theme of the stakeholder interviews was that more of these services are needed, including inpatient capacity. However, BLHC plans to close one bedded unit to decertify 20 medical beds on or before the end of DSRIP Year 3. Personnel, including nurses (R.N.), will be reassigned to outpatient clinics to better educate and manage patients with chronic disease. Closing of this inpatient unit will be enabled through greater use of BLHC's NYS Licensed Observation Unit, further reductions in average patient length of stay and expected reduction in demand for inpatient utilization by improvements in population health as planned for in this DSRIP initiative. Additionally, the determination of appropriate bed levels is going to have to take place over time and will be simultaneously driven by technical analysis and community input. As part of implementation planning, we will take the opportunity to duplicate the mini-Burger bed process that occurs regularly under state direction to better understand the over-bedding issue. The analysis will focus on balancing the needs of expansion in areas that needs it (behavioral health) with closing beds where they may not be needed (inpatient).

***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.

As in many communities, the BLHC Emergency Department becomes a catch-all for all unmet medical needs. Whenever a patient finds that they have a need that they can no longer wait to address, they will present in the ED—the most expensive setting possible. Sometimes this is because they simply cannot access their primary care physician after hours or on a weekend. And sometimes it is a function of lack of affordable health insurance. Perhaps a behavioral health issue has interfered with a patient's ability to be compliant with their chronic care regimen. The CNA demonstrates that the most common reasons for using the ED were lack of insurance (37%), cost of co-pays (26%), "couldn't get an appointment soon or at the right time" (12%) and concerns about the quality of care (9%). To truly answer this question, one would need to conduct a chart review of patients who present in the ED for two weeks to quantify the myriad of service gad issues that certainly exist in the community. As it stands, our focus group survey of more than 60 physicians in the community gathered their impression on availability of resources. From that analysis, it is clear that there is no one single cause of the service gaps to address. This speaks to the difficult challenges faced by the BLHC PPS in moving forward.

Additionally, residents of the BLHC PPS face a myriad of challenges – many socio-economic which enhance the gaps by impacting the ability to utilize services. This PPS faces high rates of poverty, an under educated population, high unemployment, and a lack of transportation are all issues that impact one's ability to access care. Many respondents in the CNA referenced a "survival mode" that residents of the BLHC PPS find themselves in. Trying to figure out how to pay the rent takes precedence over going to the doctor.

***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 in care for Medicaid patients suffering from chronic conditions such as behavioral health issues, asthma, and diabetes will focus largely on improving care coordination, care transition, and integrating care and providers across disciplines. This will involve strengthening care linkages among all types of providers, aligning specialty care services and primary care services in the same location (co-location), expanding operating hours, and training physicians and others around culturally and linguistically appropriate communications.

DSRIP is an opportunity to help align community health resources with community health needs. As such, BLHC PPS will have an ongoing feedback loop to consider the needs of the community and the resources that exist. This will focus first on the DSRIP projects that are being implemented. Under this plan:

• The Community Needs Assessment Committee will continue to meet once a month for the duration of the DSRIP project.

• The Project Manager for each project will write a report by July 1, 2015, and annual thereafter, on the community needs under their project and how well resources are aligned to meet the need. The report will be based on data collected from the community, in addition to stakeholder interviews.

• These ten reports will then be consolidated by the Project Management Office and the CNA committee, who will make recommendations for system change.

• The report and recommendations will be sent to all the other operational committees (Finance, IT, Project Implementation) who will offer comments on the report and recommendations.

• The Steering Committee will then vote on each finding—approving, denying, or modifying the finding.

• Based on the Steering Committee vote, the partners will be expected to take action as appropriate. Of course, each partner will have the right to decide for themselves, but their DSRIP funding in part will be tied to their ability to act in the best interests of the community, as determined by the BLHC PPS.

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:**

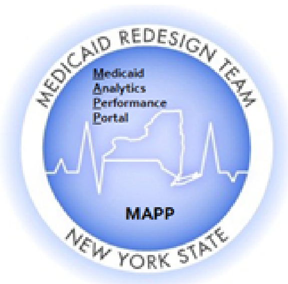
Describe, in detail, the stakeholder and community engagement process undertaken in developing the CNA (public engagement strategy/sessions, use of focus groups, social media, website, and consumer interviews).

The PPS held four town hall meetings attended by more than 100 community members to allow for input on the needs of the community and the proposed projects. Notices about these meetings were widely distributed through community partners and on the PPS website. Additionally, the community was also given the opportunity to provide feedback on the application through a public comment period posted to the PPS website.

Approximately CNA 600 surveys were completed by Bronx residents. Respondents were identified and recruited by local organizations, including community based organizations, senior centers, social service and health providers, and through street outreach. The surveys were translated into 10 languages.

For the quantitative CNA, 24 key informant interviews (involving 30 individuals) were conducted with community members. The key informants were identified with input from the PPS. Some of the informants had population specific experience, including immigrant groups, older adults, children and adolescents. Others had expertise in specific issues, including, substance abuse, supportive housing, care coordination, corrections, and homelessness. All key informants were asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population.

Twenty-one focus groups were conducted for the quantitative CNA. Most of the focus groups were with community members, including



residents from low-income neighborhoods and residents identified as having unique health and service needs, including individuals with behavioral health issues, LGBTQ, and immigrants and/or other limited English proficient (LEP) individuals. Focus group participants were recruited by local organizations. Community member interest in the focus groups was high, with some groups including up to 30 individuals. In addition to the resident groups, we conducted a small number of focus groups with community leaders, as well as providers, including behavioral health providers, care coordinators, and physicians.

For the qualitative CNA, 11 in-depth individual interviews were conducted including patients, clinicians, and organizational leadership. Participants were drawn from a variety of community based organizations and providers.

***Community 2:**

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

For the quantitative CNA, 21 focus groups were conducted in the Bronx. As discussed above, most of the focus groups were with community members. Focus group participants were recruited by local organizations. Additionally, there was also a small number of focus groups conducted made up of community leaders, providers, and care coordinators. The focus groups was conducted in a variety of languages including Spanish, French, and English.

For the qualitative CNA, 11 focus groups were conducted with patients, community members, clinicians and organizational leaders. The 34 participating patients were recruited from a Federally Qualified Health Center (FQHC), a dental services clinic, a home health agency, two organizations that provide substance use treatment along with transitional housing and behavioral health services. The 21 clinicians were drawn from two substance use and behavioral health services agencies, two health home agencies, and a large dental practice. The organizational leaders represented an FQHC, AIDS services, managed care, and unions. One focus group was conducted in Spanish by bilingual moderators and two focus groups had translators present during the group.

***Community 3:**

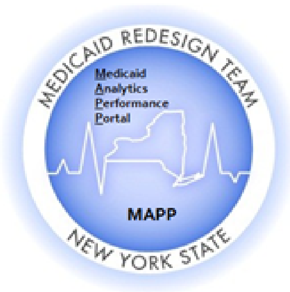
Summarize the key findings, insights, and conclusions that were identified through the stakeholder and community engagement process.

To date, the stakeholder process has helped provide insight into the myriad of socio-economic challenges facing the community that impact residents' ability to prioritize health care services. For some services, such as mental health and substance use, it is as simple as there are not enough providers or programs to meet demand. For the majority of services, they are not being accessed because there are so many other more pressing needs and issues that patients are facing such as putting food on the table, paying bills, obtaining and maintain employment, staying safe in a violent neighborhood and transportation. The overarching theme and takeaway from the stakeholder and community engagement process is that health care has to be made "easier" for residents to access or they simply won't until it is an emergency and they have to access services because it is a medical emergency at that point.

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.

[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Addict Rehabilitation Center Fund	Treatment centers in New York that primarily focus on mental health and substance abuse services.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
2	Advance Care Alliance	Provides the services to people with intellectual and/or developmental disabilities and their families. ACA was formed by three provider networks—Alliance Care Network, Advance of Greater New York, and Long Island Alliance—who together represent more than 90 well-established, not-for-profit agencies operating in New York City, Long Island, and the Hudson Valley	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
3	Affinity Health Plan	Health Plan for Medicaid or uninsured populations in New York	Having payers be part of the conversation on improving the health



New York State Department Of Health
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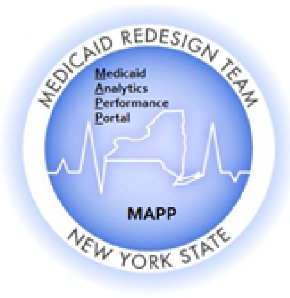
DSRIP PPS Organizational Application

Bronx-Lebanon Hospital Center (PPS ID:27)

[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

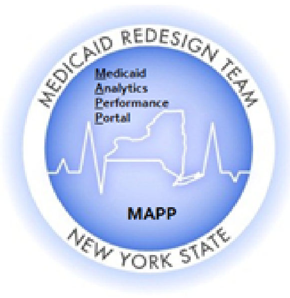
#	Organization	Brief Description	Rationale
			care system is critical
4	All Med	Article 28 Diagnostic and Treatment Center ("D&TC") providing medical care ranging from internal medicine to cardiology, specialized HIV care, gastro and beyond	Having community partners to provide necessary medical are to Medicaid patients is critical
5	Alliance Home Services, Inc.	A home care provider. Services provided by home care agencies can include health care, medical care, medication management, feeding, bathing, light housekeeping and more.	Lowering preventable readmission from persons with chronic conditions is part of the strategy
6	Allied Health Service	Home care provided by registered nurses, licensed practical nurses, certified home health aides, certified personal care aides, companions and homemakers	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
7	American Dental Offices, PLLC	Dental Services	Dental services are critical to good health. Large dental practice
8	AREBA Casriel, Inc	Addiction Treatment Center	Improving behavioral health services and removing stigma is a large part of the PPS strategy
9	Argus Community, Inc	OMH (Article 31) Provider. Mental health clinic	Improving behavioral health services and removing stigma is a large part of the PPS strategy
10	Arms Acres & Conifer Park	Housing Program	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
11	Baah Asante, MD	Physician	Critical to have physicians providing primary care in network
12	Bluehaven Confidential Counseling and Psychotheraphy Services	Counseling Center	improving behavioral health services and removing stigma is a large part of the PPS strategy
13	BOOM! Health	Community based organization focused on the needs of marginalized and stigmatized communities at highest risk of health disparities, substance use, and HIV/HCV. Care Management	Ensuring adequate support services to help the patient address all of their non-medical issues is criticall to keeping them healthy
14	Bronx Jewish Community Council Home Attendant Services, Inc	Provide enhanced quality of life to the residents of the Bronx, particularly older adults, by offering services, support and coordination of community resources.	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
15	Bronx Psychiatric Center	Provides a continuum of inpatient, outpatient and related psychiatric services with inpatient hospitalization at the main campus. Two outpatient sites in the borough of the Bronx	Improving behavioral health services and removing stigma is a large part of the PPS strategy
16	Bronx Works, Inc	A settlement house agency working throughout the Bronx to improve the social and economic well-being of Bronx residents since Emergency shelter, homeless outreach, eviction prevention, entitlement advocacy, workforce development, youth and senior programs, and health care management and benefits navigation are some of the services offered	Having adequate and safe housing is a critical component of staying healthy in the community
17	Camelot of Staten Island	Counseling services for adults, adolescents, children, and families whose lives have been affected by drug or alcohol use.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
18	Care for the Homeless	Nursing home facilities	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
19	Cassena Care	Nursing home facilities	Lowering preventable readmissions from persons with chronic conditions



Bronx-Lebanon Hospital Center (PPS ID:27)

