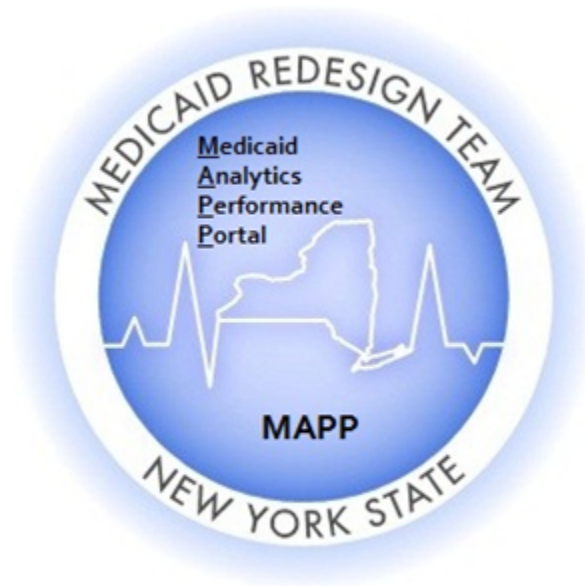


New York State Department Of Health Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Lutheran Medical Center



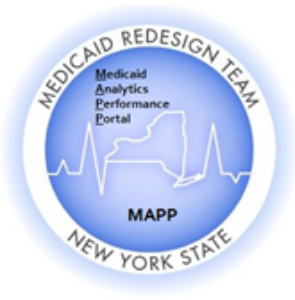
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

TABLE OF CONTENTS:

Index..... 4
Section 1 – Executive Summary..... 5
 Section 1.0..... 5
 Section 1.1..... 5
Section 2 – Governance..... 15
 Section 2.0..... 15
 Section 2.1..... 15
 Section 2.2..... 17
 Section 2.3..... 20
 Section 2.4..... 21
 Section 2.5..... 22
 Section 2.6..... 23
 Section 2.7..... 24
Section 3 – Community Needs Assessment..... 26
 Section 3.0..... 26
 Section 3.1..... 27
 Section 3.2..... 28
 Section 3.3..... 29
 Section 3.4..... 31
 Section 3.5..... 33
 Section 3.6..... 35
 Section 3.7..... 37
 Section 3.8..... 41
Section 4 – PPS DSRIP Projects..... 49
 Section 4.0..... 49
Section 5 – PPS Workforce Strategy..... 50
 Section 5.0..... 50
 Section 5.1..... 50
 Section 5.2..... 52
 Section 5.3..... 54
 Section 5.4..... 55
 Section 5.5..... 56
 Section 5.6..... 56
 Section 5.7..... 56
 Section 5.8..... 57
Section 6 – Data Sharing, Confidentiality & Rapid Cycle Evaluation..... 59
 Section 6.0..... 59
 Section 6.1..... 59
 Section 6.2..... 60
Section 7 – PPS Cultural Competency/Health Literacy..... 62
 Section 7.0..... 62
 Section 7.1..... 62
 Section 7.2..... 63
 Section 7.3..... 64
Section 8 – DSRIP Budget & Flow of Funds..... 66
 Section 8.0..... 66
 Section 8.1..... 66
 Section 8.2..... 67
 Section 8.3..... 67
Section 9 – Financial Sustainability Plan..... 69



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

Section 9.0.....	69
Section 9.1.....	69
Section 9.2.....	70
Section 9.3.....	71
Section 9.4.....	72
Section 10 – Bonus Points.....	74
Section 10.0.....	74
Section 10.1.....	74
Section 11 – Attestation.....	75



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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: **32_SEC000_Lutheran Financial Stability Test.pdf**

Description of File

File Uploaded By: cc330208
File Uploaded On: 12/21/2014 09:33 AM

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

Section 11 will allow you to certify your application. **Once the application is certified, it will be locked.**

If you have locked your application in error and need to make additional edits, or have encountered any problems or questions about the online Application, please contact: DSRIPAPP@health.ny.gov

Last Updated By: cc330208
Last Updated On: 12/22/2014 10:22 AM

Certified By: cc330208	Unlocked By:
Certified On: 12/22/2014 01:04 PM	Unlocked On:
Lead Representative: Claudia Caine	



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

***Goals:**

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

#	Goal	Reason For Goal
1	Develop a fully integrated delivery system of health and social service providers by DY 5	<p>The Brooklyn Bridges PPS (the PPS) is committed to transforming health care delivery through an integrated delivery system (IDS) comprised of an organized, collaborative network of primary, specialty, behavioral, post-acute, long-term care, and community-based health and social service providers. The IDS will share data, eliminate care gaps, facilitate care transitions, and address the range of health and social needs, improving the health of the entire population served which will include, at minimum, DSRIP attributed patients.</p> <p>Community-based primary care partners, supported by a robust network of specialty and other ambulatory care and community-based organizations, are the foundation of the PPS. This community-based primary and ambulatory care focus will advance the transition of health care delivery from the inpatient to the outpatient setting and will be instrumental in meeting the needs of complex patients to reduce unnecessary hospital use by 25% by Demonstration Year (DY) 5.</p>
2	Achieve PCMH NCQA 2014 Level 3 certification for all primary care partners by DY 3	Supporting partners to achieve Patient Centered Medical Home (PCMH) Level 3 certification is an essential part of the PPS system integration strategy. The PCMH model supports the PPS's goal to create an IDS with advanced primary care practice at its core. Pursuit of this goal will enable partners who are not already PCMH certified to undergo rapid practice transformation with the support and assistance of the PPS. Through the PCMH model, the PPS and its partners will improve patient engagement, outcomes of care, and population health management (PHM) that targets high-need populations and ensures access to and appropriate use of health care services.
3	Achieve Level 2 Meaningful Use and RHIO/SHIN-NY connectivity for eligible partners by DY 3	Effective access to a complete medical record, using electronic medical records (EMR), health information exchange (HIE) and other health information technology (HIT), improves a patient's episodic care and makes care coordination and PHM feasible, scalable and sustainable. The Meaningful Use (MU) standards and incentives, along with prior investments in RHIOs and the SHIN-NY for HIE, provide the infrastructure for data collection to populate repositories and registries and for analysis and reporting. Features such as direct exchange, secure messaging, encounter notifications, alerts, patient record lookup, referral tracking and direct messaging with patients enable providers to delivery higher quality episodic care, manage patient panels and best coordinate care among



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Goal	Reason For Goal
		providers. These tools allow care team members to spend less time performing routine tasks and more time interacting with patients who need their assistance.
4	Achieve clinical interoperability of PPS partners and the PPS by DY 2	Clinical interoperability is critical to improve episodic care, ensure caregiver access to complete patient information, make care delivery more patient-centered, facilitate PHM and support provider networks' transition to sustainable value-based reimbursement agreements. Interoperability allows data to be aggregated and efficiently analyzed to better assess patient need, stratify populations to target appropriate supports and interventions, coordinate care, and engage patients. It also supports the use of common clinical evidence-based protocols and care pathways, improving health care outcomes. Finally, interoperability will support the shift to value-based payment arrangements.
5	Implement evidence-based practices to address tobacco use, diabetes, asthma, and HIV in DY 1	<p>Chronic illnesses, including diabetes and respiratory conditions, represent the greatest proportion of preventable hospitalizations in Brooklyn. Asthma is in the top four diagnoses of Medicaid beneficiaries who visit the Lutheran Medical Center emergency department (ED) more than 3 times annually. HIV was Brooklyn's fifth leading cause of premature death, and presents significant geographic and racial/ethnic disparities in prevalence. These conditions present opportunities to reduce preventable hospitalizations and ED use among the PPS's attributed patients and our community generally.</p> <p>Implementing evidence-based practices in ambulatory care settings will improve care, PHM, patient engagement, and patient self-efficacy and confidence in self-management.</p> <p>The PPS is collaborating with other PPSs to align the development and implementation of evidence-based clinical guidelines for these conditions, which will ensure consistency for all partners across the borough's PPSs.</p>
6	Implement central services to support PPS clinical and fiscal integration beginning in DY 1	The PPS will develop central services to support clinical care transformation and partner integration. These central services will include a Patient Navigation Center (PNC), Information Technology (IT) infrastructure, data and analytics, PPS-wide clinical guidelines, performance monitoring, workforce training, and the financial infrastructure to distribute incentive payments. These services will equip partners with systems that: support PHM; allow optimal communication across organizations; position partners to play an active role in engaging patients in their care; and, enhance the ability to identify risk in the population and support high need patients.
7	Reduce excess acute and long-term care beds by DY 5	As part of its IDS vision, the PPS intends to shift financial, clinical and workforce resources from inpatient, acute care to community-based, ambulatory care, including patient-centered behavioral health, substance abuse, and social support services. System transformation and reallocation of resources consistent with this vision requires collaboration among all Brooklyn PPSs to develop a comprehensive strategy and action plan to reduce excess acute care and long-term care bed capacity in Brooklyn.
8	Integrate behavioral health screening and treatment services in primary care settings by DY 3	Access to high-quality mental health and substance abuse services in Brooklyn is a significant, unmet community need and a health care delivery system gap that contributes to high costs and poor health outcomes. The PPS will integrate behavioral health and primary care services by increasing primary care capacity within the PPS and integrating behavioral health services with partnering primary care sites through the PCMH and IMPACT models. This will increase the availability of behavioral health services and will concomitantly reduce care fragmentation for patients. Ultimately, the expansion of behavioral health capacity and access will support the PPS's goal to avoid unnecessary ED visits and inpatient utilization, thereby reducing health care costs and improving health outcomes in its service area.
9	Implement a PNC, beginning in DY 1; complete implementation by DY 4	The PNC will be the core of the PPS central service infrastructure. The PNC will provide culturally competent navigation and care coordination



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

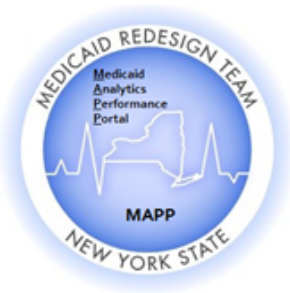
#	Goal	Reason For Goal
		<p>services. These services, delivered telephonically, in-person and web-based by clinical care managers and community health workers (CHWs), will bolster PPS objectives related to:</p> <ul style="list-style-type: none"> * Promoting effective and efficient use of healthcare services, including PCMH enrollment, by attributed Medicaid members; * Advancing patient activation to ensure treatment adherence/continuation; * Connecting patients to community-based resources that respond to unmet social needs that affect health and well-being; * Providing patient education and health coaching to improve patient self-management; and, * Providing support during care transitions including post-discharge. <p>These objectives are central to supporting clinical integration of our partners and reducing avoidable ED and inpatient hospital use.</p>
10	Reduce avoidable ED use and inpatient admissions by 25% by DY 5	<p>The reduction of avoidable ED use and inpatient admissions by 25% during the DSRIP project period is a requirement of the State's waiver, and a prerequisite to receipt of DSRIP dollars. The PPS will achieve this through system transformation. Implementing evidence-based programs will better facilitate management of chronic conditions, reducing unneeded admissions and ED use. Care management and navigation services will link high need patients to community-based services and provide supports (e.g., medication reconciliation) to avert ED visits. Additionally, the PPS's ED care triage and observation unit projects will be instrumental in reducing avoidable ED and inpatient utilization. The IDS and RHIO will provide data to a patient's care provider, allowing that provider to better address patient needs. Together these services and the reduction of avoidable ED visits and admissions also support success of value-based payment arrangements.</p>
11	Enter value-based Medicaid managed care plan contracts, transitioning to risk contracts by DY 5	<p>Value-based payment arrangements with Medicaid managed care (MMC) plans will help the PPS achieve two fundamental aims: financial integration of the IDS and long-term financial sustainability.</p> <p>Medicaid payment reform will change reimbursement systems from existing fee-for service (FFS) to value-based arrangements that promote quality outcomes, and clinical and financial integration. FFS Medicaid does not sufficiently reimburse providers to offer a full scope of population health and social services. Value-based payments will promote provider-driven care transformation by giving partners the resources and incentives to provide patients the right care, at the right time, in the right place.</p> <p>The PPS will successfully execute new, value-based payment arrangements to support the individual partners, the IDS as a whole, and, ultimately, sustainable high value care after the DSRIP program ends.</p>

***Formulation:**

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

The Brooklyn Bridges PPS, led by Lutheran Medical Center (Lutheran) and NYU Langone Medical Center (NYULMC), is a tight-knit network of partners designed to produce meaningful results through the marriage of community-centered care and academic medicine. Primary care practices, including nine Federally Qualified Health Centers (FQHCs), seven Diagnostic Treatment Centers (DTCs) and over 29 primary care practice sites, anchor our network and account for over 60% of total attributed lives. Our nimble network is strengthened by a broad base of community partners working with us to transform health care delivery.

Through the Community Needs Assessment (CNA), the PPS identified the unmet needs of our community: inequitable distribution of health resources; inadequate access to primary, specialty and behavioral health care; poor connections to critical social services; and insufficient cultural and linguistic competency, among other needs. The PPS is committed to helping its partners through: 1) central IT and PNC services; 2) funding; and, 3) sharing Lutheran Family Health Centers (LFHC) and NYULMC expertise with PHM.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

***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.

Within five years, Brooklyn Bridges will be a clinically and financially integrated delivery system entering into Medicaid value-based contracts. PPS-wide achievements will include: 1) PCMH NCQA 2014 Level 3 certification; 2) clinically interoperable systems; 3) patient navigation services that connect individuals with health and social services; and, 4) standard and widespread PHM systems and protocols. While DSRIP resources will be devoted to transforming care for Medicaid patients, the IDS care design will extend to all patients, regardless of payer. The PPS therefore intends to pursue a multi-payer, value based contracting strategy to include Medicare and commercial payers as well as Medicaid plans; this strategy is key to the PPS's long-term financial sustainability. The PPS has already initiated value-based contracting discussions with its largest Medicaid plans, HealthFirst and Amerigroup. Additionally, NYULMC experience with Medicare Advantage, commercial ACO contracts and Medicare's Bundled Payment for Care Improvement (BPCI) demonstration will be invaluable to the PPS as it develops central services and a strategy related to risk contracting.