[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

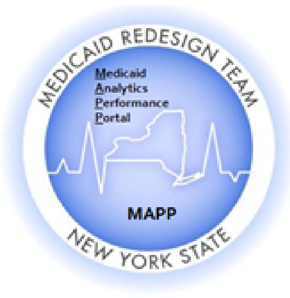
#	Organization	Brief Description	Rationale
			is part of the strategy
20	Center for Alternative Sentencing and Employment Services (CASES)	Programs serving at-risk youth in the Supreme and Family Courts as well as those with recent justice involvement, adults with mental illness and substance abuse disorders in the Supreme and Criminal Courts, technical parole violators detained on Rikers Island, and individuals who have committed low-level offenses who are sentenced to perform community service in Staten Island	Many formerly incarcerated youth and adults reside in the BLHC PPS so it's critical to have organizations providing services to this population to be involved in the PPS
21	Centers Healthcare	A consortium of twenty-three specialty, multi-purpose, healthcare, nursing and rehabilitative centers	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
22	Chaula Patel, MD	Physician	ritical to have physicians providing primary care in network
23	Chavannes Thomas, MD	Physician	Critical to have physicians providing primary care in network
24	Community Care Management Partners, LLC	Community based home health services	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
25	Community Healthcare Network, Inc.	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
26	Concern for Independent Living, Inc	Housing program to help keep residents in the community	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
27	Concord Medical Center	Physician's Office: Dr. Saeed and Dr. Jamil Nawaz	Critical to have physicians providing primary care in network
28	Counseling Services of New York	Licensed outpatient chemical dependency treatment program.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
29	Communilife	A community based organization that provides a continuum of service that include supportive housing, mental health services, and respite beds.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
30	Conifer Park	OASAS (Article 32) Provider. Substance Abuse treatment	Improving behavioral health services and removing stigma is a large part of the PPS strategy
31	Concourse Nursing and Rehab Center	Nursing Home	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
32	Damon House New York, Inc	Not-for-profit primary medical health clinic and dental care. Diagnostic and Treatment Center	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
33	Damian Family Care Center	Diagnostic and Treatment Center	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
34	Daughters of Jacob	Nursing Home	Lowering preventable readmissions from persons with chronic conditions is part of the strategy



Bronx-Lebanon Hospital Center (PPS ID:27)

[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
35	Daytop Village, Inc.	Diagnostic and Treatment Center	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
36	Dennelisse Corporation	Community based organization focused on personal empowerment	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
37	Dominican Sisters Family Health Service Inc.	Long Term Care Provider	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
38	Dr. Martin Luther King Jr. Health Center, Inc.	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
39	EAC, Inc	The program utilizes the authority of the courts to motivate offenders with mental illness to participate in treatment plans, and provides judicial monitoring of their progress and ongoing support to help ensure that offenders successfully complete treatment programs. Within the mental health court, the clinical team provides diagnosis, treatment, and risk assessment evaluation to facilitate the diversion into individualized services.	Many formerly incarcerated youth and adults reside in the BLHC PPS so it's critical to have organizations providing services to this population to be involved in the PPS
40	Empire State Home Care Services	Certified Home Health Agency	Certified Home Health Agency
41	EPRA	Providing vocational services	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
42	East Tremont Medical Center	Primary Care Clinic	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
43	Episcopal Social Services	OPWDD (Article 16) provider. certified treatment facilities that provide clinical services to individuals with developmental disabilities as well as to those caregivers	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
44	EXCELLENT HOME HEALTH CARE	Home health care	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
45	Evers Pharmacy	Pharmacy Services	Having community partners to provide necessary medical are to Medicaid patients is critical
46	FEDCAP Rehabilitation Services, INC	Offers vocational training and employment resources to those who face barriers to employment	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
47	Federation Employment & Guidance Service (FEGS) Health and Human Services	Providing a diverse network of cost-effective health and human services, which meet the changing needs of the Jewish and broader communities, business and our society	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy



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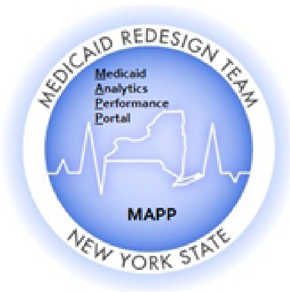
[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
48	First Care of New York, Inc	Home Health Care Service Agency	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
49	Fortune Society	Offers an array of services for the incarcerated or formerly incarcerated	Many formerly incarcerated youth and adults reside in the BLHC PPS so it's critical to have organizations providing services to this population to be involved in the PPS
50	Gateway Counseling Center	Offering counseling services to people from across the entire spectrum of disability.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
51	Gay Men's Health Crisis	Care Management	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
52	GCC Pharmacy (DBA Bronx Eden Pharmacy)	Pharmacy Services	Having community partners to offer pharmacy services to Medicaid patients is critical
53	Geel Community Services, Inc	Organization that provides case management and services to the homeless and mentally ill	Improving behavioral health services and removing stigma is a large part of the PPS strategy
54	Giancarlo Guido, MD	Physician	Critical to have physicians providing primary care in network
55	God's Love We Deliver	Organization that provides meals to people who are too sick to shop or cook for themselves	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
56	Gold Crest Center	Skilled nursing and rehabilitation care center	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
57	Goodwill Industries of Greater New York and Northern New Jersey, Inc.	Not-for-profit organization providing a variety of support services and vocational training in the community	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
58	Grand Manor Nursing and Rehabilitation Center	Nursing and rehabilitation facility	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
59	Greenhope Services For Women, Inc	Residential treatment program for formerly incarcerated women.	Many formerly incarcerated youth and adults reside in the BLHC PPS so it's critical to have organizations providing services to this population to be involved in the PPS
60	Greenwich House, Inc	Offers programs in social services, arts and education	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
61	Harlem Medical Group	Family Health Centers with 7 locations	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP



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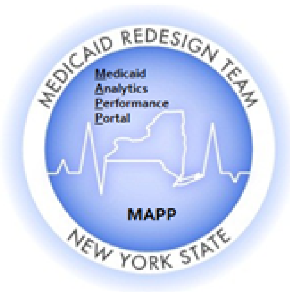
[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
62	Harlem United	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
63	Hebrew Hospital Home of Westchester	Non-profit nursing home for elder care, rehabilitation and palliative care. Services included long term home health care, in-home personal care, medical model adult day health programs and Managed Long Term Care plan.	Providing palliative and rehabilitative care to adult patients to help older patients remain in their homes as well as care for themselves.
64	Health People	Variety of programs including smoking cessation/quitting techniques, HIV/AIDS prevention and support including Children & Teens emotional support dealing with HIV/AIDS. Services also include crisis prevention, care givers training, Family Crisis Counseling, Asthma Community Education and more.	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
65	Healthfirst	Managed Care Organization	Having payers be part of the conversation on improving the health care system is critical
66	HELP/PSI Inc.	Diagnostic and treatment center	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
67	HELP PSI Services Corp	A safety net provider rendering primary, mental health and dental healthcare services in the South Bronx. Other collated services include Health Home and Adult Day Health Centers.	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
68	HELP/Project Samaritan Health Services, Inc.	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
69	Hemant Patel Physician, PLLC	Physician's office: Dr. Hemant Patel	Critical to have physicians providing primary care in network
70	Hospice of New York, LLC	Provides hospice services	Critical organization to helping to address the full spectrum of needs of patient
71	Housing Works, Inc	Diagnostic and Treatment Center	Offering continuum of care with preventative services to patients.
72	Hudson Heights IPA	Physician network	Critical partner to increasing access to primary care and other medical services across the BLHC PPS DSRIP
73	iHealth	Advocacy organization	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
74	Institute for Puerto Rican/Hispanic Elderly	Care management	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
75	Jewish Association for Services for the	OMH (Article 31) Provider. Mental health clinic	Improving behavioral health services



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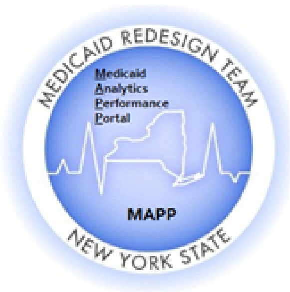
	Aged		and removing stigma is a large part of the PPS strategy
76	JLDH Medical Services, PLLC	Physician's Office: Dr. Jose Batlle Primary care	Critical to have physicians providing primary care in network
77	Kings Harbor Multicare Center	Provides long-term and short-term skilled nursing care for more than 700 residents.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
78	Kingsbridge Heights Nursing Center	Nursing home facility	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
79	Little Flower Children and Family Services of NY	OPWDD (Article 16) provider	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
80	Lifeline Systems (dba Philips Lifeline)	Medical alert service	A unique organization that helps seniors and persons with disabilities stay in their homes
81	Lower Eastside Service Center	Organization offering substance use treatment both outpatient and residential treatment tracks; Primary healthcare; Vocational counseling; Housing assistance	Improving behavioral health services and removing stigma is a large part of the PPS strategy
82	Lower Westside Household Services Corporation	Organization provides home care and health related services.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
83	Madan B. Paul, M.D.	Physician	Critical to have physicians providing primary care in network
84	Marco Hernandez, MD	Physician	Critical to have physicians providing primary care in network
85	Maria Perea Barbosa	Physician	Critical to have physicians providing primary care in network
86	MedAlliance	Article 28 clinic providing diagnostic and treatment services	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
87	MedcarePlus, PLLC - Alseny Balde	Physician practice	Critical to have physicians providing primary care in network
88	Melchor T. Domingo. MD	Physician	Critical to have physicians providing primary care in network
89	Methodist Home for Nursing & Rehabilitation	Provides skilled nursing and rehabilitative care.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
90	MHA-NYC	Provides advocacy, service and public education on mental health including a National Suicide Prevention Lifeline, Family Resource Centers , Adolescent Skills Centers, internet based cognitive behavioral therapy with text, chat, and telephone supports, and NYC Teen text, among other programs.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
91	Morris Park Nursing & Rehab	Nursing home facility	Lowering preventable readmissions from persons with chronic conditions



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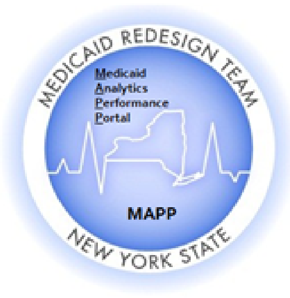
			is part of the strategy
92	Morris Heights Health Center	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
93	Morrisania Dialysis Center	Renal Dialysis Center	Diabetes is a leading cause of death in the BLHC PPS and a focus of our DSRIP project
94	Multi Medic Physician Services PC	Physician Practice	Critical to have physicians providing primary care in network
95	MZL Home Care Agency, LLC	Home Care services specializing in creating care programs for seniors and disabled patients.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
96	NADAP	Organization offering employment, assessment, case management and Health Home care coordination programs	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
97	Narco Freedom Inc.	A network of drug treatment and health related services. Beginning as a methadone treatment center, services have expanded to include several modalities of chemical dependency treatment, primary medical care and social support services.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
98	New York Harm Reduction Educators (NYHRE)	A non-profit organization devoted to promoting the health, safety and well-being of marginalized, low-income persons who use drugs	Improving behavioral health services and removing stigma is a large part of the PPS strategy
99	NEW ALTERNATIVES FOR CHILDREN, INC. (NAC)	OMH (Article 31) Provider. Mental health clinic	Improving behavioral health services and removing stigma is a large part of the PPS strategy
100	New York Renal Associates Dialysis Center	Offers hemodialysis to patients suffering from renal failure.	Diabetes is a leading cause of death in the BLHC PPS and a focus of our DSRIP project
101	NEW FOCUS CENTER	OASAS (Article 32) Provider	Improving behavioral health services and removing stigma is a large part of the PPS strategy
102	NY Foundling	OPWDD (Article 16) provider	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
103	Night and Day Group	Physician's Office: Dr. Cluny Lefevre, Primary care	Critical to have physicians providing primary care in network
104	Odyssey House, Inc.	OASAS (Article 32) Provider. Substance Abuse Clinic	Improving behavioral health services and removing stigma is a large part of the PPS strategy
105	OVAL PHARMACY	Pharmacy Services	Having community partners to provide necessary medical are to Medicaid patients is critical
106	PAC Program	Substance abuse treatment	Improving behavioral health services



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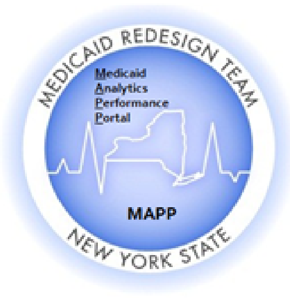
			and removing stigma is a large part of the PPS strategy
107	Palladia, Inc	Services offered include residential substance abuse treatment; outpatient and transitional treatment; homeless and domestic violence shelters; alternatives to incarceration; permanent supportive housing programs; and a wide range of special initiatives and collaborations.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
108	Pelham Parkway Nursing Care & Rehabilitation Facility, LLC	Skilled nursing and rehabilitation facility	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
109	Peter Bae, MD	Physician	Critical to have physicians providing primary care in network
110	Phoenix Houses of New York, Inc.	OASIS (Article 32) Provider. Substance Abuse treatment.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
111	Pioneer Home Care, Inc	Skilled nursing services including nursing, home health aide, personal care, occupational therapy, physical therapy and speech-language pathology.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
112	Premier Home Health Care Services	Providing home health care services	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
113	Primary Care Development Corporation	Nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
114	Project Renewal	Diagnostic and Treatment Center	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
115	Promise Home Care Agency	Providing home health care services	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
116	Promoting Specialized Care and Health (PSCH)	Providing counseling, resource coordination, case management, reimbursement for special equipment and home renovations and respite services of youths with developmental disabilities, among many other programs and services.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
117	QSAC, Inc.	OPWDD (Article 16) provider	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
118	Rasik Patel, MD	Physician	Critical to have physicians providing primary care in network
119	Rebekah Rehab & Extended Care Center	Providing short-term rehabilitative health services, complex clinical and long-term care	Lowering preventable readmissions from persons with chronic conditions



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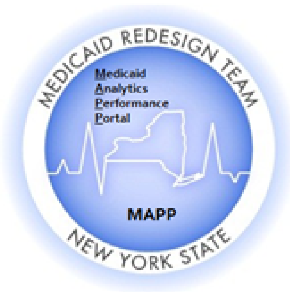
#	Organization	Brief Description	Rationale
			is part of the strategy
120	Regeis Care Center	Provided extended-stay nursing care to seniors with varying levels of disabilities	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
121	Regen Dwarka, MD	Physician	Critical to have physicians providing primary care in network
122	Renaissance Home Health Care	Home Care Agency	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
123	Riverdale Mental Health Association	OMH (Article 31) Provider. Mental health clinic	Improving behavioral health services and removing stigma is a large part of the PPS strategy
124	Rufus Sadler, MD	Physician	Critical to have physicians providing primary care in network
125	Samuel K. Mensah, MD	Physician	Critical to have physicians providing primary care in network
126	Samaritan Village	Diagnostic and Treatment Center	Improving behavioral health services and removing stigma is a large part of the PPS strategy
127	Selfhelp Community Services, Inc.	Social Services agency focused on independent living for seniors and senior care	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
128	SKIP of New York	A free medical concierge for medically fragile and developmentally disabled children, linking them to a broad array of programs, services and equipment.	A unique community resource that helps children and their families find the care they need
129	St. Christopher's Inn	Temporary homeless shelter providing services for men in crisis. Offers a continuum of quality health care services that facilitate physical, emotional, and spiritual healing.	Providing services for homeless men and care continuity as part of the care coordination strategic plan.
130	St. Vincent de Paul Residence	Assisted Living Facility	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
131	Success Counseling Services, Inc	Counseling Services for drug and alcohol addiction	Improving behavioral health services and removing stigma is a large part of the PPS strategy
132	Surendra R. Patel	Physician	Critical to have physicians providing primary care in network
133	Sureshchandra Shah, M.D.	Physician	Critical to have physicians providing primary care in network
134	Terrace Healthcare Center	Skilled nursing facility	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
135	The Salvation Army	The Salvation Army Greater New York Division administers a wide variety of social services which	Ensuring adequate support services to help the patient address all of their



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		are largely made possible through contracts with government agencies such as the New York City Department of Homeless Services and the New York City Administration for Children's Services.	non-medical issues is critical to keeping them healthy
136	The Center for Family Support	OPWDD (Article 16) provider	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
137	The Floating Hospital, Inc.	FQHC	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
138	Transcare New York, Inc	Medical transportation organization	Patients have challenges with medical transportation
139	Terence Cardinal Cooke Health Care Center	OPWDD Article 16 Provider. certified treatment facilities that provide clinical services to individuals with developmental disabilities as well as to those caregivers	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
140	TRI Center	TRI Center blends state-of-the-art clinical techniques with time-tested recovery methods...delivering a customized, personalized recovery program designed to heal holistically – mind, body, and spirit.	Improving behavioral health services and removing stigma is a large part of the PPS strategy
141	Unique People Services, Inc	Providing a home and supportive services to persons with special and challenging needs. 24 supportive housing programs where residents receive meals and other support services that include case management for formerly homeless persons with HIV/AIDS, long-term and permanent housing for formerly homeless persons with a mental illness, and permanent housing for adults with developmental disabilities.	HIV/AIDS is a critical problem in the BLHC PPS and partners must work together to address how to offer coordinated treatment to the whole person
142	University Diagnostic Medical Imaging	Radiology Services	Having community partners to provide necessary medical are to Medicaid patients is critical
143	University Consultation	Not-for-profit Behavioral Health Organization	Improving behavioral health services and removing stigma is a large part of the PPS strategy
144	Uptown Health Care Management, Inc	Providing prevention and care of acute illnesses (primary care) at clinics	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
145	Urban Health Plan	Providing primary care, specialty care, behavioral health, dental care, and support services including care management, nutrition counselling, health education, and transportation at 8 health center sites, 8 school based health centers and three part time clinics.	Increasing access to primary care and other medical services is a core of the BLHC PPS DSRIP
146	VIP Community Services, Inc	Providing addiction recovery services including Medication Supported Recovery (Methadone and Suboxone), Residential Treatment, Outpatient Services, Ambulatory Detoxification Services; primary healthcare (including HIV specialty); HIV Case Management; Care Coordination; Shelter;	Improving behavioral health services and removing stigma is a large part of the PPS strategy

[Bronx-Lebanon Hospital Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Transitional and Permanent Supportive Housing; and a soon to open OMH Mental Health Outpatient Clinic.	
147	Visiting Nurse Service of New York	Not-for-profit home- and community-based healthcare organization. Also operates a Medicaid Managed Long Term Care Plan (MLTC) in New York City and New York State, as well as a Medicare Advantage Plan for chronically ill populations.	Lowering preventable readmissions from persons with chronic conditions is part of the strategy
148	Vocational Instruction Project Community Services, Inc.	OASAS Article 32 Provider	Improving behavioral health services and removing stigma is a large part of the PPS strategy
149	Weston United Community Renewal	Provides housing and support to people who are homeless and mentally ill	Ensuring adequate support services to help the patient address all of their non-medical issues is critical to keeping them healthy
150	William Kalafatic, MD	Physician	Critical to have physicians providing primary care in network
151	Xeron Clinical Laboratories, Inc	Clinical laboratory, providing laboratory service to patients, physician offices, nursing homes, adult homes, hospitals, rehabilitation centers, dialysis centers and home-bound patients.	Having community partners to provide necessary medical are to Medicaid patients is critical
152	Corbin Hill Food Program	Food pantry, community gardens, farmers markets	Bringing fresh produce to food deserts, the underserved in the South Bronx and Harlem. Their focus is reducing obesity, and lowering risk associated with chronic conditions.

☑ Section 3.8 - Summary of CNA Findings:

Description:

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

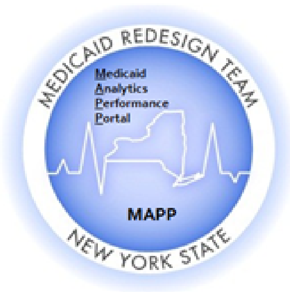
***Community Needs:**

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

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

[Bronx-Lebanon Hospital Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for integrated care across the spectrum of primary and specialty services	Need for integrated care across the spectrum of primary and specialty services	Quantitative CNA Qualitative CNA



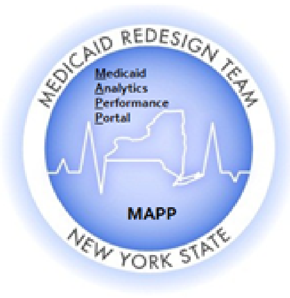
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Bronx-Lebanon Hospital Center (PPS ID:27)

[Bronx-Lebanon Hospital Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			Physician Survey Prevention Quality Indicators (PQI) BLHC Emergency Department Data Potentially Preventable Emergency Visits (PPV)
2	Need for expanded access to primary care services	CNA discussed the challenges patients had accessing primary care services in the evenings (extended hours) and on the weekends Patients with chronic conditions needs extended access to primary care to reduce hospitalization rates and	Quantitative CNA Qualitative CNA Prevention Quality Indicators (PQI) Potentially Preventable Emergency Visits (PPV)
3	Need for greater care transition support to prevent 30-day readmissions for at-risk populations	86,156 hospital admissions were projected to be followed by a readmission (at risk admission). Lack of understanding of discharge directions by the patients at high risk of readmission with chronic conditions can lead to readmissions	Quantitative CNA Qualitative CNA NYS DOH data Prevention Quality Indicators (PQI) Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits Potentially Preventable Emergency Visits (PPV)
4	Need for better diabetes management	Diabetes is the 5th leading cause of death for males in Bronx and is the 4th leading cause of death for females in Bronx	Quantitative CNA Qualitative CNA Physician Survey NYS DOH Data NY Vital Health Statistics
5	Need for greater integration of primary care and behavioral health services	CNA found integration between behavioral health and physical health services poor fragmented. Behavioral health services are in high demand with lower access in comparison to primary care. 53% of CNA survey respondents reported that behavioral health services were "available," compared to 77.6% who reported primary care services were "available."	Quantitative CNA Qualitative CNA Physician Survey NYS DOH Data
6	Need for evidence-based strategies for diabetes in at-risk populations	Approximately 10% of the total Medicaid population in the PPS has diabetes, with 3% of this population experiencing condition-related utilization and hospital admissions. According to CNA survey results and focus groups, community members identify diabetes as their top health concern.	Quantitative CNA Qualitative CNA Medicaid hospital inpatient Potentially Preventable Readmission (PPR) Rates Potentially Preventable Emergency Visits (PPV) Prevention Quality Indicators (PQI) Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits NYS DOH Data
7	Need for expansion asthma home-based self-management	Among Medicaid children in the Bronx, the asthma rate of 701.47 per 100,000 is higher than the NYC	Quantitative CNA Qualitative CNA



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

DSRIP PPS Organizational Application

Bronx-Lebanon Hospital Center (PPS ID:27)