***Regulatory Relief:**

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

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

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

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

#	Regulatory Relief(RR)	RR Response
1	OMH: 14 §§ NYCRR 599.3(b), 599.4(r), (ab); OASAS: 14 NYCRR §§ 800.2(a)(6),(14), 810.3, 810.3(f), (l)	<p>The PPS seeks this RR for project 3.a.i.</p> <p>Reason for request: Office of Mental Health (OMH) regulations require Article 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30% of the provider's annual visits and the total number of visits is at least 2,000 visits annually (OMH threshold). Office of Alcoholism and Substance Abuse Services (OASAS) regulations require an Article 28 provider to obtain a certification from OASAS if it provides any substance abuse services. Under 3.a.i, Article 28 partners will increase their provision of both mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is likely that some of the partners participating in 3.a.i will cross the OMH threshold, and all Article 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would impede 3.a.i goals and slow project implementation. Undergoing through the certification process would be an unnecessary administrative burden, and multiple certification requirements are financially and programmatically infeasible for many Article 28 providers. Further, complying with certification rules would have little benefit to patients. For example, Article 28 providers are already required to</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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		<p>maintain medical records that meet Department of Health (DOH) standards; requiring their records to also meet OMH standards would not improve patient care. Forcing partners to comply with new and unnecessary administrative processes and rules will discourage partners from delivering such integrated care.</p> <p>Potential alternatives: Partners could avoid OMH and OASAS licensure by keeping their provision of mental health services below the OMH threshold and avoiding any substance abuse care. However, it would likely be difficult for certain partners to stay below the 30% limit, particularly if they are located in areas with a high behavioral health need, and trying to stay within that limit could result in turning away patients needing mental health care. Although the draft Integrated Outpatient Services regulations could address some of these issues, this and related requests are being sought because it is unclear how those new rules might be implemented.</p> <p>Patient safety: Waiving licensure requirements would unlikely endanger patient safety because Article 28 providers must already comply with a detailed regulatory regime aimed at ensuring patient safety. Nevertheless, working with OMH and OASAS, Article 28 providers that increase their provision of mental health and substance abuse services under 3.a.i would examine their policies to determine if any policies would need to be developed to ensure patient safety given the service changes. Any additional policies that would be required, if any, will be modeled on OMH and OASAS regulatory requirements.</p>
2	10 NYCRR §§ 401.2(b), 401.3(d)	<p>The PPS seeks this RR for project 3.a.i.</p> <p>Reason for request: Section 401.2(b) allows an Article 28 facility's operating certificate to be used only by that Article 28 operator at that Article 28 provider's site of operation. DOH has interpreted this to mean that the operator must have exclusive site control and cannot share the site with another entity. Section 401.3(d) prohibits an Article 28 provider from leasing or subletting any portion of its facility unless the lessee/sublessee conforms with all of the requirements imposed on Article 28 providers. In effect, these two provisions prohibit Article 28 providers from sharing space with any provider not licensed under Article 28, including a physician group practice, a clinic licensed by OMH, or a substance abuse clinic licensed by OASAS. This would prohibit Article 28 providers from allowing other partners with expertise in mental health care or substance abuse services to provide care in their facilities, thereby limiting their options at integrating care.</p> <p>Potential alternatives: Article 28 providers could avoid these rules by declining to share space altogether and instead rely on their own expertise to provide behavioral health care. While some partners in the PPS are likely to do so, others lack expertise in behavioral health care. This latter group of Article 28 providers would then be forced to refer patients to behavioral health partners in other locations, making it less likely that the patients would receive the care they need.</p> <p>Patient safety: The purpose of the relevant regulations is to ensure that an operator has control of the site and therefore can maintain an environment that is conducive to patient safety. Article 28 providers who receive these waivers will have agreements in place with the leasing provider that give the Article 28 provider sufficient authority over the leased space to ensure patient safety in that space. Moreover, these partners will develop whatever written plan for the sharing of space that may be required by DOH. Finally, the partners will comply with applicable federal regulations governing shared space.</p>
3	10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2,	The PPS seeks this RR for projects 2.a.i, 2.b.iii, 2.b.ix, 3.a.i, and 3.c.i.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Regulatory Relief(RR)	RR Response
	709.3, 710.1	<p>Reason for request: The projects listed above are likely to require partners to undertake construction and service changes that would implicate the Certificate of Need (CON) rules. In particular: a) Project 2.a.i (Integrated Delivery System) requires a large investment in primary care capacity and some partners will need to expand operations in order to meet that enhanced capacity; b) Project 2.a.i also requires investment in health information technology (HIT) infrastructure, and some HIT investments enacted by partners will fall within the scope of CON regulation; c) Project 2.b.ix (Observation Unit) requires construction and renovation at both a hospital and a nursing home (an outpatient unit will be moved to the nursing home as part of the project, and the nursing home will decertify beds in order to house the outpatient unit); d) Projects 2.b.iii (ED triage) and 3.a.i (behavioral health integration) will likely require the expansion of services at licensed providers, and may also require construction and renovation; and e) the plan for Project 3.c.i (diabetes) envisions the provision of new podiatry and vision services at certain Article 28 providers. Requiring a demonstration of public need and a separate application for these projects is unnecessary. DOH approval of the DSRIP projects and their implementation plans should be sufficient, particularly in light of the fact that the PPS has conducted a community needs assessment, and used the results of that assessment to inform its project selection. DOH should waive the CON regulations for the projects listed above.</p> <p>Potential alternatives: The alternative to a regulatory waiver would be to continue to require partners to demonstrate public need for DSRIP projects. Doing so, however, would be highly duplicative of the DSRIP application process itself, as DOH's approval of the above projects demonstrates DOH's belief that the projects are in the public's interest. Such additional approval process would delay the implementation of these projects and impede the PPS's ability to impact avoidable admissions and ER visits.</p> <p>Patient safety: Waivers of CON regulations would not implicate patient safety in this context. CON regulations are designed to prevent the overutilization of services. While overutilization of services can cause patient harm in some circumstances, the potential for harm is much more likely when partners seek to increase the provision of surgeries, imaging, and other intensive services. There is little threat to patient safety when there is a potential increase in the provision of primary care services, as the Public Health and Health Planning Council recognized in its December 2012 recommendation of eliminating CON review for primary care facilities.</p>
4	OMH: 14 NYCRR §§ 551.6, 551.7; OASAS: 14 NYCRR §§ 810.6, 810.7	<p>This project seeks RR for project 3.a.i.</p> <p>Reason for request: Section 551.6 requires Article 31 providers who are licensed by OMH to undergo prior approval review if they undertake certain projects, including the establishment of a new satellite location and the expansion of caseload by at least 25% of clinic treatment programs. Section 551.7 requires a demonstration of public need as part of this review. Similarly, Section 810.6 requires Article 32 providers who are licensed by OASAS to undergo prior approval review if the provider offers services at a new location or increases capacity of a service where capacity is identified in the provider's operating certificate, and Section 810.7 requires the applicant to demonstrate public need for its project as part of the review. Project 3.a.i is likely to fall within the reach of these regulations. As part of behavioral health integration, Article 31 and Article 32 providers are likely to provide services at new locations, including within an Article 28 facility. While establishing a new satellite location is technically subject to "E-Z PAR" review, in practice this process is not easy for partners: they must obtain a letter of support from a local government unit, and the process can be lengthy. Requiring prior approval review for the behavioral health</p>

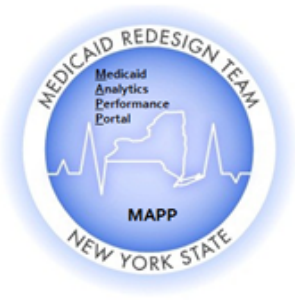


**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Regulatory Relief(RR)	RR Response
		<p>integration project would be duplicative of the DSRIP process itself, since the PPS will already have to submit its implementation plan to the state for review. There is no need to impose a separate prior approval review process on top of the review process embedded into DSRIP itself.</p> <p>Potential alternatives: The PPS could avoid this requirement by relying on Article 28 providers to provide mental health and substance abuse services on their own, but Article 28 providers would need waivers to do so, as discussed above. Moreover, Article 31 and 32 providers have expertise in behavioral health care, and the PPS should have the option on utilizing those partners with a deep behavioral health knowledge base in its implementation of the behavioral health integration project.</p> <p>Patient safety: Foregoing the prior approval process will not have an impact on patient safety. To the extent OMH and OASAS have any concerns about Article 31 and Article 32 providers expanding their operations into primary care settings, the PPS will work with these agencies to develop policies to assure patient safety.</p>
5	10 NYCRR §§ 702.3, 710.9, 711.2, 712-2.4, 713-4.3, 713-4.4, 713-4.5, 713-4.7-4.10	<p>The PPS seeks this RR for projects 2.a.i, 2.b.ix, and 3.a.i.</p> <p>Reason for request: Sections 711.2 and 712-2.4 set construction standards for hospitals, and Subpart 713-4 sets construction standards for nursing homes. Section 710.9 requires a preopening survey after the completion of a construction project. In order to meet Project 2.a.i's goals to provide more primary care services to underserved areas, there will be an expansion of the capacity of primary care partners, which will likely require new construction and renovation. As part of the Observation Unit project, an outpatient unit will be moved from Lutheran Medical Center to the Lutheran Augustana Center for Extended Care and Rehabilitation, a skilled nursing facility, to make room for the new Observation Unit, and therefore sections of both the medical center and the nursing home will undergo construction. Project 3.a.i will require a reconfiguration of spaces of primary care partners in order to provide behavioral health care services at those sites. The design of these new spaces may conflict with particular regulatory requirements for the design of clinics, hospitals and nursing homes. Such regulatory requirements incorporate provisions of the Guidelines for the Design and Construction of Health Care Facilities, which set out detailed rules for these facilities. Moreover, having to undergo the preopening survey process could lead to delays in the opening of the new unit, and therefore at the very least an expedited survey process is necessary.</p> <p>Potential alternatives: The PPS could follow all of these construction standards. However, doing so may require the PPS to forgo the temporary Observation Unit in Augustana entirely. Following these standards, could also result in a design of the permanent Observation Unit that conflicts with DSRIP's goal of having the unit in "close proximity to ED services."</p> <p>Patient safety: Certain provisions of the construction standards, such as parts of the Life Safety Code, are designed at ensuring patient safety. The PPS will work with DOH to ensure compliance with all standards that directly relate to patient safety.</p>
6	10 NYCRR § 405.19(g), Proposed 10 NYCRR § 405.32(b)(1)(ii)	<p>The PPS seeks RR for project 2.b.ix.</p> <p>Reason for request: Section 405.19(g) limits the number of observation beds to the lesser of 40 beds or 5% of a hospital's capacity and requires Observation Units to be in a distinct physical space. Section 405.32(b)(1)(ii), a proposed regulation that which has a comment period that is set to expire on December 15, 2014 would eliminate Section 405.19(g) and would require hospitals to have policies to ensure that</p>

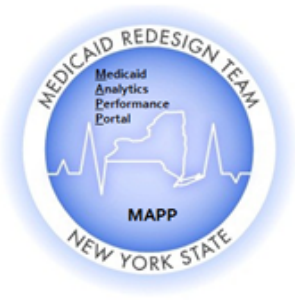


**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Regulatory Relief(RR)	RR Response
		<p>patients requiring observation care receive that care in "the proper clinical location." Given the separate regulatory requirement that most hospitals have separate pediatric inpatient units, it is possible that Section 405.32(b)(1)(ii) could be interpreted to require the segregation of children and adults into distinct Observation Units. While the PPS's project plan initially envisions an exclusively adult Observation Unit, pediatric patients will eventually be incorporated into the unit. The PPS seeks either an interpretation of the regulation that would allow children and adults to be treated in the same unit or a waiver of this particular regulatory provision. (Note that if Section 405.32 is not promulgated and Section 405.19(g) remains in force, the PPS seeks a waiver of the requirement that an Observation Unit is limited to 40 beds/5% of a facility's beds as it is possible that an Observation Unit may expand beyond this size).</p> <p>Potential alternatives: As an alternative to an Observation Unit that combines adult and pediatric care, the PPS could reserve the Observation Unit for adults only. Children who are on observation status would instead be treated in Lutheran's pediatric inpatient unit. However, such a requirement would mean that medical staff providing observation care would need to travel to different areas of the hospital, reducing efficiencies in care that Observation Units are designed to promote.</p> <p>Patient safety: Child safety is among the highest priorities of the PPS, and the PPS recognizes that in certain circumstances it is appropriate to care for children and adults in separate spaces. Therefore, once pediatric patients are accepted into the Observation Unit the PPS will attempt to have children treated in a separate area of that unit from adults to the extent feasible given admissions. Moreover, the PPS will develop a policy under which children will be moved to the pediatric inpatient unit to for their observation care if there are circumstances that give rise to concerns about pediatric patient safety. However, the PPS wishes to retain the flexibility to treat both children and adults in the Observation Unit when no such safety concerns are present.</p>
7	10 § NYCRR § 600.9(c)	<p>The PPS seeks this RR for all projects.</p> <p>Reason for request: Section 600.9(c) prohibits a medical facility from sharing gross income or net revenue with an individual or entity that has not received establishment approval. This could be interpreted as prohibiting a hospital that receives DSRIP funds from distributing those funds to non-established partners, such as physician groups, who are in the same PPS. Such an interpretation would be contrary to one of the key elements of DSRIP: the distribution of funds by the lead coalition provider to other partners participating in the PPS.</p> <p>Potential alternatives: There are no feasible alternatives, since following a strict interpretation of Section 600.9(c) would prevent lead coalition partners from distributing state funds to the PPS participating partners.</p> <p>Patient safety: Waiving this regulation would have no impact on patient safety.</p>
8	10 NYCRR § 405.9(f)(7)	<p>The PPS seeks this RR for all projects.</p> <p>Reason for request: Section 405.9(f)(7) requires hospitals to ensure that patients may not be discharged or transferred to another location based on his or her source of payment. This regulation could be interpreted to prohibit hospitals from transferring their patients to other partners within the same PPS, since the hospital would have a financial relationship with the other provider. For example, if one hospital in a PPS were to transfer a patient to the lead coalition provider because the lead coalition provider specializes in</p>

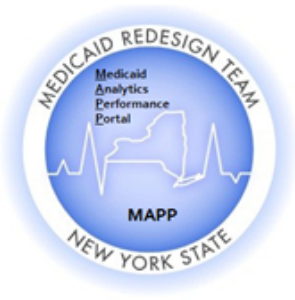


**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Regulatory Relief(RR)	RR Response
		<p>treating the patient's condition, this could be viewed as a transfer based on source of payment since the lead coalition provider distributes DSRIP funds to the transferring hospital.</p> <p>Potential alternatives: There are no feasible alternatives. If Section 405.9(f)(7) were interpreted strictly hospitals could not transfer their patients to the lead coalition provider, and possibly other transfers would be restricted as well. This would harm patient care, as the lead coalition provider specializes in care that PPS patients need.</p> <p>Patient safety: To the extent that such policies do not yet exist, partners in the PPS would adopt policies and procedures to ensure that transfers to other facilities are made based on patient need and not based on financial relationships. Hospitals would be allowed to transfer patients to the lead coalition provider and other partners within the PPS, and they will be encouraged to do so when it is in the best interest of the patient. However, these policies would emphasize that partners should never transfer a patient based on source of funding when another destination is more appropriate for the patient's care.</p>
9	<p>DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)</p>	<p>The PPS seeks this RR for projects 2.a.i, 3.a.i, 3.c.i, and 3.d.ii.</p> <p>Reason for request: Section 86-4.9(c)(8) prohibits freestanding ambulatory care facilities from billing for services provided off site. Section 401.2(b) allows an Article 28 to use its operating certificate only for services at its designated site of operation, which has been interpreted as prohibiting partners from providing off-site services. Sections 599.14 and 822-3.1(b) impose similar rules on mental health and substance abuse partners, respectively. Partners would benefit from the ability to provide services off site in carrying out multiple DSRIP projects particularly as it relates to carrying out Project 2.a.i: Allowing facilities to provide care in alternative settings would help promote an integrated delivery system and would discourage facilities from providing care in silos. Projects 3.c.i and 3.d.ii aim to improve diabetes and asthma care, and facility-based practitioners may seek to provide services in the home as part of that enhanced care. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home (3.a.i). In short, partners seek the flexibility to provide needed care in the setting that is most conducive to treatment.</p> <p>Potential alternatives: The PPS could rely on partners that are licensed to provide services in the home or non-credentialed practitioners to provide home-based care under DSRIP projects. For example, the PPS plans to utilize community-based organization and community health workers to provide care under the asthma home-based self-management program. The PPS plans to utilize these workers to the greatest extent possible. However, there likely will be instances where a patient needs a more intensive level of care and the services of a registered nurse, nurse practitioner, or physician employed by an Article 28 provider. Article 28 providers should be reimbursed for these services when patients need them in their homes.</p> <p>Patient safety: Practitioners are required to protect their patients no matter the location of care, and therefore allowing those practitioners to provide services off site is not a threat to patient safety. To the extent that DOH believes that partners need to take measures to protect patients receiving care in the home, the PPS will work with DOH to develop provider policies in this area.</p>
10	<p>10 NYCRR § 766.4(a), (b)</p>	<p>The PPS seeks this RR for projects 2.b.iii, 2.b.ix, 3.a.i, 3.c.i, and 3.d.ii.</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Regulatory Relief(RR)	RR Response
		<p>Reason for request: Section 766.4 allows doctors, midwives, and nurse practitioners to order licensed home care services, but it does not allow physician's assistants (PAs) to order such care. As part of their efforts to keep patients out of the hospital, the DSRIP projects listed above are likely to involve orders for home care. For example, some patients who are come to the emergency room or who obtain care in the PPS's Observation Unit may be in need of personal care services back at home. Likewise, PPSs may provide home care to patients to help manage their diabetes and asthma care. Allowing PAs to order home care as part of these projects would enable these partners to order such care regardless of type of practitioner and thus could potentially play a role in reducing inpatient admissions.</p> <p>Potential alternatives: PPS partners could avoid the need for this waiver by relying on physicians, midwives, and nurse practitioners to order licensed home care services. For partners that employ few PAs, complying with Section 766.4 is not a great concern. Some partners, however, rely heavily on Pas – with similar skillsets and licensing requirements as those of midwives and nurse practitioners – in their everyday practice. For these partners, forcing PAs to find the appropriate physician or nurse practitioner to order care would be inefficient.</p> <p>Patient safety: PAs often are given the same scope of authority as nurse practitioners. Granting physicians' assistants the power to order home care—a power already granted to midwives and nurse practitioners—is not a danger to patient safety.</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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 PPS is implementing a Collaborative Contracting Model effectuated through a Master Services Agreement (MSA) that will govern its operations. The MSA will be entered into by 1) Lutheran, as lead applicant; 2) NYULMC; and 3) all other partners including health care providers, health plans, and community-based organizations that will participate in the PPS. The PPS will be governed by an Executive Committee that is representative of the partners. The Executive Committee will be supported by a Finance Sub-Committee, an IT Sub-Committee, and a Clinical Sub-Committee. The PPS also will have a Quality Council, described in greater detail in Section 6.2, that will oversee the Rapid Cycle Evaluation plan and report directly to the Clinical Sub-Committee. A copy of the organizational chart for the PPS is attached.

The MSA will detail the specific responsibilities of Lutheran, NYULMC, and the other partners. It will incorporate, as schedules, clinical protocols and IT requirements with which the partners will be required to comply, and provisions governing the distribution of DSRIP funding. Sub-Committees will develop and the Executive Committee will approve these schedules, which will be amended as necessary,



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

thereby ensuring that they accurately reflect partner capabilities and needs. By binding partners through an MSA, the PPS will create a high-performing network that will ultimately be capable of successful risk contracting.

As the PPS's fiduciary, Lutheran will enter into the DSRIP contract with DOH, will collect DSRIP funding from DOH, and will distribute such funding to the partners and to third-party vendors that provide the central services necessary to support PPS operations, such as HIT, call center functionality, clinical care management, and other such services. As fiduciary, Lutheran will exercise ultimate care and oversight should the governance process come to a stalemate or should the success of the program be in jeopardy. Lutheran has significant experience in administering a wide range of state and federal grants and contracts, and therefore is well-positioned to play this role.

Lutheran will work in partnership with NYULMC, which will provide services to the PPS including IT services, data analytics, infrastructure support for the PNC, guidance on implementation of evidence-based best practices, clinical and PHM, rigorous rapid cycle evaluation, and continuous quality improvement activities. Through the Collaborative Contracting Model, Lutheran and NYULMC will work closely with their partners. Each partner will be responsible for complying with the MSA, including adhering to clinical and IT protocols, data sharing policies, privacy and security requirements, and relevant regulatory compliance requirements. Each partner also may participate in PPS governance and decision-making through membership on the Sub-Committees.

By enabling any eligible organization that enters into the MSA to participate in the PPS, the PPS's use of the Collaborative Contracting Model will maximize participation by a broad range of stakeholders. Furthermore, by establishing an inclusive governance structure that gives partners on-going input into and oversight of the PPS's operations, the PPS's use of this Model will permit the PPS to evolve over time while maximizing stakeholder buy-in. Both of these elements will be critical to success.

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: **32_SEC021_Brooklyn Bridges PPS Governance Organizational Structure.pdf**

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*Structure 2:

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

The PPS's governance is built around an inclusive and transparent governance structure, representative of its partners. The PPS will be governed by its Executive Committee, which will be responsible for, among other matters, strategic leadership, establishing methodologies for the distribution of DSRIP funds, evaluating partner performance, and general oversight of the DSRIP program. The Executive Committee will be supported by three standing committees: the Finance Sub-Committee, IT Sub-Committee, and Clinical Sub-Committee.

Each Sub-Committee will have distinct charges and authorities and will be staffed by Lutheran, NYULMC, and partner representatives with appropriate experience and expertise, which will help ensure optimal governance and management of the PPS and its DSRIP program.

* The Finance Sub-Committee will develop and oversee the methodology for distributing DSRIP funds and will develop the PPS's value-based contracting strategy.

* The IT Sub-Committee will develop data management strategy and policies to optimize HIT's critical role in redesigning care delivery, thereby enabling the PPS to effectively manage at-risk populations.

* The Clinical Sub-Committee will oversee the implementation of the clinical aspects of each DSRIP project, establish quality standards and metrics, and develop clinical care management staffing and protocols.

In addition to the three standing committees, the Executive Committee may establish other Sub-Committees as needed to manage and oversee the PPS over time. To ensure diversity in Executive Committee and Sub-Committee composition, the PPS will have a Nominating Committee, which will seek nominees from a wide range of partners when recommending members to serve on the Executive Committee and the Sub-Committees. The Nominating Committee will ensure Committee and Sub-Committee nominations represent the full range of



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

Page 17 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

participants in the PPS including hospitals, FQHCs, physician groups, behavioral health providers, developmental disability providers, skilled nursing facilities, home health care agencies, unions, managed care plans, and community-based organizations.

The Executive Committee and Sub-Committees will use a consensus-based process, described in more detail in Section 2.2, which will build support and buy-in for decisions, making the PPS an effective and cohesive organization. All Sub-Committee actions will be subject to the review and approval of the Executive Committee and Lutheran, as PPS fiduciary. Through their review and ultimate authority, the Executive Committee and Lutheran thereby ensure adequate PPS governance and management. Additionally, the PPS will continue to have a Project Advisory Committee (PAC), consistent with DSRIP requirements (as described in Section 2.3).

*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 PPS deems the development of clinical protocols and quality standards and metrics as essential to creating the complex, patient-centered care management process that is critical to PPS success. Accordingly, the PPS has established a Clinical Sub-Committee, with a Quality Council, both of which will include partner representatives with clinical expertise including representatives from hospitals, FQHCs, physician groups, behavioral health providers, skilled nursing facilities, home health care agencies, and health homes.

This Sub-Committee will oversee the implementation of the clinical aspects of each DSRIP project and develop clinical care management staffing and protocols. It also will oversee the Quality Council's establishment of quality metrics, standards, and improvement policies across the projects. The Executive Committee will review and approve these metrics, standards, policies, and protocols to ensure not only quality but also consistency with the PPS's specific and general goals. The Clinical Sub-Committee will monitor each partner's adherence to the approved quality standards and clinical protocols and notify the Executive Committee of any noncompliance with these standards and protocols. This Sub-Committee also will monitor and evaluate the PPS's overall progress in meeting the established clinical and quality objectives. The work of the Clinical Sub-Committee and its Quality Council, in conjunction with oversight from the Executive Committee, will ensure a strong clinical governance model that will hold individual partners and the PPS as a whole accountable for realizing clinical outcomes.

*Structure 4:

Where applicable, outline how the organizational structure will evolve throughout the years of the DSRIP program period to enable the PPS to become a highly-performing organization.

The Collaborative Contracting Model and associated governance structure have been designed to ensure optimal oversight and management of the PPS and DSRIP program. However, the PPS recognizes the need for the governance and organizational structure to evolve as the PPS moves toward sustainability and value-based contracting in DY 3-5. The initial operational structure described in this application will go into effect on April 1, 2015, and has been designed to allow focus on implementing effective IT, clinical, and financial governance, providing oversight of DSRIP program milestones, enforcing partner obligations, and evaluating and tracking PPS and partner performance relative to established metrics.

The PPS expects to begin the transition to risk-based contracting in the third year of the five-year DSRIP program, with the goal of becoming financially sustainable through value-based contracts by the end of year 5. During this transition, the PPS anticipates that partners will become fully integrated and possess strong capabilities to manage outcomes and quality.

As this occurs, the PPS will evaluate vehicles, such as accountable care organizations (ACOs) or independent practice associations, for contracting with payers. The PPS also will evaluate different value-based payment models, such as bundled payments, shared risk arrangements, and capitation arrangements. The PPS's organizational structure is expected to evolve to enable negotiation with payers, oversight of value-based contracting, and greater transparency into performance.

The PPS continuously will evaluate its governance and organizational structure to ensure it continues to meet the needs and objectives of the partners as well as the larger and longer-term organizational and financial goals of the PPS.

Section 2.2 - Governing Processes:



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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's Executive Committee initially will consist of the following representatives:

- * Claudia Caine, Lutheran Medical Center
- * Larry McReynolds, Lutheran Family Health Centers
- * Jeanne Lee, Lutheran Augustana Center for Extended Care and Rehabilitation
- * Dr. Gary Kalkut, NYU Langone Medical Center
- * Sarah Munson, NYU Langone Medical Center
- * Susan Beane, Healthfirst
- * Donna Lichti, Visiting Nurse Service of NY
- * Melissa Guglielmo, Allure Group
- * Marco Damiani, Metro Community Health Centers/Cerebral Palsy Associations of New York State
- * Cecile Charlier, 1199SEIU
- * Louis Kestenbaum, ODA Primary Health Care Network
- * Lisa Perry, CHCANYS
- * Medicaid beneficiary (to be determined)

The Executive Committee, chaired by Claudia Caine, Lutheran's President and Chief Operating Officer, will provide strategic leadership, approve the methodology for allocating DSRIP funds, evaluate partner performance, and provide oversight of the PPS and the DSRIP program. Each member will be responsible for bringing his or her expertise and experience to benefit the PPS and will provide valuable input to the governing body as a representative of a type or kind of partner that the member represents.

*Process 2:

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

To ensure highly qualified representation from a diverse set of partners, Lutheran invited all interested stakeholders to participate in the PPS planning process. Lutheran hosted three in-person meetings and two all-partner webinars to provide updates on the PPS planning process to its partners. Lutheran invited and encouraged all partners to submit nominations for appointment to the Planning Committees and Work Groups under those Committees (Executive, Finance, Central Services Planning, Clinical Project Planning and Development, and Community Needs Assessment) that played a lead role in the PPS's planning process. Nominees were selected based on their relevant experience, leadership roles in their communities, insight into how to coordinate care among diverse patient populations, commitment to the success of DSRIP and the PPS, willingness to make the necessary time commitment, and ability to motivate optimal participation in the PPS's activities. They also were selected to be representative of the types of organizations that are participating in the PPS.

To ensure continuity and maintain institutional knowledge, many of those who served on the Planning Committees and Work Groups have committed to continue as members of the Executive Committee and/or Sub-Committees during the PPS's operational stage. As such, Lutheran already has appointed the members of the operational stage Executive Committee, all of whom have been actively engaged in the planning process, and plans to select the members of the various Sub-Committees from among those who have participated in the PPS's planning phase. In addition, Lutheran expects to expand membership to reflect any additional recommendations from its partners.

Executive Committee and Sub-Committee members will serve for an initial term of one year, beginning on April 1, 2015. The Executive Committee and each Sub-Committee will be governed by a charter, which will specify necessary qualifications and competencies of potential Executive Committee and Sub-Committee members. Across the Executive Committee and various Sub-Committees, these competencies are likely to include clinical quality assurance and improvement, PHM strategies, and financial planning. Beginning with the second year of the DSRIP program, Lutheran will appoint Executive Committee and Sub-Committee members from among a slate of qualified individuals proposed by the Nominating Committee. Throughout the term of the DSRIP program, the Executive Committee and each Sub-Committee will consist of representatives of Lutheran, NYULMC, and a broad and diverse range of partners.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

***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.

As stated above, to help ensure sufficient representation across the PPS in its planning stage, Lutheran encouraged participation from every partner in the PPS and hosted meetings and webinars to keep partners involved in the PPS planning process. More than 27 organizations currently are represented on the PPS's Planning Committees and Work Groups, and Lutheran expects their continued participation on the Executive Committee and Sub-Committees during the PPS operational stage. These organizations include hospitals, FQHCs, physician groups, behavioral health providers, developmental disability providers, skilled nursing facilities, home health care agencies, unions, managed care plans, and community-based organizations. They represent the full range of participants in the PPS.

***Process 4:**

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

As noted above, Lutheran included its partners – hospitals, FQHCs, physician groups, behavioral health providers, developmental disability partners, skilled nursing facilities, home health care agencies, unions, managed care plans, and community-based organizations – in the Planning Committees and Work Groups and will continue to include them in the operational phase Executive Committee and Sub-Committees. The PPS will continue to reach out to community-based organizations, particularly those that serve high need patients that the PPS will target – such as individuals with HIV/AIDS and substance use disorders – and accordingly can help the PPS achieve its clinical objectives. As noted earlier, community-based organizations that participate in the PPS, like the other partners, will enter into the MSA with Lutheran and NYULMC.

***Process 5:**

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

The Executive Committee and each Sub-Committee will employ a consensus-based decision-making process to foster collaboration and make the PPS most effective. A majority of the members of the Executive Committee/Sub-Committee will constitute a quorum, and each Executive Committee/Sub-Committee member will have one vote. By way of motion, any member of the Executive Committee and/or Sub-Committee can raise an item for approval. If any action is not approved by at least 75% of the members constituting a quorum, then it will not be considered consensus-based. As the PPS fiduciary, Lutheran must provide final approval of all consensus-based actions of the Executive Committee. All consensus-based actions by a Sub-Committee must be submitted to the Executive Committee for review, and, if approved by the Executive Committee, to Lutheran, as PPS fiduciary, for its final approval. This decision-making process also will include a procedure for resolving any conflicts or issues, as described below.

***Process 6:**

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

If a Sub-Committee is unable to reach consensus on an action, the Sub-Committee will submit to the Executive Committee a summary of issues on which consensus has not been reached. The Executive Committee will work with the Sub-Committee to reach consensus. If consensus is not reached with the Executive Committee's assistance, the Executive Committee will make a recommendation to Lutheran, and Lutheran will determine the appropriate course of action.

If the Executive Committee is unable to reach consensus on an action, the Executive Committee will submit to Lutheran (as fiduciary) a summary of issues on which consensus has not been reached. Lutheran will work with the Executive Committee to reach consensus. If consensus is still not reached, Lutheran will determine the appropriate course of action.

***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.

The PPS is fostering a transparent governing process by including a wide range of partners in the Executive Committee and the Sub-Committees. In addition, the Executive Committee and each Sub-Committee will keep minutes of all meetings and will distribute those minutes, once approved by the Executive Committee/Sub-Committee via email or secure site to all partners. The Executive Committee and each Sub-Committee also will distribute other key materials from each meeting, as well as disseminate information about decisions



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

Page 20 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

and developments through a publicly accessible website. In addition, the PPS will solicit feedback from partners through online surveys, and such feedback will be reported and discussed at meetings of the Executive Committee and/or the relevant Sub-Committee. Decisions made by the PPS governing body also will be shared at stakeholder meetings. This transparent, inclusive governance model will ensure stakeholder buy-in to the PPS's goals and projects.

***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.

To ensure the engagement of Medicaid members, at least one Medicaid beneficiary will serve as a member of the Executive Committee. The PPS also will hold quarterly stakeholder meetings and develop a website to provide on-going updates and to receive comments and answer questions on the DSRIP program from the communities the PPS serves. The first of these meetings was held on December 12, 2014. Further, the PPS will either require or encourage each partner to work with trusted community-based organizations to encourage Medicaid beneficiaries to use PPS resources, including those who under-utilize Medicaid services for whom navigation and other PPS resources will be essential. Finally, the PPS is working with the New York City Department of Health and Mental Hygiene, an important stakeholder, to implement Domain 4 projects.

✔ 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 PPS's PAC structure was launched in July 2014 for the PPS planning phase. The planning phase PAC consists of the five Planning Committees and Work Groups under those Committees, described in Section 2.2: Executive, Finance, Central Services Planning, Clinical Project Planning and Development, and Community Needs Assessment. The planning phase PAC includes representatives from 27 partner organizations, including hospitals, FQHCs, physician groups, behavioral health providers, developmental disability providers, skilled nursing facilities, home health care agencies, unions, managed care plans, and community-based organizations. These five PAC committees have met more than 48 times to date, illustrating the PAC members' involvement in all facets of the PPS's planning efforts.

In the operational governance phase, both the structure and the composition of the PAC will change. As of April 1, 2015, the PAC will no longer consist of the five Planning Committees and Work Groups under those Committees, but will instead be a single committee consisting of approximately 25 to 30 individuals. It will continue to include representatives of Lutheran, NYULMC, health care provider organizations, and community-based organizations, who will be selected based on their commitment to the PPS, their areas of expertise relative to the DSRIP projects being implemented, their leadership roles in the community, and consistent with any other DSRIP-related requirements.

***Committee 2:**

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

In the operational phase, rather than being involved in the day-to-day development and operation of the PPS, the PAC will serve as an independent group that acts in an advisory capacity to the Executive Committee/Sub-Committees. The PAC will meet as a group at least quarterly to receive progress reports from the Executive Committee and to provide feedback to the Executive Committee on the PPS. The PPS also will host regular all-partner meetings, in which PAC members will participate, to provide on-going updates and obtain feedback on PPS implementation. To ensure the PAC has a strong voice in the governance structure, the PAC also will provide on-going feedback on the direction of the PPS's implementation and whether the goals of DSRIP are being met.

***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).

As noted above, during the planning stage, the PAC consisted of the five Planning Committees and Work Groups under those Committees, which had primary responsibility for the full range of PPS organizational structure planning, including the development of the



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

Page 21 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

governance model, selection of the PPS's clinical projects, oversight of the Community Needs Assessment (CNA), and development of a plan for distributing DSRIP funds.

With respect to the input the PAC had during the CNA, the CNA Committee held three meetings to gather input on CNA development and analysis. The CNA Committee also participated in the planning of the Stakeholder Engagement Meeting held on December 12, 2014, during which CNA findings were presented to stakeholders. CNA analyses and findings were shared with all the Committees and Work Groups as well as at the all-partner meetings.

*Committee 4:

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

As noted above, in the planning phase, the PAC consisted of five Planning Committees and Work Groups under those Committees, with representation from 27 partner organizations, including hospitals, FQHCs, physician groups, behavioral health providers, developmental disability providers, skilled nursing facilities, home health care agencies, unions, managed care plans, and community-based organizations. Accordingly, the PAC was fully representative of the partners and community organizations included in the PPS network. In the operational phase of the DSRIP program, the PAC will consist of approximately 25 to 30 individuals and will continue to include representatives from all of the organizations referenced above, ensuring that it will continue to be fully representative of the partners and community organizations included in the PPS network.