[Bronx-Lebanon Hospital Center] Summary of CNA Findings

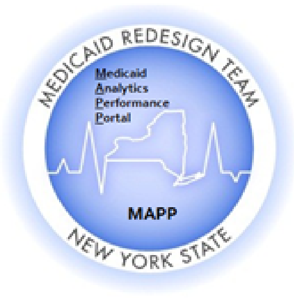
Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		overall rate of 426.91 per 100,000. The CNA highlights the impact that indoor/outdoor housing conditions and environmental factors have on triggering conditions such as asthma	Pediatric Quality Indicators (PDI) Medicaid hospital inpatient Potentially Preventable Readmission (PPR) Rates Potentially Preventable Emergency Visits (PPV) Prevention Quality Indicators (PQI) Medicaid Chronic conditions, Inpatient Admissions, & ER Visits NYS DOH
8	Need for increased access to maternal & child health programs	Percentage of preterm births in the Bronx (12.2%) was higher than in NYC (10.8%). The overall low birth weight rate for the Bronx was 9.5%, compared to 8.5% for NYC and 8.1% for the state. In the Bronx, the percentage of mothers receiving prenatal care starting in the first trimester was lower than the NYS and NYC rates (71.8% and 70.4%, respectively) by over 10%	Quantitative CNA Prevention Quality Indicators (PQI) NYS DOH Data
9	Need for increased access to HIV care	AIDS is the fourth leading cause of premature death in the Bronx	Quantitative CNA Qualitative CNA NY State DOH data NY Vital Statics Prevention Quality Indicators (PQI)
10	Need for strengthened mental health and substance abuse infrastructure across systems	Approximately 22% of the Medicaid population in the PPS has a mental health condition, with approximately 8% suffering from serious psychological distress. The prevalence of substance abuse is 8.5%.	Quantitative CNA Qualitative CNA Physician Survey Mental Health Services Utilization and Co-morbidities Potentially Preventable Readmission (PPR) Rates Potentially Preventable Emergency Visits (PPV
11	Need for increased access to specialty care services	CNA found access to specialty services to be less in all instances in comparison to primary care services	Quantitative CNA Qualitative CNA
12	Shortage of mental health service providers	53% of survey respondents indicated Medicaid beneficiaries do not have mental health services available to them	Quantitative CNA Qualitative CNA Physician Survey Vital Health Statistics Mental Health Services Utilization and Co-morbidities
13	Need for patient navigation, including patient engagement and education.	Health literacy, community values, language barriers, and lack of engagement with healthcare services can result in avoidable use of hospital services. Navigation services will provide bridge support until the patient has the confidence to self-manage their own care.	Quantitative CNA Qualitative CNA

[Bronx-Lebanon Hospital Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
14	Need for more care coordination.	Funding for high-demand services, such as care coordination, is limited and consequently salaries for the positions are relatively low. In the PPS, there are not enough care coordinators to meet the demand	Quantitative CNA Qualitative CNA
15	Need to increase behavioral health services for children and adolescents	CNA found that behavioral health services for children and adolescents is lacking in the PPS	Quantitative CNA Qualitative CNA NY Vital Health Statistics Mental Health Services Utilization and Co-morbidities
16	Need for more education, resources and promotion of healthy lifestyles	Providers have reported that patients lack of understanding about healthy choices requires more education	Quantitative CNA Qualitative CNA
17	Lack of patient follow up after hospital discharge	CNA discussed the challenges with getting patients to complete necessary follow up for outpatient services to avoid readmission	Physician Survey Quantitative CNA Qualitative CNA
18	Need to create a multi-provider team for patients with complex medical, behavioral conditions and so	High at-risk patients with multi-morbid chronic conditions undergo more than two visits of preventable hospitalizations in the PPS	Quantitative CNA Qualitative CNA NYS DOH data Prevention Quality Indicators (PQI) Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits Potentially Preventable Emergency Visits (PPV)

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
27_SEC038_CNA AND MEMO FOR UPLOAD.pdf	12/22/2014 01:53:13 AM	



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: **Bronx_Section4_Text_DSRIP Project Plan Application _ Section 4.Part I(text).12.22.14 TEMPLATE FOR UPLOAD3.docx**

Description of File

File Uploaded By: vg467992
File Uploaded On: 12/22/2014 03:27 PM

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

Currently Uploaded File: **Bronx_Section4_ScopeAndScale_DSRIP Project Plan Application _Scale & Speed UPDATED _ 20141205 (GE).xlsx**

Description of File

File Uploaded By: vg467992
File Uploaded On: 12/22/2014 10:57 AM

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.

BLHC PPS is keenly aware of how the anticipated reduction of unnecessary utilization from the emergency and in-patient departments will impact hospital workforce. The PPS is prepared to develop and implement a plan that will balance the workforce reduction by maximizing skill and talent potential and diverting staff into new and evolving jobs in ambulatory, prevention community-based care and care coordination through education, training and redeployment. The strategy is to mitigate the impact of reductions by assessing interests, talent potential, and training in needed areas, including back-office support and overall supervision.

We surveyed partners, and of those that responded, there are approximately 30,000 employees within the BLHC network, and a little over

half of those employees, 15,923, are represented by labor organizations. The top three categories that partners anticipate retraining are social workers, nurses and clinical support staff. The top three categories partners anticipate redeploying at nurses, social workers and care managers. The top three categories partners anticipate hiring are medical center liaisons, nurses and social workers.

Many incumbent workers will need enhanced skills these areas: 1) patient communications; 2) ability to work in teams; 3) skills in care transitions/coordination; and, 4) updated training on new EMR technology being selected by the PPS.

The process will include the assessment of existing skills followed by training which will include coordination through the 1199 SEIU League Training and Employment Funds (TEF); unions, where applicable; internal institutional education, and institutions of higher learning within the PPS.

The BLHC PPS firmly believes that any potential reductions to the workforce will be balanced by attrition and growth in ambulatory settings. When the PPS surveyed partners, of those that responded, there are currently 538 health professional job vacancies.

The BLHC PPS understands that there may be significant impact to the workforce in a number of job categories/titles, both union and non-union. The PPS sees probable impact in these broad categories (but again, retraining, retooling and turnover attrition is expected to minimize actual job loss)
• Registered Nurses. Reduced unnecessary inpatient utilization will reduce the need for floor nurses at BLHC.
• Emergency room MDs and other medical providers focused on emergency care. Reduced unnecessary Emergency Room utilization will reduce the need for floor nurses at BLHC.
• Technical titles such as inpatient respiratory therapists, and dieticians. Reduced inpatient utilization will reduce the need for ancillary services at BLHC.
• Inpatient workers: food service, transport, environmental services, CNAs, PCTs. Reduced inpatient utilization will reduce the need for support services at BLHC.
• Middle managers responsible for inpatient and emergency room departments. Reduced volume means reduced management need.

Potential workforce increases could occur in the following categories:
• Employees to focus on the overall wellness of Medicaid patients. In the shift from sick care to well care, there will need to be greater emphasis on staff that can provide care coordination services.
• Employees working for Community Based Organizations. By shifting care from institutions to the community, there will be growth in community based provider services, such as clinics.
• Employees who handle billing. This will be true of community partners.
• Employees who handle IT tasks. The new EMR system for the PPS will mean additional training is needed and with expanded IT, there will be more data to manage.

The PPS anticipates that other categories may be impacted based on the specific project build outs and are committed to working closely with workers to keep them informed and assist with planning for fut

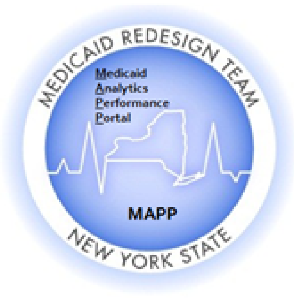
***Strategy 2:**

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.

Critical in minimizing the potential negative impact to the workforce will be effective communication, education and the alignment of labor and management within the PPS and its partners in order to identify the new and/or changing job functions as well as to communicate with the workforce the impact of those changes and the resources that will be available to them in making the transition.

The PPS will establish an inclusive communication process in which all voices and opinions will be heard and respected. All perspectives will be considered and a collaborative sharing process will be fostered.



As appropriate, a needs assessment will be conducted for each affected partner to identify training, redeployment and recruitment plans and strategies. Individual employee assessments will be conducted with employees at risk by 1199SEIU League Training and Employment Funds (TEF), which has a proven track record retraining and redeploying affected workers.

The BLHC PPS will utilize 1199SEIU TEF along with the City University of New York, Urban Health Plan and other designated workforce vendors to retool the workforce. The PPS will utilize the service of 1199SEIU member's assistance program and or similar community services to help employees cope the pace of change necessary to transform the delivery system.

The PPS will take full advantage of TEF's experience in training for new models of care and customizing curricula to meet the demand of workforce development and skill building to meet new training needs.

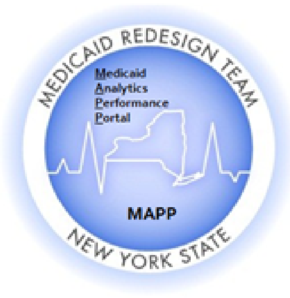
Overall, every effort will be made to create opportunities for retraining and redeployment of employees whose positions may be reduced. The goal is to identify those who have the ability and desire to move into the newly or changed positions in order to mitigate and minimize any negative impacts to existing workers.

The PPS's partners reported that there are 538 vacancies within the partner network. The PPS believes that a number of workforce shortages currently exist within the PPS, specifically in the following areas:

- Patient Navigators
- Peer counselors from the community
- Care Managers
- Health Coaches (or Transitional Care Coaches)
- Care Manager Supervisors
- Community Health Nursing (Field RN's)
- Social Workers
- Licensed Mental Health Counselors
- Behavioral Health workers
- Chronic Disease Management worker
- Home Care Nurses
- Advance Home Health Aids
- Overall support staff, including professional and provider staff who are culturally competent and trained

Considering that DSRIP projects will lead to significant changes in patients flows over the next five to ten years and will shift patients care from inpatient settings to ambulatory settings (outpatient, primary, preventative, care management agencies, and community based organizations), this will inevitably cause some hospital based departments and/or positions to be reorganized and reassigned. To address this change in the workforce, it is the PPS's intention to retrain, redeploy, and repurpose positions that may be impacted. Therefore, the shortages that currently exist within the workforce will be filled by the hospital based positions that are impacted. Training will be provided by the 1199SEIU TEF along with the City University of New York, Urban Health Plan and other designated workforce vendors to retrain, redeploy, and repurpose positions within the workforce. Training will focus on the following areas:

- Health literacy and coaching
- Patient safety
- Risk assessment
- Chronic disease prevention and management
- Asthma self-management
- Bilingual and bi-cultural competency
- Home based patient centered care
- Community resources
- Cultural competency
- Diversity and Inclusion



•Patient Experience

***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	20%
Retrain	20%
New Hire	25%

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.

While each partner will use their existing system for identifying employees and job functions for retraining as the projects are implemented, the PPS's preliminary plan is to continue to survey partners to determine gaps in positions and current staffing levels. Once gaps are identified, the PPS will identify what workers are needed to fill those gaps and how these workers need to be trained. Skill assessments will be conducted including identifying interest and potential. The PPS will then match the interest of the worker and incorporate realistic employment opportunities. All training will be need and project specific with standardized curriculum that also address Domain 1 metric and milestones. Overall, a working environment will be created for all employees to operate at the top of their title and, or licensure. When surveyed, of those who responded, 89% reported that they provide training for their staff. The top three training categories for health care professionals in the BLHC PPS network are Cultural Competencies, Managing Crisis Situations and Code of Conduct/Ethics. The PPS's partners also reported that 96% believed that their current employees have the appropriate skill set for the current positions those employees hold within the partner organization. Partners reported that they will continue to utilize existing state programs for retraining needs and the top three programs used are Workforce 1, FEGS Back to Work, and New York State Job Bank.

The PPS will provide training to workers who need new skills to fill new positions. The focus will be on the transference of skills from patient settings to community-based settings. BLHC will incorporate partner's proven best practices in organizational transformation and will establish communication networks that will allow us to share and integrate skills and expertise. The process will include coordination through the 1199SEIU League TEF; unions such as NYSNA, where applicable; internal institutional education, higher institutions of learning within the PPS to assess existing skills and determining necessary training.

Assessment of administrative support departments throughout the PPS will be conducted; for example; billing and coding will be assessed to determine ICD-10 training needs; IT for capacity in electronic health records and information sharing.

Workers, such as food service, transport, and housekeeping often have skills needed in new and emerging jobs, such as bilingual skills and knowledge of local communities. These workers may be retrained as community health workers, outreach workers and medical assistants. Nurse assistants and patient care technicians may be offered training to become LPNS, medical assistants, community health workers.

An overarching goal for the PPS as it relates to the workforce is to experience as minimal a (workforce) disruption as possible. While

retraining is important to success as roles shift, the goal for the BLHC PPS is to have the right people in the right jobs. Every effort will be made to accommodate an individual's interest levels with their respective skills sets. The various unions and their associated training arms will also make themselves available for those individuals who may require retraining. There should be open communication within the existing PPS and crossing over to other regional PPS's to encourage employment opportunities among the entire workforce.

With all the support in place for many in the workforce around the issue of retraining, the PPS would hope that individuals will embrace change and recognize the various alternatives made available to them in order to keep their jobs. With that said, individuals who want to keep their employment and whose current positions are changed as a result of DSRIP, will need to face mandatory training for re-positioned jobs in the workforce.

***Retraining 2:**

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

The PPS will coordinate with labor management where it exists, to keep whole, whenever possible, the employee's salary and benefit structure. Salary disparities exist among the workforce and salaries and wages are often times directly connected to licensure or lack of; seniority among the workforce, etc. Every available effort will be made to maximize training opportunities and therefore to maximize salary and wage benefit plans.

The PPS will create a process in which wage and benefits will be reviewed for the impacted employees and titles and where applicable, every effort will be made for a career path upwards for impacted employees. Currently, the PPS's partners are already conducting internal assessments for their existing employees and anticipated future workforce needs. It is anticipated that it is realistic for compensation discussions to be an important conversation to have with all impacted employees.

Retraining will be handled through unions and management working together through TEF and other partners. The TEF Employment Center would be a Clearing House for assessing skills, retraining staff and identifying qualified new staff.

***Retraining 3:**

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

The PPS will establish a process to educate all employees regarding the changes that are anticipated as a result of system transformation. This will be done through email, newsletters, town hall meetings, in-person meetings and labor gatherings. Employees will know well in advance how their positions might change. The PPS will follow organizational protocols for informing employees of possible retrenchments and bumping rights based on seniority. Should an employee refuse their redeployment, every effort will be made to understand their concerns, and see if a better job fit can be made within the PPS or other community organizations. Should that process continue to result in the employee's refusal the employee will be referred to employment counseling through TEF or other PPS entities.

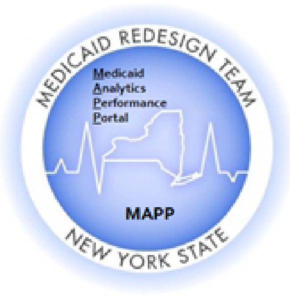
***Retraining 4:**

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

In the BLHC PPS, labor representatives include frontline workers and, where applicable, their union representatives. The Workforce Committee has had 1199 SEIU, NYSNA and 1100 SEIU Training and Employment Fund representation throughout this iterative process. These labor representatives will play an integral role in the development of the retraining plan. As a key stakeholder group, their involvement and engagement in all areas of the change process including the retraining plan is vital. Their participation in all network-wide sub-committees and work teams will ensure that their ideas are validated leading to their understanding and buy in to the process of transforming care and sustaining outcomes. These committees/groups will be diverse, representing different partners, disciplines and various levels of the workforce leading to a more representative and inclusive retraining plan. Their feedback regarding vendors and how training should be designed and delivered will be considered when making retraining decisions. The BLHC PPS partners will continue its work to educate and involve these representatives from the beginning of the transformation process.

***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	40%
Partial Placement	20%

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.

The BLHC PPS strategy will ensure that we have the right people with the right skills. This means that through the new redeployment process, the PPS will identify the right employee with the right skills at the right time for the right position. The PPS will rely on its partners to share their current process for identifying employees and job functions that need to be redeployed. A consultant will be hired to assist us in determining what areas need to be downsized and what employees will be needed and where employees need to be redeployed. Once the needs of the partners across the PPS have been identified, the quickest way to fill those positions is to transfer excess staff from other areas of the PPS. With the assistance of the 1199SEIU League TEF, the PPS can assess the skill set of the staff to be transferred and evaluate the possibility of re-skilling these individuals.

The employee selection will be in compliance with any collective bargaining agreements that may exist. Typically volunteers will first be called for among the targeted group to redeploy. If no volunteers are available, then seniority will be used.

The PPS will implement a five-year plan to deliver these workforce changes and allow time to re-skill and retool to the greatest extent possible. It is anticipated that just redeploying an employee will not be feasible. There will need to be some training or retraining for that employee to be redeployed. This plan will have to be re-evaluated on a quarterly or bi-annual basis to determine any changes that may have to be made and to assure that all organizations within the PPS is on target. The Employment Center at TEF will be used as a clearinghouse to assist in assessing and placing individuals.

***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.

We will continue with the existing process for deployment as implementation begins but the Workforce Committee will work with labor organizations and the PPS partners to establish a new deployment process. The PPS will coordinate with labor management where it exists, to keep whole, whenever possible, the employee's salary and benefit structure. Salary disparities exist among the workforce and salaries and wages are often times directly connected to licensure or lack of; seniority among the workforce, etc. Every effort will be made to redeploy an employee to a position where the employee will achieve full placement. We anticipate that it is realistic for compensation discussions to be an important conversation to have with all impacted employees.

Every effort will be made for a career path upwards for impacted employees. Our partners are conducting internal assessments of their existing employees and anticipated future workforce needs. The TEF employment center would be a Clearing House for assessing skills, redeploying staff and identifying qualified new staff. Redeployment will be handled through the union and management working together through TEF and partners.

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

The PPS will establish a process to educate all employees regarding the changes that are anticipated as a result of system transformation. Employees will know well in advance how their positions might change. The PPS will follow their organizational protocols for informing employees of possible retrenchments and bumping rights based on seniority and any other considerations appropriate to the organization. Should an employee refuse their redeployment every effort will be made to understand their concerns, (e.g. location, title, salary) and see if a better job fit can be made within the PPS or other community organizations. Should that process continue to result in

the employee's refusal the employee will be referred to employment counseling through TEF or other PPS entities.

***Redeployment 4:**

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

In the PPS, labor representatives include frontline workers and, where applicable, their union representatives. 1199 SEIU TEF has been very engaged in this training plan and has provided workforce strategy budget numbers. Workforce Committee has also had participation from NYSNA and 1199 SEIU. These labor representatives will play an integral role in the development of the retraining plan. As a key stakeholder group, their involvement and engagement in all areas of the change process including the retraining plan is vital. Their participation in all network-wide sub-committees and work teams will ensure that their ideas are validated leading to their understanding and buy in to the process of transforming care and sustaining outcomes. These committees will be diverse, representing different partners, disciplines and various levels of the workforce leading to a more representative and inclusive retraining plan. Their feedback regarding vendors and how training should be designed and delivered will be considered when making retraining decisions. The PPS partners will continue its work to educate and involve these representatives from the beginning of the transformation process.

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.

DSRIP program implementation will be focused on prevention/primary care, reduction in avoidable hospitalizations, and improved outcomes and will require additions to the workforce i.e. new hires.

These additions to the workforce will include but are not limited to:

A. Direct Patient Care Services

• Primary Care Physicians, Nurse Practitioners/Certified Nurse Midwives, and Physician Assistants - These clinicians will focus on providing comprehensive, high quality clinical services integrating, preventive services, patient engagement and treatment in a cultural sensitivity delivery system.

• RNs, LPNs - Will support the clinicians in the treatment, monitoring and education of patients.

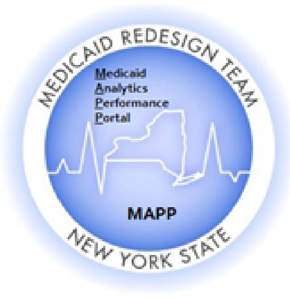
• Medical Assistants - Will provide support to the clinical team (vital signs, medical histories, updating medication lists, providing translation services, etc.

• Physical/Occupational Therapists - This staff will be providing rehabilitation services in LTC, primary care facilities and in patients' homes.

B. Case Management and Support Services

• Case Managers - As part of the clinical care team, these employees work closely with the patient to ensure that the clinical care plans meet their needs and capabilities. Case Managers provide support to both the clinicians and the patients to ensure that the desired outcomes are understood and achieved.

• Patient Navigators - These new hires will be responsible for working closely with patients in assisting them to comply with assigned care plans by providing support services such as: accompanying patients to clinical appointments, assisting with communication between patients and clinicians, collaborating with the clinical care team on the reinforcement of and compliance with medication adherence.



• Home Attendants - Provide support services to patients who are restricted to home.

• Community Outreach Workers - Assist in the identification and engagement of patients who have been lost to follow-up or have not responded to the clinical team's attempts to engage as well as outreach health literacy within the community.

• Patient Advocates - In collaboration with clinical team, work with patients to help resolve situations that prevent the patient from being able to comply with care plans.

C. Behavioral Health Services
• Psychiatrists - These clinicians will provide treatment services as well as supervision and support to the clinical and behavioral service support staff.

• Psychologists - Will focus on behavioral health treatment, screening, and prevention services as well as supervision of behavioral services support staff.

• Social Workers - Will work with clinicians and patients to ensure understanding of and compliance/implementation of service/treatment plans and medication adherence.

• Peer Support Workers - As members of the clinical team and under the direction of the clinical staff, will provide direct outreach and support to patients, with particular emphasis on achieving patient engagement and participation in community support services to achieve long term care plan goals.

• Substance use Disorder Clinicians – Will provide interventions designed to address misuse of substances that impact quality of life health issues and adherence to Primary and Behavioral Care protocols as well as, assist with implementation of system wide SBIRT services.

D. IT Infrastructure and Data Collection/Reporting
• Information Technicians – This staff is required to work on the development, management and support of the IT infrastructure that will be required for the implementation of the PPS projects.

• Clinical Informatics - These workers will be instrumental in working on the design of the tools/workflows for data collection, validation, and reporting of outcome indicators that will be required of all PPS partners.

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	200
Physician	500
Mental Health Providers Case Managers	300
Social Workers	500
IT Staff	70
Nurse Practitioners	1,000
Other	2,750

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	1,050,000	1,000,000	900,000	750,000	500,000	4,200,000

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Redeployment	325,000	325,000	1,050,000	1,050,000	1,250,000	4,000,000
Recruiting	975,000	1,025,000	400,000	750,000	1,000,000	4,150,000
Other	160,000	320,000	320,000	320,000	395,000	1,515,000

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

The PPS workforce strategy is aligned with existing program efforts and plans to ensure that all resources are utilized and maximized.

Through its lead partnership with TEF, the PPS will continue to build on the Funds' experience and the existing collaboration with Bronx Lebanon Hospital Center (BLHC).

Since 2002, TEF has used New York State HWRI funding to offer training to more than 75,000 workers, achieving a 97% completion rate. From 2012, 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). The Care Coordination Fundamentals Training was copyrighted in 2013 and has as its core new employee training, and the additional occupational and interdisciplinary team curricula as well as Train-the-Trainer services. The training's success is evident at BLHC whereby using this model, several Patient Centered Improvement Projects were implemented to increase staff responsiveness and decrease number of call bells. Data collected indicated that by the end of the project there was a 55% decrease in call bells, a 25% increase in patient responsiveness, and more than 95% of HCAHPS Immersion Project participants increased their understanding of HCAHPS survey, scores, and the financial impact on their hospital.

Patient Care Technician training is another successful collaboration between TEF, BLHC, CUNY and government resources aimed at identifying cultural and linguistically competent healthcare workers. 90% of the workers were certified and successfully upgraded. Additional TEF projects funded by HWRI through 2016 includes training in Emerging Technology/Electronic Health Records (HER), Managed Long Term Care, Medical Assistant, Patient Care Technician, Patient Centered Care, Certified Home Health Aide and LPN could be accessed through this partnership.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

Outline the steps taken to engage stakeholders in developing the workforce strategy.