Section 2.4 – Compliance:

Description:

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

*Compliance 1:

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

The PPS will implement a compliance plan that meets the requirements of New York State Social Service Law 363-d and includes written standards of conduct and procedures that promote the PPS's commitment to compliance. The compliance plan will address specific areas, including the handling of potential fraud, performance of regular audits to monitor compliance and assist in the reduction of identified problem areas, the designation of a Chief Compliance Officer, establishment of compliance training programs, a process to receive complaints, whistleblower protection policies, a system to respond to allegations of improper or illegal activities, the investigation and remediation of compliance issues, and sanctions for individuals or entities that violate the compliance plan.

Lutheran's Senior Vice President for Corporate Compliance and Operational Planning will be the Brooklyn Bridges Chief Compliance Officer.

*Compliance 2:

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

The compliance program will be overseen by the Chief Compliance Officer, who will operate and monitor the compliance program, and will report directly to the Executive Committee. To assist the Chief Compliance Officer in identifying potential compliance issues, the compliance program will include: the establishment of a compliance hotline and email address that will enable anonymous reporting of potential compliance problems; a system for responding to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against individuals who have violated the PPS's compliance policies, applicable statutes, regulations or federal health care program requirements; and requirements to conduct regular audits to monitor compliance and assist in the reduction of identified problem areas. Finally, the compliance program will require the investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

*Compliance 3:

Describe the compliance training for all PPS members and coalition partners. Please distinguish those training programs that are under



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

Page 22 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

development versus existing programs.

The PPS compliance program will include the development and implementation of regular, effective education and training programs for partners and their employees. These education and training programs are still under development and are expected to be rolled out between April 1 and July 1, 2015. The PPS will conduct initial, in-person compliance training during the orientation of new hires and during retraining. Compliance also will be a component of all mandatory trainings which may be delivered as an on-line module or through in-person presentations.

*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.

As noted above, the compliance program will include a process to receive complaints and procedures to protect the anonymity of complainants, including the establishment of an anonymous hotline and an email address which may be used to report potential compliance issues. The PPS will develop a robust education and notice campaign to ensure that community members, including Medicaid beneficiaries, are aware of the program and how to file a compliance complaint. This will include educating CHWs, community-based organization staff, and others who have frequent contact with community members about the hotline, as well as prominent placement of posters and billboards promoting hotline awareness in high traffic community sites.

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 Sub-Committee will develop and oversee processes to support the financial success of the PPS, establish financial controls, develop and oversee the methodology for distributing DSRIP funds, and construct a value-based contracting strategy. Partners will be eligible for payments related to DSRIP project implementation costs, provider bonuses to recognize contributions to DSRIP goals, and compensation for revenue lost as a result of implementing the DSRIP program. The methodology for distributing DSRIP funds will be approved by the Executive Committee and incorporated into the MSA as a schedule. The distribution of DSRIP funds will be supervised by the Executive Committee and Finance Sub-Committee, as well as by Lutheran management and the Finance Committee of the Lutheran Board of Trustees. As lead PPS entity and fiduciary, Lutheran will retain ultimate responsibility for and oversight of the DSRIP funding.

*Organization 2:

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

The PPS will establish the ability to monitor funds flow, evaluate performance, generate reports, and distribute payments. Specific key finance functions within the PPS include the following:

- * Development of annual PPS budgets and operating plans.
- * Oversight of PPS performance against such budgets and operating plans.
- * Distribution of funds to partners and vendors.
- * Periodic audits to determine that funds are appropriately distributed.
- * Establishment of a graduated dollar level of authorization for expenditures.
- * Maintenance of records to ensure that all DSRIP funds and expenditures are appropriately accounted.
- * Establishment of a separate bank account for DSRIP funds.
- * Development and implementation of value-based contracting for the PPS under the guidance and approval of the Finance Sub-Committee and the Executive Committee.

*Organization 3:

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

The PPS will utilize internal and external auditors to ensure rigorous internal financial controls and reporting. The internal audit process will involve the Lutheran Board of Trustees, management, and other key financial personnel and will review the PPS's financial reporting



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

reliability, operating effectiveness and efficiency, and compliance with applicable laws and regulations. Internal auditors will use recognized accounting standards and will report all findings to the Executive Committee, Finance Sub-Committee, and Lutheran as fiduciary.

The Audit and Legal Committee of the Lutheran Board of Trustees appointed Deloitte as its external auditors for its annual audit. Deloitte identified no material weaknesses in Lutheran's internal financial controls and reporting in its 2013 (most recent) audit. The PPS will retain Deloitte, or an organization of a similar caliber, to perform an annual external audit, which will present its report with any identified material weaknesses to the Executive Committee, Finance Sub-Committee, and Lutheran as fiduciary.

*Organization 4:

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

The PPS will implement a compliance plan consistent with Social Service Law 363-d to include:

- * Written standards of conduct and policies and procedures that promote the PPS's commitment to compliance and address specific areas of potential fraud.
- * Designation of a Chief Compliance Officer who is responsible for the compliance program and reports directly to the Executive Committee.
- * Development and implementation of regular education and training programs for partners and their employees.
- * A process to receive complaints, and procedures to protect the anonymity of complainants and protect whistleblowers from retaliation.
- * A system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against individuals who have violated the PPS's compliance policies.
- * Regular audits to monitor compliance and assist in the reduction of identified problem areas.
- * Investigation and remediation of identified systemic problems and development of policies addressing non-employment or retention of sanctioned individuals.

Section 2.6 – Oversight:

Description:

Please describe the oversight process the PPS will establish and include in the response the following:

*Oversight 1:

Describe the process in which the PPS will monitor performance.

The Executive Committee will monitor the activities of the partners and ensure that the partners comply with their responsibilities under the MSA and that the PPS meets its pay-for-performance metrics. Using clinical, financial, and operational measures, the PPS routinely will monitor performance against key benchmarks set by data from other partners in the PPS, as well as national and regional data sets. The PPS will develop a rapid-cycle evaluation program that will leverage IT capacity to systematically collect and report established PPS metrics and milestones at a partner level. The Executive Committee also will receive reports from the Clinical Sub-Committee, which will monitor each partner's adherence to the quality standards and clinical protocols and notify the Executive Committee if partners fail to adhere to such standards and protocols.

*Oversight 2:

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

Should the Executive Committee find a partner is underperforming, it first will meet with the partner to attempt to resolve the issue. If this is unsuccessful, the Executive Committee may issue a written warning to the partner describing the underperformance or, if the nature of the underperformance warrants it, may require the partner to submit a Corrective Action Plan (CAP) for review and approval of the Executive Committee. The CAP will set forth steps for remediating the underperformance and may include milestones determining successful implementation of the CAP and dates by which each milestone must be completed. The partner will be required to submit periodic reports to the Executive Committee describing the status of the partner's compliance with the CAP, including, for a CAP with specific milestones, attestations that the partner has completed each milestone by the milestone completion date. The Executive Committee may refine the CAP from time to time as appropriate. Any member of the Executive Committee and Sub-Committees may elevate concerns regarding lower performing members.



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

Page 24 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

*Oversight 3:

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

If a partner is performing poorly, and, after the process described above, the poor performance is not remedied, the Executive Committee will schedule a closed meeting with the partner to discuss the potential imposition of sanctions, described below. At the meeting, the Executive Committee will review the partner's performance and will provide the partner with the opportunity to make a presentation that addresses the reasons for the continued poor performance and potential options for addressing the poor performance. After such discussion, the partner will be asked to recuse itself from the meeting and the Executive Committee will determine whether or not sanctions should be imposed. Sanctions may include, but may not be limited to, 1) suspension of any project implementation funds or provider bonuses that might otherwise be payable to the partner, 2) the temporary suspension of the partner's participation in the PPS or, as a last resort, 3) removal of the partner from the PPS. Any sanctions recommended by the Executive Committee will require the approval of Lutheran as the fiduciary. This procedure is consistent with the standard terms and conditions of the Medicaid DSRIP Waiver.

*Oversight 4:

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

During the implementation phase, the PPS will incorporate Medicaid beneficiary and advocate feedback about partners into the partner renewal and removal process in three ways: 1) monitoring compliance hotline complaints and considering partner-specific complaint information in the renewal and removal process, to the extent relevant and appropriate; 2) evaluating CAHPS survey results to identify any partner specific trends or issues that should be considered in the partner renewal or removal process; and 3) providing an opportunity for Medicaid consumer and advocate input into the removal of a particular partner as appropriate and necessary to inform the Executive Committee's deliberations regarding a partner CAP, possible sanctions, or removal of a partner.

*Oversight 5:

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

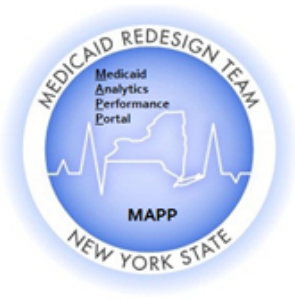
The PPS will maintain a public website and written materials that provide information about the PPS, the DSRIP program, what it means for a provider or community-based organization to participate in the PPS, how to access a list of partners, and what DSRIP means for patients. The website and materials will also provide the PPS compliance hotline number, PPS email address, and other contact information as appropriate. The PPS website will list all partners and will be updated if partners are removed from the PPS. In addition, the PPS PNC, described in Section 4, will have an up-to-date list of PPS partners and can provide this information telephonically to consumers and community-based organizations. The PPS will ensure that its website, written materials, and PNC provide robust language access in multiple languages read and spoken by the PPS's community members, including Arabic, Bangla, Chinese, Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish.

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.



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

Page 25 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)



Please Check here to acknowledge the milestones information above



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

- 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.

Brooklyn Bridges, in partnership with other Brooklyn PPSs, contracted with the New York Academy of Medicine (NYAM) to conduct a borough-wide CNA. To inform the primary data collection, the PPS provided a list of key informants and collaborating organizations, offered feedback on the primary data collection instruments, and closely reviewed iterative drafts of the CNA analysis. The findings from the Brooklyn CNA informed the PPS's vision, clinical project selection, and preliminary implementation planning.

The CNA Committee, comprised of PPS PAC members representing community-based organizations, health care providers, the Brooklyn Health Home, and health plans, directed the CNA process. The CNA Committee reviewed the findings of the CNA analysis and coordinated information sharing with the PPS's Clinical Project Planning and Development Committee and Work Groups to inform project selection, intervention design, and target populations. The full CNA Committee met on September 5th, October 17th, and October 27th. The Committee reviewed the findings and led the planning for a borough-wide Stakeholder Meeting that was held on December 12, 2014 with nearly 150 community members, community-based organizations, and other interested stakeholders in attendance. The borough-wide Stakeholder meeting included a panel presentation by representatives from Brooklyn Bridges, Community Care Brooklyn, and the HHC PPS that provided an overview of DSRIP, a review of the CNA findings and the project selections of each PPS, and addressed questions on the impact that system-wide transformation will have on Brooklyn.

Despite the challenge of conducting a borough-wide CNA during a compressed time period, the CNA process culminated in a comprehensive analysis of Brooklyn health care system strengths and the unmet health needs of the community.

*Overview 2:

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

NYAM leveraged both primary and secondary data sources to inform the CNA's development.

Primary Data. Surveys, available in 10 languages, were completed by 681 Brooklyn residents. The survey focused on basic demographics, health concerns, health care utilization, barriers to care, and use of community and other services. Twenty-eight key informant interviews were conducted with individuals who had specific expertise in population health or social determinants of health. 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. NYAM conducted 24 focus groups with a diverse cross-section of community members, including residents from low income neighborhoods described in detail in Section 3.7.

Secondary Data. NYAM aggregated and analyzed publicly available data to assess health care and community resources, disease prevalence, demographic characteristics, and social determinants of health. NYAM supplemented its data analysis with a literature review,



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

including reports prepared by Brooklyn providers, the DOH, NYC Departments of Health and Mental Hygiene (NYC DOHMH) and City Planning, academic institutions, and others. Data includes, but is not limited to: NYS Community Health Indicator Reports; Behavioral Risk Factor Surveillance System; Statewide Planning and Research Cooperative System; Prevention Quality Indicators; Pediatric Quality Indicators; Potentially Preventable Emergency Visits; Hospital-specific profiles of quality of care for selected conditions; Medicaid Chronic conditions, Inpatient Admissions, and Emergency Room Visits; Medicaid hospital inpatient Potentially Preventable Readmission Rates; NYS Prevention Agenda 2013-2017 tracking indicators; American Community Survey 2012 5-year estimates; Vital Statistics and NYC DOHMH and Department of Corrections data, among others

✔ 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	14	2
2	Ambulatory surgical centers	119	0
3	Urgent care centers	21	1
4	Health Homes	4	1
5	Federally qualified health centers	19	9
6	Primary care providers including private, clinics, hospital based including residency programs	8817	356
7	Specialty medical providers including private, clinics, hospital based including residency programs	3890	666
8	Dental providers including public and private	1888	112
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	73	11
10	Behavioral health resources (including future 1915i providers)	6036	258
11	Specialty medical programs such as eating disorders program, autism spectrum early	280	3
12	diagnosis/early intervention	1	1
13	Skilled nursing homes, assisted living facilities	64	39
14	Home care services	28	21
15	Laboratory and radiology services including home care and community access	42	1
16	Specialty developmental disability services	493	13
17	Specialty services providers such as vision care and DME	223	105
18	Pharmacies	140	1
19	Local Health Departments	1	1
20	Managed care organizations	12	9
21	Foster Children Agencies	55	6
22	Area Health Education Centers (AHECs)	1	0

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

***Infrastructure 2:**



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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

Brooklyn's health care resources are not evenly distributed, leading to overuse of emergency departments (ED) for non-urgent or preventable conditions. To develop more specific recommendations for DSRIP investment, the PPS supplemented the CNA analysis with clinical project planning, provider surveys, stakeholder engagement, and secondary research including recommendations of the Brooklyn Health Systems Redesign Work Group ("Berger Work Group") in 2011.

Several neighborhoods in Brooklyn have no hospitals, including Greenpoint, East New York, and Bensonhurst-Bay Ridge. At the same time, the Berger Work Group found that only 71% of Brooklyn's 6,389 licensed hospital beds are occupied and the borough could reduce approximately 1,000 beds and still be below the 85% occupancy standard. The PPS intends to invest in community-based primary and specialty care, transitioning resources out of acute care settings.

Outpatient primary care sites are also unevenly distributed. There is a dearth of FQHCs in East Flatbush and Flatbush, highly populated areas with high rates of uninsured. There are nine federally-designated primary care health professional shortage areas in Brooklyn— Bedford-Stuyvesant, Bushwick, Coney Island/Gravesend, Crown Heights, East New York, Midwood, Redhook, Sunset Park, and Williamsburg. The Berger Work Group suggests that Brooklyn's high rates of preventable inpatient and ED use are the result of insufficient primary care capacity and poor geographic distribution of existing resources. Only 55% of Brooklyn CNA survey respondents said that they access non-emergency health care services at a primary care doctor's office and one-quarter reported that primary care medicine was "not very available" or "not available at all." CNA analysis suggests that Brooklyn lacks culturally and linguistically competent primary care providers and specialists. The PPS will invest in primary care access and capacity by increasing the number of ambulatory providers, improving provider "after hours" access during weekends and evenings, increasing the scope of care that primary care facilities offer on site, developing new models of patient-centered medical care, and enhancing cultural and linguistic competency.

Only 47% of CNA survey respondents reported that mental health services were "available" or "very available;" residents reported a severe shortage of pediatric and adolescent mental health professionals. There are very few alcohol/drug use programs located in Flatbush, Canarsie-Flatlands, and Southwest Brooklyn. Fifty-nine percent of respondents identified substance abuse services as being "not very available" or "not available at all." The PPS will invest in developing behavioral health capacity integrated into primary care settings to more effectively meet demand and adequately serve patients in the community. This investment will occur at the PPS's network of nine FQHCs, seven diagnostic and treatment centers (DTC) and 29 private Brooklyn primary care practice sites located in high need communities.

Because the two columns in the table above draw from different data sources, their findings are often inconsistent.

✔ Section 3.3 - Community Resources Supporting PPS Approach:

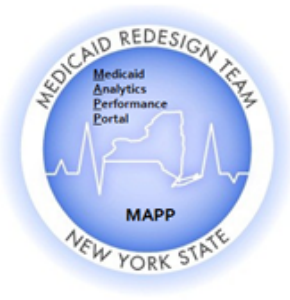
Description:

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

***Resources 1:**

Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Resource Types.