The BLHC PPS has an extensive stakeholder and worker engagement process which is inclusive and has included 1199 SEIU, NYSNA, and all interested partners and their employees. First, there are monthly town halls meetings where attendees are provided with PPS updates and an opportunity to share their comments with PPS leadership and decision makers. Second, patients and community members are engaged through interaction with community boards and surveys to provide real time constructive comments on how projects will impact patient's health outcomes. Third, BLHC PPS has created a public website to facilitate transparency and communication with all interested parties. Fourth, PPS partners are conducting internal communication strategies to keep workers informed and engaged on the potential and existing impacts on the workforce. Fifth, a broad coalition of partner organizations have a seat on the Workforce Committee. The PPS will grow this process throughout DRIP implementation.

***Engagement 2:**

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

The PPS has engaged 1199SEIU union representatives as well as individuals from the 1199SEIU Training and Employment Fund and NYSNA. Labor representatives are included in all discussions and are active participants in decision making for the PPS. The PPS will continue to engage 1199SEIU and NYSNA at every level in order to not only ensure future contract negotiations are considered but that the worker's input is communicated to PPS decision makers. The BLHC PPS will develop a stakeholder analysis to determine which specific communication needs are lacking and develop a comprehensive plan to address those gaps. There is outreach to the actual line workers not only through their labor representatives, but also by BLHC PPS leaders through face-to-face meetings, email and surveys.

***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 has worked through the existing intra-union structure to communicate with frontline workers. Moving forward, the PPS will engage directly with frontline workers through specifically tailored Town Hall meetings and open forums. We will work with each labor organization to identify the correct frequency of those town hall meetings and open forums. The goal of this schedule is to eliminate rumors and allow for workers to hear from decision makers as decisions are being made. The PPS will continue to post all documents on the PPS website and if needed will provide a page for frontline workers. The PPS will have designated stakeholder and outreach coordinators to be available to frontline workers on an individual basis. These positions will be tailored to the specific goals of the PPS and the needs of the workers. This means that at times the communication will be focused on updates and other times the communication may be focused on strategy planning and consensus building. Our commitment to enhancing not only the patient but the worker experience will drive us to ensure that we are responsive to all situations in our community.

***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 have dedicated positions for stakeholder and worker engagement within the PPS structure. These positions will focus specifically on communicating with stakeholders and workers. Stakeholder work groups will be created and convened quarterly and there will be quarterly reports shared with the public. We will focus some meetings in smaller community settings within the Bronx. Monthly Town Hall meetings will continue in order to provide timely updates to the public in case the other stakeholder and worker engagement opportunities are inconvenient for interested parties. If necessary, we may provide Town Halls specific to patients, providers and workers as decisions are made. We will create a safe, transparent environment where attendees feel supported to voice their thoughts, concerns and share their comments. In order to create an integrated health care delivery system, we will all need to work together and that relationship is built on trust and communication.

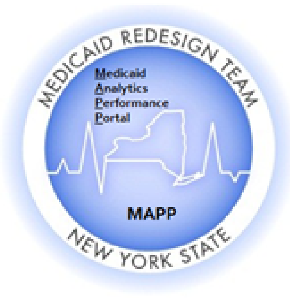
☑ Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

☑ Please click here to acknowledge the milestones information above.



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

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

Description:

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

This section is broken into the following subsections:

- 6.1 Data-Sharing & Confidentiality
- 6.2 Rapid-Cycle Evaluation

Scoring Process:

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

- 6.1 is worth 50% of the total points available for Section 6.
- 6.2 is worth 50% of the total points available for Section 6.

Section 6.1 – Data-Sharing & Confidentiality:

Description:

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

***Confidentiality 1:**

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

By incorporating leading industry proven solutions, the PPS will deliver near real-time, effective care coordination by connecting existing HIT platforms and leveraging the RHIO interoperability to create a longitudinal patient record and clinical data repository. Successful integration of data and sharing of patient information will require that the PPS provider participation agreements and DUAs comply with all federal and state laws. The IT committee will establish common data sharing standards, define supported platforms and lead information governance in coordination with the PPS Steering committee guidance, taking into the broad IT capabilities of providers as informed by the IT assessment in order to ensure timely access to information. As part of the integration plan, the IT committee is creating an implementation strategy to ensure eligible providers progress toward meaningful use stage II and PCMH level III standards in line with DSRIP domain 1 metrics.

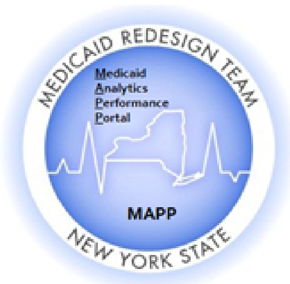
***Confidentiality 2:**

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

The PPS System Security Management will centrally manage creation of user profiles, roles, and confidentiality definitions to drive user assignments providing a single data governance and access model, including execution of BAAs and DUAs. Three consent models are proposed, each of which will reflect HIPAA standards and privacy rules. The Implied Consent Model presumes existence of data in the system and implies consent for it to be viewed by authorized users. The Patient Consent Model requires patient consent before sharing data or opting out of the system. The Selective Consent Model where confidential data may be flagged to enable or block viewing; configurable by different medical domains such as lab results or medications. The IT committee will create policies for all providers, compliance training, annual audit process, and process to identify and mitigate potential risks, and an incremental IT adoption plan to move providers to more mature IT platforms from paper to electronic.

***Confidentiality 3:**

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



The PPS will gradually harmonize aggregated clinical, demographic, and financial data across the connected PPS partner communities, using a commercial integrator technology while leveraging RHIO interoperability, to create a core data sharing infrastructure and data repository that will provide web-based functionality providing all PPS governing bodies and providers with a comprehensive, yet filterable view of all patients and relevant data for performance and clinical management. The system will provide all users with alerts, notifications, and messaging – within their day-to-day workflow creating a dynamic interoperability and promote the envisioned spectrum of care continuity. A preliminary IT assessment indicates a significant proportion of eligible providers have made progress toward Meaningful Use, yet the PPS will have to provide interim work-around strategies for data sharing and connectivity as providers invest in IT platforms during the initial DSRIP years.

Whether utilizing sophisticated integrated IT platforms or paper, we will support the instantaneous ability to view and filter patient or population health-level data. Similarly, and will create project and disease specific registries providing contextual data for a single patient, multiple patients, or population demographic management. The solution will offer consolidated clinical summary views and enable the patient's care team to drill down and utilize information in a readily manageable, customizable format. Optimizing the system's web-based features, all partners will have access to shared, real-time, patient data including those community paper-technology practices migrating to embrace HIT to harness the power of their patient's health information with increasing reliability as new information is continuously added to the system. Change management across the PPS relative to IT and Clinical workflow will be managed centrally, on an at least quarterly basis.

Section 6.2 – Rapid-Cycle Evaluation:

Description:

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

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

***RCE 1:**

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

The PPS IT Team is comprised of the following:
• Clinical and administrative leadership
• Clinical analysts
• Rules engine programmers
• Medical logic module developers
• Data query specialists
• Technical infrastructure support team
Collaborating with the PPS governing bodies (Project Development/Implementation, Finance/Payment Reform, Workforce, and Community Needs Assessment), analytic projects, metrics, core measure reporting, regulatory compliance, and data mining will be defined, and tools created to provide instantaneous dashboard displays for on the spot user interfaces, performance reports for PPS leadership, and quarterly management assessments to monitor benchmark achievements. Based upon the guidelines set by the PPS leadership and subcommittees, the IT Analytics Team will combine PPS data (quality, utilization, outcomes, satisfaction, financial), then leverage the technology within the PPS to recommend to leadership DSRIP process improvements and rapid cycle change management.

***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.

Data management is critical for success. Dashboards will be created describing a patient or group of patient's compliance with clinical quality measures, well-being risk scores, other risk scores based upon system and project defined metrics, with health management messaging, alerts and tasks. A member organization or individual practitioner will be able to instantly review a "Performance" dashboard to compare how they score against defined clinical quality measures targets, trending previous to current periods; how disease specific populations in their practice rate compared to other providers in their practices and other practices within the PPS. Leadership will utilize macro versions of dashboards to assess and manage provider performance.
The PPS will also develop strategies with its subcommittees to leverage the clinical data available within the core data sharing infrastructure permitting analytics that will provide real-time, point-of-care information to end users.

***RCE 3:**

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

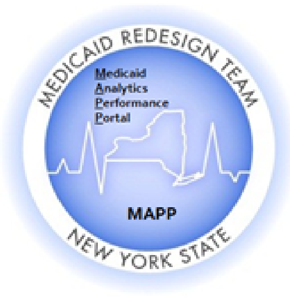
To collaboratively approach the components for population health then determine work priorities, trending reports for PPS partner managers and quarterly reports to the Steering Committee will be provided using information on performance, quality, risk assessments, and financial operations. Core data sharing infrastructure will enable communications of these priorities across all care settings, enabling the creation of risk-based/stratified care plans that identify gaps in care to assure the well-being of every PPS patient.
PPS partners and their clinicians will have a continuous flow of daily information to provide "just-in-time" adjustments to a patient's care, monitoring of population health and care coordination with community care navigators reaching into a patient's home. Such dashboards will be pre-populated with DSRIP benchmarks and goals to assess continuous progress and performance by project/provider type, and will be utilized by PPS leadership for oversight.

***RCE 4:**

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

The HIT system will utilize robust data sets supporting proactive comprehensive care and DSRIP performance management, operating within an integrated data network providing data-driven clinical decision making. The community workforce will be mobilized to extend the care team from the hospital, clinical office, or ambulatory care center to the patient's home creating a primary care led team initiative. The system seeks to connect patients with the high valued resources existing within the PPS to integrate our patient's values into their care plans while overcoming the non-clinical barriers to maximize health outcomes.

Core DSRIP performance metrics and milestones will be integrated within performance dashboards and PPS reporting at the governance, partner and individual provider level to ensure transparency and enable pro-active risk management. Subcommittees will be responsible for goal setting and monitoring across the PPS, raising risks to leadership and recommending remediation.



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:

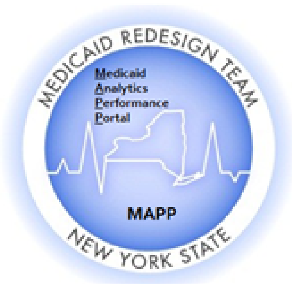
Description:
The National Institutes of Health has provided evidence that the concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs 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.

The rich diversity of the PPS community presents many challenges to providing culturally competent healthcare services. The CNA shows that 84% of PPS residents identify as non-white, with 66% identifying as Hispanic or Latino, and 25% of respondents said they speak English "not very well." Approximately 21% of BLHC PPS residents are not U.S. citizens and there are 1.4 times the number of preterm births for blacks and 1.2 times for Hispanics as compared to non-Hispanic whites. CNA data also discusses the challenges of communicating with a provider due to language barriers. For example, the qualitative CNA reports that patients whose primary language was Spanish complained that many of their providers did not speak Spanish and that inhibited their communication. One Spanish-speaking healthcare consumer said, "I immediately am talking with the doctor, well if they talk like I do; if they talk English I shut down because I can't talk English, not a word." U.S. Census data show that 57% of Bronx residents speak a language other than English at home. Centers for Disease Control statistics indicate the top 10 non-English languages spoken by Bronx residents at home, in descending order, are Spanish (nearly 50% of the population); Italian; Kru, Ibo, and Yoruba; French; Albanian, Russian; Chinese; Bengali; Tagalog; and Korean. Culture extends well beyond country and language of origin and includes economic status, disability, religion, gender identity, immigration status and age. According to the NIH "these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services."

***Competency 2:**



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

The vision for delivering culturally competent care is to provide all PPS providers with foundational instruction, as well as ongoing resources and support, on "culture" and how it impacts health and service delivery. Cultural competency training will be mandatory for all PPS providers. Most PPS providers already mandatorily train all staff on cultural competence upon hire and yearly thereafter. The curriculum includes: what is culture and what is cultural competence; what are the cultural dimensions of the organization's workforce and surrounding community; what are challenges to achieving cultural competence; tools and skill building; and emerging issues, i.e. serving the LGBTQI community or new-immigrant communities. Training will be tailored for front-line workers who deal directly with patients and their families either in a clinical or community-based setting in order to reduce barriers to care and improve patient outcomes. In addition to mandatory training, additional education will be offered. For example, BLHC offers classes through the SEIU Training Fund to support and foster Spanish-speaking employees at basic service levels to upgrade their status to Patient Care Technicians in order to provide more culturally competent care to patients and to promote health literacy of patients. Additional ongoing processes include providing resources and support to PPS staff who encounter cultural barriers when serving patients and providing interpretation services free of charge – face-to-face, telephonic, and video, when available - for non-English languages including American Sign Language. PPS providers will be educated and encouraged to match patients with individual providers who speak their language and understand their culture. Additionally, most PPS providers have recruitment and staffing policies indicating that every effort will be made to hire people of diverse backgrounds and linguistic capabilities. All providers will adopt these policies.

***Competency 3:**

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

The PPS will continue to contract with Community Based Organizations (CBOs) to develop and deliver cultural competence curricula that will reduce barriers to care for people of diverse backgrounds. For example, a CBO is currently contracted with BLHC to provide training on healthcare issues facing the LGBT community, and the 1199 SEIU Training and Education Fund provides a one-day session on cultural competence to appropriate staff. As the PPS evolves into a more cohesive entity, the CBOs who have committed as partners today and the CBOs that will join in the future will be engaged to support cultural competence, focusing on any gaps identified in the CNA or any gaps that arise through measuring patient satisfaction with their care and service. Additionally, the stakeholder engagement processes described in the both the Governance and the Community Needs Assessment sections of this application describes the strategy for ensuring that diverse stakeholders are engaged on key and critical topics impacting the PPS; cultural competence is one of those key topics about which stakeholders, including Medicaid beneficiaries, will provide input and guidance.

☑ Section 7.2 – Approach to Improving Health Literacy:

Description:

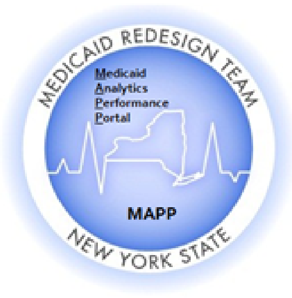
Health literacy is "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions". Individuals must possess the skills to understand information and services and use them to make appropriate decisions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

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

***Literacy:**

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

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



Program.

PPS residents speak a multitude of languages, come from a multitude of cultures, have varying degrees of literacy in both English and their languages of origin, and have disabilities and cognitive impairments that create barriers to understanding critical health information. The strategic vision of the PPS is that patients and their families will understand the health information presented to them and will be empowered to make educated choices and decisions about their own health. The qualitative CNA showed that patients are frustrated by what they viewed as poor communication with their providers. In particular, they felt that their doctors did not listen to them and they had difficulty understanding their doctors. One patient had several recommendations: "Institute training to improve communication with patients. This should include: using clear language; checking that patients understand what they have been told; and providing high quality translation services."

To improve the health literacy of the population, the PPS will weave the philosophy of health literacy throughout its mission and vision statement, introduce mandatory staff training, formal PPS policies and procedures, operations, and most importantly, patient/family communications. Consumers need and deserve health information that is understandable in formats that are accessible. For example, written materials will be at a maximum 6th grade reading level according to state Medicaid guidelines and will be offered in large print for seniors and people with low vision. The success of the DSRIP projects selected depends on participants understanding their rights and responsibilities. All 10 DSRIP projects will incorporate measures to address and improve health literacy.

BLHC already contracts with CBOs that deliver health literacy training and will continue to explore and deploy community resources. Ongoing, the PPS will measure consumer satisfaction with health literacy efforts and will constantly seek to improve.

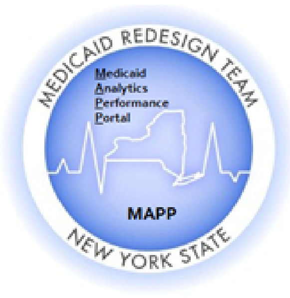
☑ Section 7.3 - Domain 1 – Cultural Competency/Health Literacy Milestones :

Description:

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

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

☑ Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Bronx-Lebanon Hospital Center (PPS ID:27)

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.

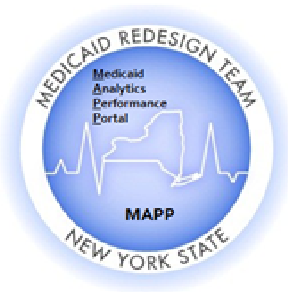
A DSRIP Funds Plan has been created. This will certainly evolve over time. It has seven budget categories that BLHC PPS will utilize to distribute funds. The categories are:

• Administrative costs (11%)
• Project implementation costs (16%)
• Payments to providers for attainment of metrics (42%)
• Bonus payments to high performing providers (5%)
• Sustainability funds to offset losses (18%)
• Contingency fund (5%) to fill gaps; and,
• Provision of social services (3%)

The BLHC PPS will contract with the Mount Sinai PPS for MSO services. It is important that financial operations be aligned. The Distribution Plan recognizes certain wide fixed costs, as well as the variation of costs, for each project budget. Milestones established for the clinical projects will inform the distribution of funds according to actual milestone achievement.

Each of the projects has, and will continue to refine, its budget in consultation with its Finance Committee advisor and within each of those budgets the activities of each provider and its contribution to the goal of the project is valued. The Implementation Planning Phase (January and February 2015) will be an important part of this effort. This percentage of the budget and each provider's participation represents the funds that the provider is eligible to receive through that project. The PPS will consider the impact of each project on specific providers and any support that individual providers may need to transition to the new health care delivery system.

The Steering, Finance, and Project Development Committees represent a wide range of providers and stakeholders, representing all the



provider classes in the PPS. Together, the committees will ensure that the distribution of funds will occur as designed through transparent representation. The primary burden will fall to the Finance Committee. Action steps for sharing funds among the provider classes listed in the question include:
1) As assessment of the importance of that provider to potential success of the project in question. This will be used to set the budget.
2) An assessment of that provider's actual contribution. This will be used to set the actual performance payment (and any high performance bonus) to the provider.
3) A negotiation between the provider and the PPS. The funding process needs to be fair and transparent, with back and forth amongst the relevant parties.

The distribution of funds is consistent and/or ties to the governance structure by virtue of the fact that the Funds Flow document reflects the values and approval of the Steering Committee. It was important to the Steering Committee to have sufficient room for admin/implementation, in addition to being able to reward providers for performance excellence. The governance structure that will move from a Contracting Model to a Delegated Model provides time and opportunity for each of the representatives on the major governance committees to fully address the distribution of funds in recognition of the DSRIP goals and the PPS projects.
The goal of DSRIP is to achieve the project metrics. The fund distribution bust supports that by: 1) rewarding success, with bonuses for high performers, thereby creating an incentive to be successful; and, 2) protecting providers from revenue losses caused by more successful outcomes (in order to promote provider stability). Funds for administrative and implementation costs, as well as a contingency fund, leave the PPS well prepared for DSRIP. For example, the proposal will give the PPS flexibility to reward high performing providers and make choices about poorly performing providers to either support them through the transition or decide that they are no longer a good partner in attaining DSRIP goals. Fund distribution considers that methodology planned by the Mount Sinai PPS, as well as one that reflects the need

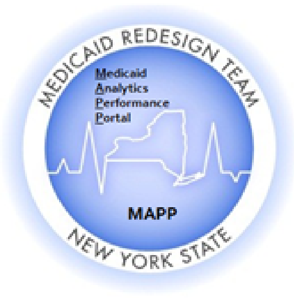
Section 8.2 – Budget Methodology:

***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	0%
2	Revenue Loss	18%
3	Internal PPS Provider Bonus Payments	5%
4	Administrative Costs	11%
5	Project Costs & Resource Requirements	16%
6	Contingency Fund	5%
7	Provider Performance Incentive Payments	42%
8	Other Essential Services	3%
	Total Percentage:	100%



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

Description:

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

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

☑ Please click here to acknowledge the milestones information above.

SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

Description:

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

This section is broken into the following subsections:

- 9.1 Assessment of PPS Financial Landscape
- 9.2 Path to PPS Financial Sustainability
- 9.3 Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability
- 9.4 Domain 1 - Financial Sustainability Plan Milestones

Scoring Process:

This section is worth 10% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

- 9.1 is worth 33.33% of the total points available for Section 9.
- 9.2 is worth 33.33% of the total points available for Section 9.
- 9.3 is worth 33.33% of the total points available for Section 9.
- 9.4 is not valued in points but contains information about Domain 1 milestones related to Financial Sustainability which must be read and acknowledged before continuing.

☑ Section 9.1 – Assessment of PPS Financial Landscape:

Description:

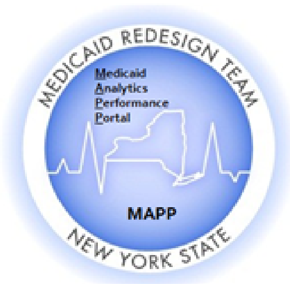
It is critical for the PPS to understand the overall financial health of the PPS. The PPS will need to understand the providers within the network that are financially fragile and whose financial future could be further impacted by the goals and objectives of DSRIP projects. In the narrative, please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

***Assessment 1:**

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

The BLHC PPS has completed an extensive survey of all potential partners and vendors regarding their financial status, operations, client mix, IT capabilities and participation in other PPS projects. This "mega-survey" asked for financial data including income, and operating metrics, payer mix, as well as financial issues of concern. The questions asked were based on DOH's financial stress test for Lead Entities. The survey was completed by December 1, and the data continues to be analyzed at a deeper and deeper level. Based on these results, we believe that the vast majority to providers are fiscally sound. However, we will be vigilant for changes internal and external to DSRIP that will affect financial stability. For example, current OMH & COBRA TCM programs payments will be reduced to health home payments, jeopardizing the sustainability of the Care Coordination agencies. This situation will be monitored closely. During the implementation phase, we will develop specific

Following a review of the findings, the Steering Committee and Finance Committee will evaluate the utilization of the Sustainability Funds to support at risk providers in the transition to the new healthcare environment. The PPS will be particularly sensitive to hospital, large SNFs and other safety net providers that may implement bed reductions during the DSRIP and plan to use sustainability funds to assist with that transition. As part of the Implementation Plan, the Committees will develop an operational definition of "fragile provider" that will be used to trigger specific support and protection to those providers. It will likely be based on the state's financial stress test criteria used to evaluate the Lead Agencies.



The MSO will continue to monitor financial stability throughout the DSRIP and will immediately report concerns and possible solutions to the Finance and Steering Committee.

***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.

DSRIP goals anticipate that hospitals, nursing homes, and other institutional facilities will see a reduction in revenues as services are moved to out-patient settings and avoidable institutional services are reduced. The impact will be noticeable for all institutional providers and acute for those who are financially fragile. The Lead Entity alone anticipates a significant reduction in revenue when the 25% reduction in avoidable hospitalizations is achieved. Nursing homes that have not upgraded their skills to care for residents who might otherwise have been transferred to hospitals will be directly impacted by the focus on clinical projects on the avoidance of such transfers. Finally, the improvement of access to primary care services will reduce ambulatory sensitive ER utilization as fewer patients need to be transferred to inpatient care, thereby impacting the hospital negatively and the primary care providers positively.