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	349	14
2	Food banks, community gardens, farmer's markets	407	7
3	Clothing, furniture banks	120	3
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	75	9
5	Community outreach agencies	32	15



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
6	Transportation services	15	3
7	Religious service organizations	61	5
8	Not for profit health and welfare agencies	528	68
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	22	17
10	Peer and Family Mental Health Advocacy Organizations	29	16
11	Self-advocacy and family support organizations and programs for individuals with disabilities	29	29
12	Youth development programs	833	21
13	Libraries with open access computers	60	0
14	Community service organizations	333	35
15	Education	1299	23
16	Local public health programs	40	4
17	Local governmental social service programs	68	2
18	Community based health education programs including for health professions/students	40	4
19	Family Support and training	29	29
20	NAMI	1	0
21	Individual Employment Support Services	100	16
22	Peer Supports (Recovery Coaches)	36	23
23	Alternatives to Incarceration	15	6
24	Ryan White Programs	122	5
25	HIV Prevention/Outreach and Social Service Programs	53	15

***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.

The PPS will deploy a targeted outreach and referral strategy by working closely with its social service partners who have expertise in serving low-income racial and ethnic groups including African-American, Caribbean, Hispanic, Chinese, Russian, Polish, South Asian, and Arab populations. These agencies will help address cultural and social determinants of health by strengthening residents' connections to social services and providing additional support to families and individuals in crisis.

Forty percent of CNA survey respondents reported that social services were "not very available" or "not available at all." As part of the PPS's focus on targeting communities with high rates of asthma, diabetes and other health conditions that contribute to avoidable hospital admissions and re-admissions, the PPS will work with social services organizations to extend their reach to "hot spot" neighborhoods.

There is a dearth of community gardens and farmers' markets in southern and central Brooklyn. Across lower income neighborhoods, respondents described poor access to fruit and vegetables, an abundance of fast food restaurants and bodegas, and poor quality supermarkets. Forty percent of respondents reported that healthy food was "not very available" or "not available at all" in their neighborhood. Access to affordable and healthy food is critical to reducing diabetes, obesity, and cardiovascular disease; the PPS will work with agencies including God's Love We Deliver, Bed-Stuy Campaign for Hunger, Brooklyn Perinatal Network, CAMBA, Ridgewood-Bushwick Senior Citizens Council, and others to assist eligible families in enrolling in food assistance programs in which they are eligible, and educating them on available food pantries, soup kitchens, and farmers markets that accept EBT as well as healthy cooking educational resources.

Research shows that addressing employment and housing issues has a significant impact on improving health. These are two areas cited by respondents where resources are in high demand. Two-thirds of survey respondents reported that job training was "not very available" or "not available at all." Almost 70% of respondents identified affordable housing as "not very available" or "not available at all."



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

Transportation is also a critical issue for individuals and has a direct impact on whether they are able to access the most appropriate health care setting. Respondent perception is that accessing transportation assistance is complicated and unreliable. The PPS will work with its social service partners who have expertise in job training, housing support, and transportation assistance to expand their reach to communities that have traditionally been underserved and are in most need of these supports.

The PPS recognizes that there are some categories of community partners that have not yet been directly engaged including NAMI, libraries, and religious service organizations. The PPS will expand its network of community resource partners throughout the DSRIP implementation phase through on-going stakeholder engagement.

Because the two columns in the table above draw from different data sources, their findings are often inconsistent.

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:

Brooklyn is a diverse borough, rich in history, culture, recreation, and commerce. Brooklyn's population of 2.5 million comprises one-third of New York City's (NYC) total population, and is roughly 13% of the statewide population. Nearly two-thirds (64.7%) of Brooklyn's population are working age adults aged 18-64, approximately one quarter (23.7%) are children aged 0-17, and just over ten percent (11.6%) are over the age of 65. The age distribution of Brooklyn's population mirrors that of NYC and New York State (NYS), with a slightly lower proportion of older adults in Brooklyn (11.6%) than either NYC (12.2%) or NYS (13.6%).

*Demographics 2:

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

Brooklyn's population is racially, ethnically, and linguistically diverse with significant populations from multiple racial and ethnic groups (e.g., African-American, Latino, Caribbean, Chinese, Russian, Polish, South Asian, Orthodox, Jewish and Arab) requiring attention to ensure cultural competency and health literacy. One in three identify as Black/African-American(25% in NYC and 15.7% in NYS) a fifth as Hispanic/Latino, and a tenth as Asian. Health care disparities are pronounced in low-income neighborhoods, communities of color and for immigrants. Approximately 17% of residents are non-citizens, compared to NYC (18%) and NYS (11%). About 35% are foreign-born. Over 22,000 residents report having migrated to the US less than one year ago.

Approximately 25% of residents (566,247) report speaking English "less than very well." Nearly half report speaking a language other than English at home. Approximately 17% speak Spanish or Spanish Creole, 7% speak Chinese, and 5% speak Russian.

*Demographics 3:

Income levels:

The median household income in Brooklyn is \$45,000 per year, lower than NYC (\$52,000) and NYS (\$58,000); median incomes in Brooklyn for Hispanic/Latinos and Black/African-Americans are even lower at \$36,730 and \$40,747, respectively, according to 2013 Census data. A large percentage of Brooklyn households (22%) live below poverty, compared to NYC (19%) and NYS (14%). For some communities, including a number of immigrant groups, economic constraints are compounded by very long work hours and multiple jobs, which negatively impact residents' ability to carve out time and resources for accessing primary health care and practicing healthy behaviors.

*Demographics 4:

Poverty levels:

Slightly more than one in five (22%) of households in Brooklyn live below the federal poverty level (FPL), compared to 19% in NYC and 14% in NYS. The highest rates of poverty are in the northern and northeastern parts of the borough, in the neighborhoods of Williamsburg-Bushwick, East New York, and parts of Bedford-Stuyvesant/Crown Heights, where approximately one in three households have incomes



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

below the FPL. There are also high rates of poverty in Sunset Park and Coney Island, where approximately 25%-30% of households have incomes below 100% FPL. Furthermore, CNA interviewees and survey respondents note the high cost of living in NYC, which render income and poverty guidelines unrealistic.

There are approximately 1.3 million Medicaid beneficiaries living in Brooklyn (approximately 50% of Brooklyn's population), with the highest proportion in Brownsville, Williamsburg-Bushwick, East New York, Bedford-Stuyvesant, Sunset Park, Borough Park, Flatbush, East Flatbush, and Bensonhurst.

*Demographics 5:

Disability levels:

Disability levels in Brooklyn vary by neighborhood. Ambulatory difficulty among the population who are aged 65 and older is concentrated in two geographic clusters, one extending from the far northern tip of the borough in Greenpoint in a southeasterly direction to East New York, and the other from Sunset Park southeasterly through Borough Park to Sheepshead Bay. Ambulatory difficulty rates are much lower for those age 18 to 64 but still affect a sizable number of people in this age group, with a similar geographic pattern. Individuals with physical and/or cognitive disabilities are disproportionately low-income, have a high number of co-morbidities and are in great need of access to specialized ambulatory care that can meet their unique needs. Currently, these individuals are dependent on systems that provide inadequate accommodations and as a result, face a number of logistic, psychosocial, and emotional barriers to care.

*Demographics 6:

Education levels:

While the majority of Brooklyn residents have a high school degree, less than one-third have earned a bachelor degree. Eight out of ten (78%) Brooklyn residents aged 25 and higher have a high school degree or equivalent, on-par with NYC (79%), but lower than NYS (85%). The proportion of those aged 25 or older who have earned a bachelor degree is lower at 30%, compared to 34% in NYC and 33% statewide. According to 2013 Census data, 34% of those over age 25 who are under the poverty line have less than a high school degree, compared to 29.5% for NYS and 33.5% for NYC. In addition, 22.6% of those over age 25 and under the poverty line have a high school degree or equivalent, compared to 15.2% for NYS and 20.6% for NYC.

*Demographics 7:

Employment levels:

The overall unemployment rate in Brooklyn is 10.3%, roughly equivalent with NYC (10.2%), but higher than NYS (8.7%). According to 2013 Census data, the unemployment rate in Brooklyn varies widely across ethnic and racial groups: 14.1% of the Black/African-American population is unemployed and 12.9% of the Hispanic/Latino population is unemployed while the unemployment rate for Whites is 6.7%. Unemployment in the borough ranges from 6.2% to 17.7% with the highest rates in the northern and central portions of the borough, and Coney Island.

*Demographics 8:

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

In 2012, there were 84,754 NYC DOC Jail Admissions among NYC residents. Brooklyn residents accounted for 21,693 of those admissions. The rates of NYC DOC Jail Admissions per 100,000 people in Brooklyn vary by neighborhood from 134/100,000 to 2,436/100,000, with the highest rates in Brownsville, Bedford-Stuyvesant, Bushwick, and Crown Heights. Significantly, the number of new NYC Jail and NYS Prison admissions has been steadily declining over the past 15 years. Additionally, rates of serious crime vary by neighborhood with a rate of 6.2/1,000 residents in Borough Park, Kensington, and Ocean Parkway to 43.5/1,000 residents in Brooklyn Heights and Fort Greene and 43.1/1,000 residents in Bedford-Stuyvesant.

Related to those institutionalized in the borough, OMH data indicate that more than 3,000 individuals were in OMH residential programs in Brooklyn in 2012 (including congregate, apartment, supported housing, and other support programs).

File Upload (PDF or Microsoft Office only):

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



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

File Name	Upload Date	Description
32_SEC034_New York State Health Workforce Planning Data Guide_Attachment2.pdf	12/21/2014 09:28:50 AM	
32_SEC034_New York State Health Workforce Planning Data Guide_Attachment1.pdf	12/21/2014 09:27:00 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment7.pdf	12/21/2014 09:24:58 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment6.pdf	12/21/2014 09:23:24 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment5.pdf	12/21/2014 09:21:26 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment4.pdf	12/21/2014 09:19:37 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment3.pdf	12/21/2014 09:18:17 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment2.pdf	12/21/2014 09:16:33 AM	
32_SEC034_Brooklyn_MRT_FinalReportAttachment1.pdf	12/21/2014 09:14:08 AM	
32_SEC034_CHCANYS_ExpanSustain_April2013 (5).pdf	12/21/2014 09:11:36 AM	
32_SEC034_CHCANYS_ExpanSustain_April2013 (4).pdf	12/21/2014 09:08:42 AM	
32_SEC034_CHCANYS_ExpanSustain_April2013 (3).pdf	12/21/2014 09:06:42 AM	
32_SEC034_CHCANYS_ExpanSustain_April2013 (2).pdf	12/21/2014 09:04:55 AM	
32_SEC034_CHCANYS_ExpanSustain_April2013 (1).pdf	12/21/2014 09:02:48 AM	

✔ 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:

Diseases of the heart are the leading causes of death in Brooklyn. The top ten causes of death and their rates per 100,000 are as follows: diseases of the heart (196.8), cancer (145), influenza and pneumonia (28.6), diabetes (24.9), chronic lower respiratory disease (17.4), cerebrovascular disease (stroke) (17.3), essential hypertension and renal diseases (12.1), accidents except drug poisoning (10.2), HIV (8.3), and mental and behavioral disorders due to accidental poisoning and other psychoactive substance use (7.8). The leading causes of death in the borough are consistent with those in NYC and NYS.

The top five causes of premature death in Brooklyn and their rates per 100,000 are: cancer (267), heart disease (201), unintentional injury (45), diabetes (38) and AIDS (29). This aligns with the top five causes of premature death in NYC, and matches the top three causes of death in NYS, for the same time period. Like many other health indicators, minority populations fare worse than White populations on premature death; the percentage of Hispanic and Black individuals with premature deaths are more than twice that of White individuals.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

Chronic conditions, including respiratory conditions such as asthma, cardiovascular conditions such as hypertension and diabetes represent the highest number of potentially preventable admissions (PQI) in Brooklyn. These conditions are concentrated in the lowest income neighborhoods throughout the borough. Additionally, approximately 65-80% of all emergency visits were considered potentially preventable.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

The highest Observed/Expected (O/E) PQI ratios were consistently found in north-central Brooklyn, a cluster of zip codes from Downtown in the west to Bedford-Stuyvesant and Bushwick in the east, and in Coney Island. For absolute numbers of PQI admissions, the geographic areas of concern extend south and further east from these areas to Crown Heights and Brownsville and East New York. The rate of emergency visits that are considered potentially preventable is 74.5%. The highest Medicaid PQI hospitalizations among young adults occur in Williamsburg-Bushwick and Bedford-Stuyvesant/Crown Heights. Hospitalization for coronary disease was higher for Black and Hispanic populations than for White, as was the diabetes complication hospitalization rate, especially for those over age 18.

*Challenges 3:

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

Brooklyn has fewer potentially avoidable ED visits (PPV) per 100 beneficiaries than NYC or NYS. Despite this, the proportion of ED visits that are considered potentially preventable is quite high at 74.5% for Brooklyn as a whole, which ranges from 64.6% to 80.4% among zip codes. The same areas of the borough with elevated PQI O/E rates, a north-central swath extending from downtown in the west to East New York in the east, have the highest proportions of ED visits designated as potentially preventable, as do Flatbush and Canarsie, south of the central and eastern part of this area. Risk factors contributing to these rates include barriers to primary care (including appointment wait times and the potential need for multiple visits), chronic conditions, and lack of insurance. The PPS selected the Patient Navigation Center, ED Care Triage, and Observation Unit projects, among others, to target avoidable hospitalizations.

*Challenges 4:

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

Prevalence rates in Brooklyn for diabetes, asthma, cardiovascular disease, depression, behavioral health conditions, HIV and STDs are high. Diabetes is considered by many residents and key informants to be the most significant health issue in Brooklyn. The diabetes composite PQI (S01) for Brooklyn (1.00) (3,072 PQI Admissions) is overall the same as for NYC (1.01) and NYS (1.00). Communities served by PPS partners in Borough Park, Red Hook, and Sunset Park have among the highest combined utilization of diabetes services.

Approximately 6% of Medicaid beneficiaries had asthma-related service utilization (including pharmacy). Asthma is a driver of considerable avoidable ED admissions and re-admissions for Lutheran as one of the top four diagnoses of Medicaid beneficiaries who visit the Lutheran ED more than three times a year. Asthma is the second most frequent diagnosis for Medicaid beneficiaries who visit the Lutheran ED more than six times a year.

In 2012, the number of PQI admissions for circulatory conditions among Medicaid beneficiaries accounted for 23.3% of all such admissions in NYS. The overall O/E ratio for the borough was 1.04 for Circulatory Composite PQI hospitalizations (3,694 PQI admissions), with 22 of 37 zip codes having an O/E ratio over 1.00.

More than 6% of all people in Brooklyn report experiencing serious psychological distress (SPD), compared to 5.5% in NYC overall. In NYC, people who are currently SPD are more likely to report binge drinking in the last 30 days than people who did not report SPD and are more than twice as likely to report being a current smoker. A contributor to SPD may be social isolation which particularly affects Sunset Park/Northern Bay Ridge residents compared to the rest of NYC (60.2 percent vs 32.2 percent, 2011 Community Health Survey). According to data from the OMH, approximately 54.8% of Brooklyn residents who received mental health service utilization had at least one chronic medical condition.

The fifth leading cause of premature death in the borough is AIDS (692 deaths), which accounts for one-third of all deaths in NYC. The rate of new HIV diagnoses among Black/African American people living in Brooklyn is more than five times the rate among Whites in the borough; the rate of new HIV diagnoses among Latinos living in Brooklyn is over 2.5 times that of Whites.

In 2012, the rate of gonorrhea and chlamydia among women aged 15-44 years was 1.3 times the State rate. Among men, the gonorrhea rate was 1.4 times the State rate.

*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:

During the period from 2010-2012, the most recent available data, the overall Low Birth Weight (LBW) rate for Brooklyn was 8.2%, compared to 8.5% for NYC and 8.1% for NYS. Across Brooklyn zip codes, the LBW rates ranged from 5.2% to 13.4%, with the highest



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

Page 35 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

rates in Bedford-Stuyvesant, Crown Heights, Flatbush, Brownsville, East New York and Canarsie. These neighborhoods also experience the highest rates of infant mortality.

In the same period, the number of live births per year averaged 41,969 in Brooklyn, representing 35.5% of NYC births and 17.5% of NYS births. The percentage of births in Brooklyn to women without insurance or covered by Medicaid was 65.9%, compared to 59.7% in NYC and 50.1% in NYS; the percentage of childbirth to women with Medicaid or uninsured across Brooklyn zip codes ranged from 12.5% to 91.2%. 10.9% of all births in Brooklyn were pre-term with disproportionately higher preterm rates for Black and Hispanic women.

In Brooklyn, 72% of mothers who received prenatal care started between their first and third month of pregnancy, 25.4% started in their 7th and 9th month of pregnancy, and 6% had late or no prenatal care.

*Challenges 6:

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

The prevalence of obesity in Brooklyn is higher than in NYC or NYS, with 27% of Brooklyn residents classified as obese, versus 24.2% in NYC and 23.6% in the State. Among children and adolescents, approximately one in five is obese (21.7%), on par with NYC, but higher than NYS (17.6%, excluding NYC).

The percentage of tobacco users among adults in Brooklyn is roughly on par with NYC and NYS rates (16.0% in Brooklyn versus 15.5% in NYC and 16.2% in NYS in 2012). Smoking rates are much higher in the Chinese and Arab communities than among other populations.

About 4.8% of Brooklyn Medicaid beneficiaries had alcohol/drug use-related service utilization and the age-adjusted percentage of adult binge drinking was 16.4%. Alcohol use is the most frequent diagnosis for patients with Medicaid who visit the Lutheran ED, and alcohol/substance abuse is the top driver for 30 day re-admissions.

Clearly, behavior-related risk factors present a significant challenge to transforming the health of Brooklyn residents. Thoughtful and rigorous integration of behavioral health, social, and peer support services with healthcare delivery is critical to PPS success.

*Challenges 7:

Any other challenges:

Environmental risks, including roaches, rodents, and mold in the home, are prevalent in Brooklyn. Rates of serious housing code violations that are "immediately hazardous or serious" are high in many of the same neighborhoods with significant numbers of preventable respiratory PQL hospitalizations: Bedford-Stuyvesant, Crown Heights, Williamsburg, Bushwick, Brownsville, East New York, Flatbush and East Flatbush. In Bushwick, the prevalence of asthma is attributed largely to indoor and outdoor environmental conditions, including poor housing conditions, traffic, and the historic industrial base of the community. In Sunset Park, there is a history of toxic environments due to "brownfields," especially along the formerly industrial waterfront.

The cost of medical care remains problematic and is a barrier to effective disease management. The income criteria for Medicaid are described as unrealistic, given the cost of living in NYC, and many working poor who do not qualify for Medicaid cannot afford insurance offered through the New York State of Health Marketplace. Implementation of a Basic Health Program in 2016 will likely improve insurance access for some of members of the community

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.**

According to the Berger Work Group report, on average, only 51% of Brooklyn's 6,389 licensed hospital beds were occupied in 2011. Based on the Berger's analysis of population and utilization patterns, Brooklyn needs fewer than 5,400 beds to reach the optimal 85% occupancy medical-surgical planning standard. The Berger Work Group found that Brooklyn could reduce approximately 1,000 beds and



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

still be at or below the 85% standard. A Brooklyn bed reduction strategy requires collaboration across the PPSs serving the borough; a single PPS cannot influence overall bed reductions absent a coordinated, borough-wide approach. As such, the PPS has committed to work with a coalition of Brooklyn-based PPSs to devise a plan for "right sizing" acute care bed capacity in the borough to address over-capacity.

Independent of this effort, as part of its DSRIP planning process, Lutheran has identified at least 40 skilled nursing facility (SNF) beds that will not be needed if delivery system transformation is effective and patients are able to receive more appropriate long-term care services in their homes and appropriate ambulatory settings rather than in an institutional setting. Lutheran Augustana Center for Extended Care and Rehabilitation intends to phase out these beds over the course of the DSRIP project period, and will submit a more specific timeframe and plan for doing so as part of the PPS implementation plan.

High rates of primary care-treatable ED use and PQI hospitalizations suggest the concurrent need for better access to more appropriate and effective primary care. To reduce avoidable hospitalizations and readmissions and reach DSRIP milestones, Brooklyn requires primary care investment to ensure patients are accessing the most appropriate care in the community. Admissions and readmission rates also indicate the need for improved patient navigation and care management services including appointment scheduling, care transition management, treatment plan support and medication adherence support.

Behavioral health services are a critical component of delivery system redesign. Community members have raised concerns about the adequacy of the capacity of behavioral health resources. CNA respondents perceive access to mental health services as limited and indicate that many individuals may not know how to access appropriate services. Respondents further reported that many families try to address behavioral problems internally and do not seek the most appropriate health care. Providers also report a fragmented system with poor integration with primary care services and poor coordination between mental health and substance abuse services.

*Gaps 2:

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

The CNA found the distribution of primary care providers to be uneven in Brooklyn, with fewer providers in neighborhoods with the highest number of low-income people and the greatest health care needs. While community providers have endeavored over the years to improve outreach efforts, community concerns regarding the adequacy and accessibility of outpatient care persist.

From respondents' perspective, the time and cost incurred in seeking medical care create barriers to effective use of prevention and disease management services. Community members and providers consistently describe long wait times to schedule visits and long waits during the course of a visit. The possible need for multiple visits (such as for diagnostic testing) discourages timely use of community-based primary care services and makes EDs a rational choice for low-cost, "one stop shopping."

While there are a number of community-based organizations in Brooklyn that provide assistance with health care access issues, the data suggests more resources are needed to equip them with staff and training to support demand, including a structured and adequate funding stream for care managers, health navigators, counselors, and community health workers.

Community members and providers recognize the impact of poverty and a lack of community resources on health and well-being. Low-income Brooklyn residents describe very stressful lives with concerns that include, but are not limited to, employment, housing, safety, access to healthy food, and appropriate resources for children and teens. Immigrant communities report workdays of 16 hours or more and the pressures of assimilation persistent. Across populations, community members attribute high rates of diabetes, hypertension, obesity, depression, and other illnesses to their daily stresses. They hope for community programming and other resources to assist with basic needs.

*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.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

The PPS is committed to transforming healthcare delivery and envisions an integrated delivery system comprised of an organized, collaborative network of primary, specialty, behavioral, post-acute, and long-term care as well as community-based providers to address the substantial community needs identified in the CNA. The PPS will be clinically and fiscally accountable for the health outcomes and status of the entire population and will equip providers with systems that support population health management and communication across organizations. The PPS population health strategy will focus on engaging patients through improved navigation services and identifying risk to support the highest need patients in the population.

The cornerstone of the PPS is ambulatory care delivered by FQHCs, DTCs, and community-based physicians. These providers bring a wealth of cultural and clinical community knowledge, and many have strong existing relationships with community-based organizations that provide needed supportive services. The capabilities and reach of these partners will be elevated with the resources of the academic partner, NYULMC, which brings experience in meaningful health information exchange, centralized care coordination, and managing patients under risk arrangements - resources that will be tailored to serve the Medicaid population. This marriage of community-centered care and academic medicine will join the fragmented pieces of the Brooklyn safety net to create a comprehensive, integrated delivery system.

The PPS will invest in projects (ED Care Triage and Observation Unit) that reduce costly utilization while reconnecting patients to more appropriate and effective settings for care. A centralized Patient Navigation Center will provide support for care transitions, engagement and retention in primary care, and linkage to supportive services. Disease management projects will address some of the primary drivers (diabetes and asthma) of preventable admissions. The integration of behavioral health screening and services into a robust primary care network will increase capacity and access to critically needed behavioral health services, and population-wide HIV and tobacco use cessation programs will tackle root causes of poor health outcomes.

Section 3.7 - Stakeholder & Community Engagement:

Description:

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

*Community 1:

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

In developing the Brooklyn CNA, NYAM undertook a detailed stakeholder and community engagement process to identify residents' perceptions of: the impact of community and environmental conditions on health promotion and disease prevention; primary health concerns and health needs; available health-related programming and services and service gaps; access, health-related programming and services; and opportunities for improving health promotion and health care needs. This process included collecting key informant interviews, focus groups and resident surveys.

In addition to the 24 focus groups described below, NYAM conducted 28 key informant interviews with 35 individuals. Brooklyn PPSs selected the key informants, whose expertise included population-specific knowledge of particular immigrant groups, older adults, children and adolescents as well as issue-specific knowledge of substance abuse, supportive housing, care coordination, criminal justice, and homelessness. Interviews, which lasted from 45 to 120+ minutes, asked informants about their 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 to benefit the local population.

NYAM also surveyed Brooklyn residents ages 18 and older, who were recruited by local organizations, including community-based organizations, senior centers, and social service and health providers, and through street outreach to engage a diverse and representative sample of community members. The 681 surveys were completed by residents throughout Brooklyn with varying socio-demographic characteristics, including 44.3% Black/African American, 31.8% Latino, 13.7% Asian, 53.7% foreign born, 26.3% limited English proficiency, 82.4% living below the FPL, 53.4% enrolled in Medicaid and 13.0% uninsured. To ensure cultural competency, surveys were translated into 10 languages: Arabic, Bangla, Chinese (simplified and traditional), Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish.

Brooklyn Bridges also led the planning for a borough-wide Stakeholder Meeting that was held on December 12, 2014 with over 115



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

community members, community-based organizations and other interested stakeholders in attendance.

***Community 2:**

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

As part of the stakeholder engagement strategy, NYAM conducted 24 semi-structured focus groups, each lasting approximately 90 minutes, to inform CNA development. The majority of focus groups comprised community members, including residents from low-income neighborhoods and residents with unique health and service needs, including individuals with behavioral health issues, older adults, LGBTQ people, immigrants and individuals with limited English proficiency. Local organizations, community-based organizations, senior centers, social service providers, tenant associations, and health providers assisted with recruiting focus group participants. Community interest in focus groups was high, with some groups including as many as 30 individuals.

In addition to resident-driven focus groups, NYAM conducted a number of focus groups with community leaders and providers, including behavioral health providers, care coordinators, and physicians. The Brooklyn PPSs assisted with recruiting these participants to ensure inclusion of key stakeholders.

Focus groups were conducted using a semi-structured guide with questions that included perceptions of access to health and community resources.

***Community 3:**

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

The predominant theme that emerged from the Brooklyn stakeholder and community engagement process was "disparity," with residents pointing to differences among neighborhoods in distribution of resources and opportunities for improvement. Stakeholders highlight barriers to health and health care, including: long work hours, unstable housing, unsafe neighborhoods, and the need to ration scarce financial resources to meet priority needs including healthcare, housing, childcare and food. These barriers are compounded for some sub-populations, including people with disabilities, LGBTQ, homeless, and the criminal justice involved.

Brooklyn community members and stakeholders expressed interest in partnering with health care providers and hospitals to promote good health and reduce hospitalizations. To this end, residents identified solutions help improve health outcomes, including: increased ease of access for medical visits; improved provider sensitivity; expand availability of supportive services to help manage medical conditions and care for high-risk populations; and offer health education focused on disease prevention and management, insurance, and mental health issues.

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.

[Lutheran Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	AHRC	Dedicated to enhancing the lives of individuals with intellectual and developmental disabilities and their families	Individuals with developmental disabilities have complex needs and it is critical to ensure that their health and social needs are met to reduce preventable admissions.
2	Arab American Family Support Center	Provides social services to help Arab-American immigrants better integrate into their communities through the provision of culturally, linguistically, and religiously sensitive social services	Arab residents are concentrated in key communities, such as Sunset Park and Borough Park, that are served by the PPS. The PPS will work with community groups to provide effective and culturally competent care to address the primary identified health needs of



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			these residents, such as diabetes, mental illness, and smoking.
3	Arthur Ashe Institute for Urban Health	Provides after-school programming, outreach initiatives, research, and advocacy to help address health conditions that affect minorities	There are significant health disparities across Brooklyn and it is important that the PPS works with community-based organizations to ensure the health needs of all groups are equally addressed.
4	Brooklyn District Public Health Office	Work to promote health equity and reduce health disparities by informing public policy, conducting research, and implementing community-based programs	The NYC DOHMH and its affiliated entities are an important asset for the PPS for the breadth of knowledge, data, and resources they offer.
5	Brooklyn Perinatal Network (BPN)	Enable at-risk residents to access resources needed to maintain health, reduce infant death, and improve maternal and child health status	BPN's longstanding history of serving low-income families and children can help improve health care provided to families, particularly around perinatal care.
6	Brownsville Multiservice Family Health Center	Provides and promotes integrative and high quality health care and social services to enable every individual and family in the communities we serve to achieve total health and wellness.	In order to form a true integrated delivery system, the PPS will work collaboratively with community providers to address the full spectrum of patient health and social needs.
7	CAMBA	Serving more than 35,000 individuals and families, CAMBA provides economic development, education and youth development, family support services, HIV/AIDS services, housing services, and legal services	CAMBA is deeply rooted in communities served by the PPS and will be a valuable partner in improving the accessibility of health and social services to vulnerable populations.
8	Callen Lorde	Medical facility for the lesbian, gay, bisexual, and transgender community as well as people living with HIV/AIDS	It is the mission of the PPS to provide culturally competent care and work with community resources to understand the unique health needs of the LGBT community.
9	Caribbean Women's Health Association	Provides programming that aims to improve the wellbeing of individuals, strengthen families and empower communities through comprehensive, integrated, culturally appropriate and coordinated "one-stop" service	Caribbean residents in Brooklyn are faced with poverty, prejudice, and other social barriers to health. The PPS is dedicated to reducing these barriers across communities to improve access to care and health status.
10	Center for Independence of the Disabled, New York	Ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to the social, economic, cultural and civic life of the community	The PPS seeks to provide culturally competent and equitable care to all populations, including the disabled.
11	Charles B. Wang Community Health Center	Ensure that all members of our community—regardless of ability to pay—are provided with quality, comprehensive and culturally effective primary healthcare	In order to form a true integrated delivery system, the PPS will work collaboratively with community providers to address the full spectrum of patient health and social needs.
12	Children's Aid Society	Helps children in poverty to succeed and thrive by providing comprehensive supports to children and their families in targeted high-needs New York City neighborhoods	Foster care and preventive care agencies have unique insight on the most vulnerable populations and can help improve care delivery to these populations.
13	Coalition for Asian American Families and Children	Aims to improve the health and well-being of Asian Pacific American children and families in New York City	Nearly 11% of Brooklyn residents are Asian and common health concerns include diabetes and smoking, while



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			cultural and language barriers often prevent residents from accessing appropriate care. The PPS will work with community organizations to ensure the unique needs of these residents are addressed.
14	Commission on the Public Health System	Committed to ensuring that the voices of medically underserved communities, especially their need for safety net health care providers, are heard	The PPS recognizes its influential role in transforming health care to better serve the community during and beyond DSRIP years, and will work with consumer advocacy organizations to analyze the impact of hospital transformation on patients.
15	Comunilife	Provides supported transitional and permanent housing for homeless adults struggling with HIV/AIDS, serious mental and behavioral health issues, and other chronic medical conditions	The homeless population is often disconnected from primary care and frequent users of ED services, representing an opportunity to improve preventable ED visits.
16	Community Service Society	Provides support services, research, and policy analysis that helps lower-income families get back on their feet	Community-based organizations with well-developed networks will help promote open communication between PPS and residents.
17	Corporation for Supportive Housing	Advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities	Poor housing conditions can exacerbate the medical conditions of patients, as well as generate significant stress. The PPS will work with community groups to address the housing needs of residents.
18	Crown Heights Community Mediation Center	Works to make the neighborhood safer and healthier for all through youth development and anti-violence programs	In certain neighborhoods, residents report that violence serves as a barrier to accessing care and engaging in healthy behaviors, such as exercise. The PPS is dedicated to addressing these social determinants of health.
19	Haitian American United for Progress	Helps low-income families and individuals to live healthy and productive lives	Caribbean residents in Brooklyn are faced with poverty, prejudice, and other social barriers to health. The PPS is dedicated to reducing these barriers across communities to improve access to care and health status.
20	Jewish Americans Serving the Aging	Sustain and enrich the lives of the aging in the New York metropolitan area so that they can remain in the community with dignity and autonomy	The PPS will work with community groups to address the needs of elders who often have multiple chronic conditions and complex health needs that may require long-term extended care.
21	Make the Road	Builds the power of Latino and working class communities to achieve dignity and justice through organizing, policy innovation, transformative education, and survival services	Community-based organizations with well-developed networks will help promote open communication between PPS and residents.
22	NADAP	Operates employment, assessment, case management and Health Home care coordination programs in New York City and Nassau County	Unemployment, lack of insurance, and poor care coordination exacerbate physical and behavioral health conditions, and the PPS looks to work with community groups to



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			address these community needs.
23	New York Immigration Coalition	Works to achieve a fairer and more just society that values the contributions of immigrants and extends opportunity to all	Language and culture represent significant barriers to accessing health care and the PPS seeks to address these barriers for immigrants.
24	New York Lawyers for the Public Interest	Advances equality and civil rights, with a focus on health justice, disability rights and environmental justice	The PPS seeks to provide culturally competent and equitable care to all populations.
25	NYC Department of Homeless Services	Prevent homelessness when possible and to provide short-term, emergency shelter for individuals and families who have no other housing options available	The PPS will work with community groups to better address the health and social needs of homeless residents and families.
26	NYCDOH/Rikers Island	Provides for the care, custody, and control of persons accused of crimes or convicted and sentenced to one year or less of jail time	The justice-involved population has unique physical and behavioral health care needs, and enhanced support is needed transition these individuals back into the community.
27	Ridgewood Bushwick Senior Citizens Council	Implement new and effective strategies to improve the community and provide the necessary resources to local residents so they may improve their present living conditions and work toward long-term self-sufficiency	Several PPS projects seek to provide appropriate education and activating interventions to encourage patients to self-manage their own health.
28	Services & Advocacy for GLBT Elders (SAGE)	Dedicated to improving the lives of lesbian, gay, bisexual and transgender (LGBT) older adults	It is the mission of the PPS to provide culturally competent care and work with community resources to understand the unique needs of sub-groups, such as LGBT older adults.