The Financial Sustainability Fund is designed to help those providers through the transition to a more community based, preventive and primary care focused delivery system. In addition, some PPS partners have received support from New York State in the past that will not continue under DSRIP and they will be negatively impacted by the discontinuance of these funds. It will be critical for these providers to move quickly to the new model that will develop revenue sources based on primary care, community base services and social supports. The Sustainability Fund will help distress providers make these transitions.

There are a number of ways in which the financially fragile PPS participants could be impacted by the redirection of funds under DSRIP:
• ER and inpatient services will be reduced and payments could be disrupted, reducing available cash flow. It will be important to begin discussions with managed care organizations early to expand the payments to the lead entity and other providers based on value.
• Short term expenditures needed to stand-up the projects will be a burden on all participating providers and could reduce cash-on-hand.
• Changes in the delivery system could create workforce reductions that will reduce costs but could also reduce payments.
• During the initial period the changes in care delivery and resultant changes in workforce could cause additional revenue loss that providers must address to avoid expenses that are no longer supported by revenue.
• Missing DSRIP milestones could cause cash flow difficulties for at risk providers who will have to bridge that time frame.

The Finance and Steering Committees will further develop policies to support safety net and vital access providers during the DSRIP transition using the Sustainability Fund to assist financially challenged participants. We anticipate that the Revenue Loss and Contingency Funds will help in this effort.

☑ Section 9.2 – Path to PPS Financial Sustainability:

Description:

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

***Path 1:**

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

The BLHC PPS will complete its Financial Sustainability Plan during the first quarter of 2015. The Plan will address specific challenges of financially fragile providers/partners and the steps that the provider must take to attain financial soundness, with specific sections addressing:
1) Ongoing financial monitoring procedures—for the Lead Entity and all partners.
2) Dashboard assessment/template development such that there is a shared understanding of the information that the Finance and Steering Committees will want to assess on a regular basis.
3) Budget assessments of potential provider needs versus PPS DSRIP resources.
4) Principles for where the PPS should be at the end of each year, and in five years, in terms of outcomes desired for financial stability.
5) Procedures for keeping providers open who are having stability issues.

Interestingly, the question being asked here by the state is inherently in the negative in that it implies providers are being put at risk. The Steering and Finance Committees are convinced that, in the long-run, DSRIP will be a net positive for the PPS. There will certainly be difficult transition moments in DSRIP, but the most important aspect of the Financial Stability Plan will deal with how to move the PPS closer to capitation dollars. This means greater efficiency in health care spending, and it benefits the PPS by capturing additional dollars otherwise that may have gone to health plan overhead. These are the positives in DSRIP that will be a major analytic topic over the next 12 months and beyond.

Those individual provider plans will be approved by the Finance and Steering Committees and implemented under the monitoring and oversight of the MSO. The MSO will track each at risk provider for its compliance with its individual financial sustainability plan and report any deviation from the plan to the Finance Committee.

***Path 2:**

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

The financial stability of providers will be monitored in a number of ways:

1. There will be a brief bi-monthly survey of providers asking for information on their financial status and impact of DSRIP (positive and negative).
2. The Finance Committee members are to be true community representatives and seek out information on the financial status of the community and elevate any issues they hear.
3. A path to financial stability will be set out in the Implementation Plan, based on Funds Flow.
4. A Fragile Provider Plan will be developed as a contingency so that there are ready-made steps in place to support any Fragile Providers and keep them operating as needed.

The BLHC PPS will complete its Financial Sustainability Plan during the first quarter of 2015. The PPS budget for actual project costs, performance and sustainability will provide a frame to monitor each partner's financial performance. Safety net providers in particular, will be closely monitored within the PPS and assisted with attainment of their financial goals and metrics in the PPS. The best path to financial stability will be to develop a plan for the PPS to move closer to the capitation dollar in five years.

***Path 3:**

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

The BLHC PPS goal is to create long-lasting change through the DSRIP investment. The state's promise to move to capitation at the end of five years is a powerful motivator to be successful. As such, a number of steps will be taken to sustain DSRIP changes beyond five years:

• The Lead Entity is part owner of HealthFirst, a Medicaid managed care organization accepting risk for that population. During DSRIP, BLHC PPS will build upon this relationship and experience to import ideas around risk arrangements and care coordination.

• Once the benefits of care coordination are taken into the system, it will be difficult to roll back progress. This is because providers will see the improved outcomes and healthier patients, and they will want to see more of that. The most important change the PPS is trying to achieve is culturally to promote outcomes and coordination.

• The PMO office will continue for as long is as needed as infrastructure to achieve needed change in the culture.

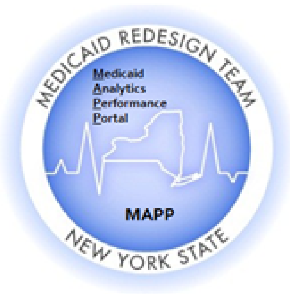
• The state's capitated model will force change—both cultural and structural. It will force the PPS to take risk and seek new gain sharing arrangements, thereby ensuring change beyond the five year windo

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.

Given the state's promise of moving to capitation, it is going to be critical to move to value-based reimbursements. To be successful, the new payment system must be fair and must reward performance and grow of out-patient care—not just punish for bad outcomes. There are 13 health plans serving Medicaid beneficiaries in the Bronx and the BLHC PPS is working closely with the 5 plans (including 2 HIV special needs plans) who serve the majority of the beneficiaries in the South Bronx. While each plan may approach contracting differently, it is the PPS's intention to establish full risk, full service agreements that encompass primary, acute, prescription drug, and long term, bringing together all aspects of an integrated delivery system under one agreement.

The BLHC PPS, through its Lead Entity, has a long-standing relationship with Medicaid managed care plans that operate in the Bronx. This is in addition to serving as a stockholder in HealthFirst. Contractually, BLHC has accepted risk from HealthFirst and has experience with both capitated and with pay-for-performance arrangements. Using this experience, the Lead Entity will work with partners in the contracted model and in the LLC to develop additional risk arrangements that more comprehensively encompass all aspects of care. Monthly meetings with the managed care organizations have already begun and will expand to include more partners. These conversations include discussions around improving EMR systems, as well as conversations talking about how create a better system for working on capitation dollars.

***Strategy 2:**

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

The long term goal of the BLHC PPS is to move closer to the premium dollar across the entire spectrum of health and social support services. The PPS knows it can be more successful at care coordination, and if so, being closer to the premium dollar will generate more revenue for the system, supporting those who are financially fragile. Capitation rewards providers for success in managing care, and the PPS believe is can provide that care successfully. The PPS will also be able to find savings across the spectrum by the reduction of ER and hospital utilization and shift of those dollars to outpatient and community based services.

While the transition will have difficult moments, the future should be more stable than today. Transformation takes time. The BLHC PPS will set interim milestones of assuming risk for bundles services in alignment with the clinical projects identified in this application. Through negotiations with the managed care plans, the PPS will assume risk for each DSRIP project as it matures. With integration of services through bundled arrangements that fund the clinical strategies developed by our project teams, the PPS will evolve into an organization prepared to accept risk for the entire population. Beyond that work, the BLHC PPS will work on rewarding quality for performance. This will be analyzed in the Implementation Plan, as part of the "high performance" bonus bucket in Funds Flow, with input from all the partners. BLHC PPS believes we can successfully do this work in part because BHLC has created one of the most successful health homes in the state—along with BLHC being part owner of a major managed care plan, Healthfirst. By having the experience in both of these endeavors—experience that very few other hospitals have—we believe BLHC is well positioned to move forward on capitation. The participating partners know how to create, design, and fund new provider types, and use that experience and success to build the BLHC PPS.

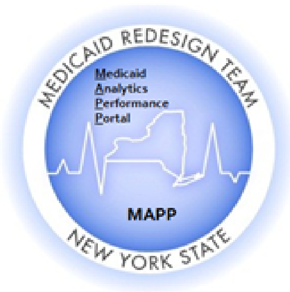
Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

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

Please click here to acknowledge the milestones information above.



SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

BLHC PPS recognizes the critical importance of centralizing our population health infrastructure. BLHC PPS is committed to creating an integrated delivery system that will join partners, payors, and their programs across sites to effectively scale efforts to meet PPS needs. To date, BLHC PPS has had important experiences in successfully achieving changes in population health to draw on as experience:
• Partial Ownership of Healthfirst. A major Medicaid managed care plan, Healthfirst is a plan dedicated to improving the health of health care of Medicaid beneficiaries. It has done innovative work in looking at unique ways of improving care delivery in terms of care coordination and population health.
• Creation of the BLHC Health Home. BLHC has created one of the most successful health homes in the state, based on services provided, including adoption of a single informational technology platform for assessments and reporting as well as outcomes achieved. By definition, the health home is designed to improve community health. It coordinates services among many providers, and it provides population health services.

BLHC PPS partnered with Mount Sinai PPS on a number of operations issues by virtue of having signed a joint support letter, including sharing a Program Management Office and MSO services. This includes Mount Sinai creating the Population Health Institute—the operations of which will help achieve DSRIP population health goals.

Indeed, Mount Sinai PPS is actively engaged in many population health activities, and BLHC PPS will be able to benefit from their learning. Mount Sinai's DSRIP application explains that their work includes interaction with, "The nationally renowned Adolescent Health Center is first of its kind in providing primary, specialty, and mental health care and support to adolescents, regardless of ability to pay. The Visiting Doctors Program is the nation's largest academic home-based primary and palliative care program, provid

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 BLHC PPS intends to utilize the 1199SEIU Training and Employment Funds (TEF) as the lead training vendor for the PPS. This will also be in collaboration with City University of New York, Urban Health Plan and other designated workforce vendors to minimize the negative impact to workers. The TEF has a track record of evaluating and selecting the most appropriate training vendor to meet employer and worker needs; writing curricula; working collaboratively with employers, unions and training providers to design and deliver high quality programs.

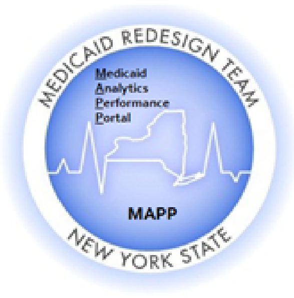
The BLHC has a long collaborative relationship with TEF. Since 2010 about 1,000 hospital employees have accessed education programs from TEF (including everything from GED programs through RN programs).

Many partners in the PPS belong to the Bronx Healthcare Learning Collaborative (BHLC), which is an innovative multi sector partnership that improves the industry and standard of care while also benefiting Health Care Workers and the communities we serve. This partnership includes TEF, CUNY, Healthcare institutions, 1199SEIU and CBOs. Together, the BHLC is working on increasing the number

of bi-lingual, Spanish speaking healthcare professionals. In 2013 and 2014, BHLC ran 2 bilingual PCT upgrade programs through TEF and Lehman College in response to the need for more culturally competent care for our patient population. Additionally BHLC have held healthcare disparity forums to increase the awareness of issues affecting Latino communities and link the issues of demand for bilingual and multi-cultural healthcare professionals to existing health disparities.

The BHLC has successfully worked with these proven training vendors to train and establish Patient Centered Care teams in the hospital and will be continuing it in ambulatory care in 2015. This project has been accepted by the Institute for Healthcare Improvement as a storyboard submission for presentation at its 2014 Annual National Forum.

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



SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

I hereby attest as the Lead Representative of this PPS Bronx-Lebanon Hospital Center that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Primary Lead Provider Name: BRONX LEBANON HOSPITAL CENTER
Secondary Lead Provider Name:

Lead Representative:	Virgilina Gonzalez
Submission Date:	12/22/2014 03:29 PM

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