✔ 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.

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need to reduce fragmented, episodic, high-cost health care and transform delivery system	In Brooklyn, high rates of avoidable admissions, readmissions, and ED visits are indicative of the need for better integrated health care across the	Primary Data Collection, Brooklyn CNA, NYAM, October 2014



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>spectrum of providers. The CNA identifies several barriers and gaps that contribute to these high rates, including lack of primary care access, language and cultural barriers, access to and patient engagement in behavioral health care, and gaps in services that address the social determinants of health.</p> <p>By leveraging a strong primary care foundation, and existing population health management assets and investing in technology and system re-design, the PPS will establish central services to facilitate data connectivity, and improve patient engagement, enable effective coordination of care. These investments will support clinical project implementation across all DSRIP domains and advance value-based contracting for the PPS and its partners to transform health care delivery from fragmented, episodic, high-cost care to integrated, community-based, value-driven care.</p>	<p>PQI Data Suite, New York State Department of Health, 2012</p> <p>PPV, NYU Furman Center, 2013</p> <p>Community Resource Maps, GNYHA HITE, 2014</p> <p>Community Demographics, US Census ACS, 5-Year Table, 2008-2012</p>
2	Need to better address patient behavioral health needs through integrated primary care settings	<p>Depression, anxiety, and alcohol/substance abuse are common self-reported health issues, and nearly 1 in 3 residents who utilize behavioral health (BH) services are also hospitalized.</p> <p>Of the almost 220,000 Medicaid beneficiaries in Brooklyn with a behavioral health-related service utilization throughout the calendar year, nearly one in three (31.2%) had an inpatient admission. Coney Island, Williamsburg/Bushwick, Greenpoint, and Borough Park are hot spots for serious mental illness, with 12%, 9.6%, 8.5% and 7.3% of residents, respectively, reporting severe psychological distress. Almost 60% of respondents identified a lack of available substance abuse services and 50% reported a lack of available mental health services. These barriers likely contribute to high prevalence of BH conditions in Brooklyn. The CNA also describes the myriad stresses on lower income residents, resulting in high levels of depression. Depression/anxiety affects 22% of residents. 44% report drug and alcohol use among their top concerns. Untreated BH conditions are linked to poor health outcomes; over 50% of adults using BH services have co-morbid chronic medical disorders and 1 in 10 children with BH service use had pulmonary disorders.</p> <p>The PPS will address these needs by integrating BH services into FQHC, Article 28 DT&Cs and medical practices—mostly in underserved communities—using the PCMH and IMPACT Models, increasing the availability of BH services in the county and reducing care fragmentation.</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>Psychological Distress Rate, NYC DOHMH CHS, 2012</p> <p>Beh. Health-Related Service Utilization & Inpatient Admissions, NYS DOH, 2012</p> <p>Chronic Medical Condition Co-Morbidity of Beh. Health Clients, NYS OMH, PCS, 2013</p> <p>Beh. Health Resources, GNYHA</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
3	Need to reduce preventable ED visits by linking patients primary care	<p>In 2013, 74.5% of all ED visits in Brooklyn were considered potentially preventable, ranging from 64.6%-80.4% among zip codes in the borough. There were over 347,000 PPVs in Brooklyn in 2013.</p> <p>About 25% of CNA survey respondents report that primary care is "not very available or not available at all" and cite reasons for ED utilization including the inability to get a timely appointment with a primary care provider, limited clinic hours or the need for multiple visits. These findings indicate the need for expanded primary care capacity and access, and resources to connect patients to primary care sites, improve patient education and health literacy, and better manage patients who present to the ED with non-emergent conditions. The PPS will meet these needs by investing in primary care expansion and access improvement, and expanding the Lutheran ED Triage unit to identify and manage individuals who present at the ED with non-emergent conditions and connect them to PCMH providers in the community. The PPS Patient Navigation Center will also be a critical resource in culturally competent patient education and PCMH referral resources.</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>PPV, NYU Furman Center, 2013</p> <p>Lutheran Medical Center data, August 2014</p> <p>B-HIP Report, August, 2012</p>
4	Need to reduce preventable inpatient admissions	<p>Brooklyn had approximately 14,000 Medicaid PQI hospitalizations in 2012, with the borough, with a higher age-adjusted PQI rate for Medicaid beneficiaries age 18+ compared to New York State overall. The greatest proportion of potentially preventable admissions in Brooklyn is for chronic conditions including respiratory and cardiovascular conditions, and diabetes.</p> <p>Many of these admissions can be avoided through stabilization and treatment in an Observation Unit setting and with robust care coordination follow-up in the community. These findings support the need for resources devoted to developing a dedicated Observation Unit for stabilization and discharge and Patient Navigation Center for community based care management.</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>PQI Data Suite, New York State Department of Health, 2012</p> <p>Lutheran Medical Center data, August 2014</p> <p>American College of Emergency Physicians, 2011</p>
5	Need for community-based navigation services to help patients access the most-appropriate care	<p>The number of PQI admissions for chronic conditions in Brooklyn is nearly three times that for acute conditions. Throughout Brooklyn, approximately 65-80% of ED visits are estimated to be potentially preventable. Taken together, these figures indicate the need to improve patient access to care in appropriate outpatient settings. In addition, CNA respondents report the need to improve language and cultural competency among partners. Thirty-five percent of the borough's population is foreign-born, with 25% of the population reporting speaking English less than "very well."</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>PQI Data Suite, New York State Department of Health, 2012</p> <p>PPV, NYU Furman Center, 2013</p> <p>Community Resource</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		To address this need, the PPS will develop a Patient Navigation Center that will serve as the PPS hub for care coordination, patient navigation, and health education and coaching services. The Patient Navigation Center will deliver culturally competent and multi-lingual services to ensure effective and efficient access to healthcare services, education and health coaching to improve patient self-management and activation, referral to community-based resources, and management of effective care transitions.	Maps, GNYHA HITE, 2014 Community Demographics, US Census ACS, 5-Year Table, 2008-2012
6	Need for PCMHs to implement a robust, evidence-based disease management approach for diabetes	<p>In Brooklyn, chronic conditions, including diabetes, represent the greatest proportion of preventable hospitalizations. There were 3,072 Medicaid PQI All Diabetes Composite hospitalizations in the borough. Across New York State, only 51% of Medicaid Managed Care beneficiaries with diabetes receive all recommended preventive services and 33% of Medicaid Managed Care beneficiaries with diabetes have poorly controlled HbA1c (>9%).</p> <p>In addition, the PPS serves Brooklyn communities that have high utilization of diabetes services among Medicaid beneficiaries. CNA survey respondents indicate concerns about obesity, diabetes, and lack of healthy eating and physical activity.</p> <p>The needs identified in the CNA suggest that evidence-based strategies implemented through PCMHs can improve population health management and patient self-management to reduce avoidable service use. To address these needs, the PPS will develop a diabetes patient registry, co-locate primary care providers with diabetes specialists, provide staff training on the Stanford Model for Chronic Disease Management, and engage community-based organizations in health education and outreach.</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>Diabetes-Related Service Utilization, DOH, 2012</p> <p>PQI Diabetes (S01, 01,03, 14), DOH, 2012</p> <p>Diabetes Resources, GNYHA HITE, 2014</p> <p>QARR, 2011</p> <p>Lutheran Community Service Plan, 2013</p>
7	Need for evidence-based asthma home-based self-management services	<p>Various environmental and social factors contribute to the prevalence of asthma in communities served by the PPS.</p> <p>There is a high rate of asthma-related service utilization (including pharmacy) in Brooklyn, particularly in Williamsburg/Bushwick, Sunset Park, and Downtown neighborhoods (among others), ranging from 3% to 10%. Brooklyn's asthma ED visit rate in 2012 was higher than for NYC and NYS at 143.9 per 10,000 compared to 139.6 per 10,000 and 88.6 per 10,000, respectively. Among Brooklyn children enrolled in Medicaid, the asthma rate is higher than in NYS, 310.87/100,000 vs. 210.39/100,000, respectively. The asthma ED visit rate of 297.3 per 10,000 for Brooklyn children is also</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>Asthma-Related Service Utilization, DOH, 2012</p> <p>PQI Asthma (S03, 05, 15), DOH, 2012</p> <p>Asthma Resources, GNYHA HITE, 2014</p> <p>Serious Housing Violations Rate, NYU Furman Center, 2013</p>



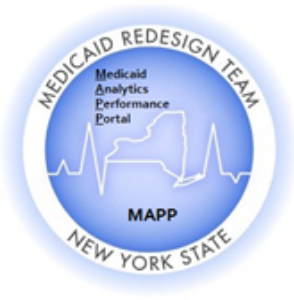
**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>higher than the state rate of 225.1 per 10,000. Environmental and social factors, such as exposure to second-hand smoke and poor housing conditions, contribute to the prevalence of asthma in communities served by the PPS.</p> <p>Implementation of an asthma home-based visiting program and evidence-based clinical guidelines will help patients address these needs and better manage asthma exacerbation factors in their daily lives, reducing avoidable service use and improving health outcomes.</p>	<p>Lutheran Community Service Plan, 2013</p> <p>DOH, 2012</p> <p>Medicaid PQI</p>
8	Need to promote tobacco use cessation through a culturally-competent tobacco cessation campaign	<p>The PPS serves communities that have among the highest smoking rates in NYC. While Brooklyn's smoking rates among adults are on par with the NYC and NYS rates at 16%, 15.5% and 16.2%, respectively, the rates within Brooklyn vary widely by neighborhood. Among Coney Island residents, nearly one-quarter (23%) report being current smokers. High smoking rates also are found in Williamsburg/Bushwick, Greenpoint, Bay Ridge/Bensonhurst, East New York/New Lots and Bedford-Stuyvesant/Crown Heights, where rates range from approximately 16-19%. Smoking contributes to costly chronic conditions such as asthma, respiratory disease, and cancer. It is estimated that cigarette use alone results in 25,000 deaths in NYS annually, and 570,000 New Yorkers are afflicted with serious disease directly attributable to their smoking. Smoking is particularly prevalent among certain sub-populations and often tied to cultural factors, indicating the need for a culturally-competent interventions.</p> <p>The PPS will implement a multi-prong, locally-led, culturally-competent tobacco use cessation campaign to include both primary care-based and community-based interventions. Interventions will focus on standardizing clinician training programs, enhancing EMRs to prompt use of evidenced-based guidelines, and working in partnership with the NYC Department of Health and Mental Hygiene to develop culturally and linguistically appropriate media materials, among others.</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>Cigarette Smoking Rates, NYC DOHMH Community Health Survey, 2011 and 2012</p> <p>Tobacco Use/Cessation, NYC DOHMH Community Health Survey, 2011 and 2012</p> <p>Center for Disease Control, 2009</p> <p>HHS, 2010</p>
9	Need to improve the access to, and retention in, HIV care	<p>In 2012, HIV was ranked the 9th leading cause of death and the 5th leading cause of premature death in Brooklyn. Nearly a quarter of Brooklyn CNA survey respondents identify HIV as a top health concern.</p> <p>Significant geographic and racial/ethnic disparities in HIV prevalence exist across Brooklyn. Certain UHF neighborhoods within Brooklyn have significantly higher HIV prevalence rates than others, and the</p>	<p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p> <p>PLWHA, HIV Rate, Racial/Ethnic Differences, New Diagnoses, DOHMH HIV/AIDS Surveillance Data 2011</p>



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>rate of new HIV diagnoses among Black people/African Americans in Brooklyn is more than 5 times the rate among Whites, representing a greater disparity than observed in NYC or NYS. The rate of new HIV diagnoses among Latinos in Brooklyn is more than 2 times that of Whites. A large proportion of CNA survey respondents (40%) say that additional health education is needed related to HIV.</p> <p>These findings indicate the need for various community-based approaches to improve the accessibility of HIV services and patient engagement in care. The PPS has engaged in joint planning with six other NYC PPSs to collaborate on population based approaches to HIV screening and treatment. This collaborative has identified and will implement common interventions, such as implementing a viral load suppression initiative, engaging primary care partners and community-based organizations to expand HIV screening, ensuring cultural competency in HIV treatment, and improving access to behavioral health services for HIV-positive patients.</p>	<p>HIV-Related Service Utilization, DOH, 2012</p> <p>HIV Resources, GNYHA HITE, 2014</p> <p>Leading Causes of Death & Premature Death, NYC Vital Stats., 2014</p>
10	Need to improve access to culturally and linguistically appropriate care	<p>The CNA identifies additional barriers to care, particularly for immigrant populations, including linguistic challenges, eligibility for insurance, and familiarity with the US healthcare system. The CNA also found a lack of culturally and linguistically competent specialists and multi-specialty centers, particularly for behavioral and mental health.</p> <p>Language barriers also limit access to health information. The CNA found that 25% of residents speak English less than "very well," nearly half speak another language at home—primarily Spanish or Chinese. Among the challenges identified are: inability of partners, staff, and others to communicate in patients' native languages and concerns about quality and access among certain bilingual partners and interpretation services.</p> <p>The CNA also identifies certain neighborhoods with concentrations of minority groups in which smoking is of high concern and asthma, lung cancer, and other respiratory disease are more common.</p> <p>This need will be addressed under all of the PPS's projects through health literacy activities, the Patient Navigation Center, and its existing and evolving partnerships with community based organizations that serve populations who are most affected by these barriers to access and care.</p>	Primary Data Collection, Brooklyn CNA, NYAM, October 2014
11	Need to connect patients to resources addressing the social determinants of	The CNA confirms what residents, healthcare providers, and those who work in community based	US Census, American Community Survey, 5



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

[Lutheran Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	health	<p>organizations already know about the Brooklyn – poor health conditions often result from social determinants of health, including conditions of poverty. A higher proportion of Brooklyn households (22%) live below the federal poverty level than in NYC (19%) or NYS (14%) as a whole, with rates as high as 34% in some neighborhoods. Nearly 50% of the borough's population is covered by Medicaid (with rates as high as 84.9% in some ZIP Codes), representing 21.2% of the state's Medicaid population. While Brooklyn is fortunate to have a deep base of community resources, only 60% of CNA respondents find social services to be readily available, indicating that there is need for partners to increase efforts to connect patients to needed services.</p> <p>The PPS Patient Navigation Center will be a critical tool in fulfilling this community need, providing telephonic, in-person, and technology enabled services to connect the community to health and social services that can address the myriad and often complex issues that impact their health and well-being.</p>	<p>year data, 2008-2012</p> <p>DOH, 2012</p> <p>Primary Data Collection, Brooklyn CNA, NYAM, October 2014</p>

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
32_SEC038_Detailed Tables_Health Care Resources.XLSX	12/19/2014 04:42:20 PM	
32_SEC038_Primary Data Tables_Brooklyn_9-29-14.XLSX	12/19/2014 12:44:35 PM	
32_SEC038_Primary Data Analysis Tables 1.9.15.14.XLSX	12/19/2014 12:42:45 PM	
32_SEC038_Detailed Tables_Population and Health Status.XLSX	12/19/2014 12:41:46 PM	
32_SEC038_Detailed Tables_Population and Health Status 2.XLSX	12/19/2014 12:34:01 PM	
32_SEC038_Detailed Tables_Community Based Resources.XLSX	12/19/2014 12:30:17 PM	
32_SEC038_Appendix A - Maps of Brooklyn FINAL_part_11.pdf	12/19/2014 12:26:03 PM	
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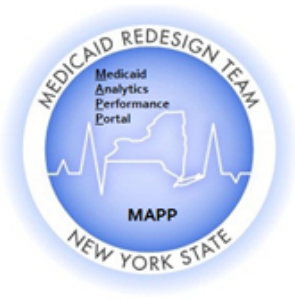


**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

File Name	Upload Date	Description
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32_SEC038_8_Organizations Collaborating on Brooklyn CNA.pdf	12/19/2014 11:23:29 AM	
32_SEC038_7_Brooklyn Key Informant List.pdf	12/19/2014 11:22:47 AM	
32_SEC038_6_Codebook.pdf	12/19/2014 11:21:56 AM	
32_SEC038_5_CNA focus group guide_final_072114.pdf	12/19/2014 11:21:01 AM	
32_SEC038_4_CNA focus group brief survey_final_072114.pdf	12/19/2014 11:20:02 AM	
32_SEC038_3_CNA KI interview guide_final_072114.pdf	12/19/2014 11:18:19 AM	
32_SEC038_2_CNA KI brief survey_final_072114.pdf	12/19/2014 11:17:24 AM	
32_SEC038_1_CNA Survey_final_72214.pdf	12/19/2014 11:15:40 AM	
32_SEC038_0_CNA Primary Data Collection documents described.pdf	12/19/2014 11:14:43 AM	
32_SEC038_Appendix B Tables Charts and Graphs_V3.1.pdf	12/19/2014 11:12:07 AM	
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New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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: **Lutheran Med_Section4_Text_Brooklyn Bridges PPS_Clinical Project Plan Narrative_FINAL.docx**

Description of File

File Uploaded By: cc330208

File Uploaded On: 12/22/2014 09:50 AM

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

Currently Uploaded File: **Lutheran Med_Section4_ScopeAndScale_Brooklyn Bridges PPS_Speed and Scale Template_FINAL.xlsx**

Description of File

File Uploaded By: cc330208

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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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.

Impact to Existing Workers:

System transformation will require concomitant changes to the health care workforce, including redeployment and retraining of existing staff, hiring of new staff, and displacement. To respond to these anticipated changes, the PPS will develop a comprehensive workforce strategy, the central principles of which will be to: 1) minimize workforce reduction; 2) prioritize voluntary redeployment to fill new/vacant positions; 3) promote retraining opportunities; and 4) promote "in place" training for current employees who will take on new functions.

DSRIP program initiatives will generate changes to the current workforce across PPS partners as the PPS builds up ambulatory care and



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

Page 51 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

care management services and reduces care in acute settings. While these changes will cause some displacement of existing providers and staff, they also will create new job functions for existing staff, and new clinical and administrative positions. The PPS plans to meet these needs through a combination of redeployment, retraining, and new hiring. These initiatives include:

- * Reduction in Long-term Care Beds. As patients receive more appropriate long-term care services at home or in ambulatory settings, the PPS anticipates a reduction of at least 40 skilled nursing facility beds at Lutheran Augustana Center for Extended Care and Rehabilitation.
- * ED Triage and ED Observation Unit (OU) Implementation. The PPS will implement an ED Care Triage initiative and build a new OU at Lutheran. These projects are expected to generate new functions for existing staff and new jobs.
- * Community-based Ambulatory Care Investment. The PPS will help fund partner sites to support the implementation of clinical interventions related to asthma, diabetes, HIV, and tobacco cessation. These interventions will generate new jobs and new job functions for existing staff.
- * New Central Services, Care Management and Patient Navigation. The PPS will develop central service resources, requiring staff to support operations. Increased care management, navigation and health education services for high-need patients also will support the PPS's PHM strategy. This new central services infrastructure will require a range of staff, including administrative support, community health workers, and clinical staff. The PPS intends to fill these positions through a combination of redeployment, retraining, and hiring.

PPS Understanding of Workforce Impact:

Drivers of change to the existing workforce include PPS clinical project implementation and central services development. The PPS aims to minimize overall staff reductions and anticipates that reductions will be largely absorbed by employee attrition. The PPS proactively will take concrete steps to redeploy the balance of displaced employees to new positions within their existing organizations or in another PPS organization. The following positions will be impacted either positively (requiring additional staff) or negatively:

- * MD, DO, and primary care physicians
- * Community health workers
- * Population health management experts
- * Human resources professionals
- * Care managers
- * Social workers
- * Allied health professionals
- * Nutritionists
- * Registration clerks
- * Paramedics and emergency technicians
- * Translators/foreign language speakers
- * Registered Nurses
- * Nursing assistants
- * Physician assistants, nurse practitioners and family nurses
- * Ambulatory care practice managers
- * Mental health specialists (i.e., psychologists and psychiatrists)
- * Process redesign experts
- * Data analysts and statisticians

The PPS also will measure DSRIP implications to unionized workers, including members of 1199SEIU, New York State Nurses Association, and United Federation of Teachers. The PPS has a dedicated union representative on its Executive Committee to ensure the PPS adequately addresses unions' potential concerns.

*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.

Workforce Gap Analysis:

To support development of a comprehensive workforce strategy, the PPS Executive Committee will oversee a robust workforce gap analysis during implementation planning. During initial project planning, the PPS conducted a workforce survey to assess existing provider and staff capacity. The PPS will build on this preliminary assessment through a series of follow-up surveys and discussions that will further



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

identify partners' current and anticipated staffing needs related to DSRIP implementation. This information will be analyzed to determine expected displacements, new staffing requirements, and new job functions and skill needs.

Minimizing Negative Impact:

- * Voluntary Redeployment: The PPS will ensure voluntary redeployment for displaced workers to allow individuals to perform the same/similar job functions at a different organization, to the greatest extent possible.
- * Retraining: The PPS will provide training for existing employees who require additional skills to meet the requirements of new positions or new functions in their current positions and prepare them for the future of healthcare delivery. This training will enhance employees' skills to facilitate the seamless transitions to new employment or new job functions. When appropriate, the PPS also will provide formal certification or licensing training.
- * Recruitment: When appropriate, the PPS will recruit new employees to meet the demand for new staffing or skills that cannot be met through redeployment or retraining efforts, e.g., adolescent mental health providers.

Workforce Shortages:

The CNA identified a number of workforce shortages that the PPS will address to ensure success with the DSRIP projects. Specifically, outpatient primary care sites are unevenly distributed in Brooklyn, and the borough lacks culturally and linguistically competent primary care providers and specialists. Only 55% of CNA survey respondents reported that they could access non-emergency health care services at a primary care doctor's office and one-quarter report that primary care medicine was "not very available" or "not available at all." The federal Health Resources and Services Administration validates this perception in its designation of nine Brooklyn communities as federally-designated primary care health professional shortage areas: Bedford Stuyvesant, Bushwick, Coney Island/Gravesend, Crown Heights, East New York, Midwood, Redhook, Sunset Park, and Williamsburg. Lutheran, the PPS's fiduciary, is located in Sunset Park.

The CNA also highlights shortages in behavioral health capacity in Brooklyn, with less than half of CNA survey respondents characterizing mental health services as "available" or "very available." Residents report a severe shortage of pediatric and adolescent mental health professionals. Poor distribution of alcohol and drug use treatment programs throughout Brooklyn also reflects workforce shortages in the community that impede access to these highly needed services. Nearly two-thirds of CNA survey respondents identified substance abuse services as being "not very available" or "not available at all."

Through its clinical projects, the PPS will invest in interventions and resources that expand primary care and behavioral health capacity and access in Brooklyn, requiring additional staff. Additionally, the widespread adoption of PCMH Level 3 certification, in conjunction with expanded hours of primary care operations, will improve primary care access through expanded capacity, also requiring expanded staffing.

***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	1.5%
Retrain	20%
New Hire	5%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

Note: If the applicant enters 0% for Retrain ('Workforce Implication' Column of 'Percentage of Employees Impacted' table in Section 5.1), this section is not mandatory. The applicant can continue without filling the required fields in this section.

Description:

Please outline the expected retraining to the workforce.



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

Page 53 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

*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.

The PPS intends to work with the 1199SEIU Training and Employment Funds (TEF) as its primary workforce strategy development and training vendor. The TEF is the largest joint labor-management workforce planning organization in the United States and has a proven history of providing quality workforce training and education to meet the changing demands of the health care industry. The TEF has a broad range of on-going education programs and a vast network of educational partners, ensuring capacity and experience in customizing curricula to serve the emerging PPS's workforce, including all allied health job titles and physicians for new models of care (e.g., ACOs and PCMH). Working closely with the PPS, TEF will screen and contract with suitable educational vendors to deliver high-quality training, conducted by expert clinical staff, experienced educators in adult learning theory, and organizational development experts. Notably, TEF uses services provided by the City University of New York whenever possible to deliver training programs that offer college credit or certificate programs.

As part of the workforce gap analysis, the PPS will assess the number of staff who will require retraining to acquire new skills, certifications or licensing. The PPS will work with TEF and its partner labor representatives to determine the process and approach to implement the training, including identifying appropriate training modalities, which may include:

- * On-the-job training: one-on-one or small group targeted training;
- * Instructor-led training: larger scale trainings where an instructor guides participants through classroom based activities;
- * Virtual instructor-led training: when logistical challenges impede on-the-job or instructor-led trainings; and
- * Web-based training: for large numbers of users on one to two hours of training material.

Retraining will be mandatory for individuals transitioning to new employment that demands new skills or existing jobs that require performance of redesigned functions in order to ensure they have the necessary skills to be successful. Training will be voluntary for individuals who can demonstrate they have the necessary skills and experience that meet the job description. Employees who are redeployed to same or similar jobs in new organizations will be unlikely to require significant technical training. However, any change in employment may require some level of transitional training to ensure successful redeployment. As noted in more detail below, the PPS will work with its workforce strategy contractor and labor representatives to develop protocols related to voluntary and mandatory retraining.

*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.

To meet DSRIP goals, the PPS anticipates a workforce redistribution from acute care to ambulatory care settings. The PPS will endeavor to manage this redistribution and mitigate disruption through the development of a retraining approach that ensures the right workforce is ready to support the new demands of the PPS. The PPS retraining approach will be developed in close collaboration with TEF, PPS partners' human resources staff, labor representatives, and frontline employees to ensure buy-in of key constituencies. The retraining approach will take into account job location, compensation, benefits, job functions, and necessary training. The PPS will make its best effort to ensure existing wages and benefits are maintained when employees are matched with like jobs. The PPS also will ensure retraining opportunities are incorporated into existing employees' career tracks to ensure that all employees have a clear understanding of promotion potential and career trajectory. The Workforce Rapid Response System described in Section 5.7 will be essential in managing employee communication and timely response to redeployment and training needs.

*Retraining 3:

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

The PPS will work with labor representatives and its partners to ensure redeployment matches are appropriate and successful for employees and partner organizations. The PPS will develop policies and procedures, in consultation with labor representatives, related to employees who refuse their redeployment assignment. The policies and protocols include a "step 2" redeployment in which employees who refuse initial redeployment assignments will be offered at least one additional alternative redeployment assignment. The PPS will work with its partners and labor representatives to determine the number of allowed redeployment refusals, and the time period in which an individual must accept a new redeployment position.

*Retraining 4:



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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

Labor representatives including 1199SEIU, both inter and intra entity, will play an active role in the development and execution of the PPS retraining plan. The Executive Committee will work with the named PPS union representatives to develop and modify the retraining plan. To ensure that the retraining plan is implemented successfully, the PPS will work closely with TEF and labor representatives as on-going advisors and active partners on all aspects of workforce training, including the development of the comprehensive workforce gap analysis, identification of retraining and redeployment training needs, and facilitation of these trainings to ensure successful workforce transitions. The PPS will ensure the collective bargaining units representing unions from the various partners will have a voice in workforce plans, including the retraining plan.

*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	55%
Partial Placement	12%

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 PPS will develop a redeployment plan and process to ensure that employees targeted for redeployment are identified early and transitioned to the most appropriate job setting.

Redeployment Assessment. To support development of its redeployment plan, the PPS will conduct a redeployment assessment, either independently or in collaboration with its workforce strategy contractor. The redeployment assessment will be designed to identify changes that are expected as a result of DSRIP project implementation, including: 1) PPS organizations that are expected to reduce or add staff; 2) expected staffing changes by position, including both displacements and vacancies; 3) opportunities to redeploy individuals to different entities in a same or similar position; and 4) anticipated training and recertification licensing requirements to redeploy workers. Assessment of redeployment assignments will take into account factors to ensure the right job fit for each employee and partner organization, including geography, job functions, required skills, required experience, and salary, among others.

Redeployment Protocols. The PPS will work closely with TEF, its partners, and labor representatives to develop consistent redeployment protocols within partner organizations and across the PPS. These protocols will include assessment of the individual's skills and ability to be retrained, vacancies, and conformity with procedures and policy as set forth in the applicable collective bargaining unit.

*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.

The PPS will work to ensure seamless redeployment transitions, including keeping employees whole, to the extent possible, in terms of wages and benefits. Additionally, the PPS will make its best effort to ensure existing wages and benefits are maintained when employees are matched with like jobs. The PPS will work with TEF, labor representatives, and partners' human resource staff to determine the impact of redeployment plans on existing employees' salary and benefits. With respect to salary and benefit changes, if compensation for a new position is at or above 95% of current compensation level, the PPS will consider whether adjustments to the current salary level are needed. If compensation is less than 95% of current salary level, the PPS will determine the appropriate salary band, and/or perform benchmarks to determine an appropriate salary for the position. Employees targeted for redeployment will receive detailed information regarding the new position which they are being offered, including information regarding how the new position compares to their current position in terms of location, job functions, skill sets, salary, benefits and initial and ongoing training requirements



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

***Redeployment 3:**

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

The PPS will work with labor representatives and its partners to ensure redeployment matches are appropriate and successful for employees and partner organizations. The PPS will develop policies and procedures, in consultation with labor representatives, related to employees who refuse their redeployment assignment. The policies and protocols include a "step 2" redeployment in which employees who refuse initial redeployment assignments will be offered at least one additional alternative redeployment assignment. The PPS will work with its partners and labor representatives to determine the number of allowed redeployment refusals, and the time period in which an individual must accept a new redeployment position.

***Redeployment 4:**

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

The PPS will work closely with labor representatives including 1199SEIU, both within partner organizations and across the PPS, to design the redeployment policies and protocols that best meet the needs of the PPS's diverse partners. 1199SEIU is a member of the PAC and sits on the Executive Committee which will oversee and approve the workforce strategy and redeployment plan.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

Please outline expected additions to the workforce. Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

***New Hires:**

Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

The following summarizes the PPS's anticipated workforce needs related to clinical project implementation:

- * ED Care Triage: physicians, nurses, nurse practitioners, ED care managers, embedded PCMH care navigators, ED intake and triage staff, community health workers (CHWs), program director and administrative staff, among others;
- * Observation Unit (OU): physicians, nurses, nurse practitioners, OU intake and triage staff; unit care managers, CHWs, unit director and administrative staff, among others;
- * Patient Navigation Center: care managers, CHWs, program director and administrative staff, among others;
- * Integration of Primary Care and Behavioral Health Services: behavioral health providers (counselors, therapists, psychiatrists, peer counselors) and CHWs, among others;
- * Deployment of Diabetes Evidence-Based Practices: care managers, specialists (ophthalmology, podiatry, nephrology), certified diabetic educators, nutritionists, nurses, nurse practitioners, behavioral health clinicians, and CHWs, among others;
- * Deployment of Asthma Home-Based Self-Management: care managers, nurses, nurse practitioners, and CHWs, among others;
- * Tobacco Cessation: CHWs, among others;
- * Access and Retention in HIV care: Health educators and CHWs, among others.

The PPS will build on and expand this preliminary assessment through a series of follow-up partner surveys and discussions that will help develop a clearer picture of partners' current and anticipated staffing needs related to DSRIP implementation. As such, the anticipated new jobs outlined in the new hires chart are preliminary estimates and will be subject to change during the implementation phase when the PPS conducts a detailed analysis. This analysis will include the expected impact of the DSRIP program in terms of employee displacements, new staffing requirements, and new job function and skill needs.

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	30
Physician	15
Mental Health Providers Case Managers	35
IT Staff	35



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

Position	Approximate Number of New Hires
Nurse Practitioners	35
Other	53

✔ 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	345,000	576,000	691,200	460,800	230,400	2,303,400
Redeployment	113,589	153,000	183,600	122,400	61,200	633,789
Recruiting	16,200	27,000	32,400	21,600	10,800	108,000
Other	86,400	144,000	172,800	115,200	57,600	576,000

✔ 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 will endeavor to identify and apply for existing state program funding to leverage available workforce development resources. As part of its implementation planning, the PPS will conduct a comprehensive assessment of existing state programs including Doctors across New York, Physician Loan Repayment, Physician Practice Support, Ambulatory Care Training, Diversity in Medicine, Support of Area Health Education Centers, Primary Care Service Corp, and Health Workforce Retraining Initiative, among others.

The PPS will identify opportunities where these state programs can support the workforce strategy implementation to supplement DSRIP workforce funding, and develop a strategy to apply for and assist partners in applying for these programs. As new funding opportunities become available, the PPS also will provide technical assistance to its partners to support them in the application and implementation process.

✔ 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.

Partners were invited to PAC and partner planning meetings where updates were given and feedback was provided on PPS planning efforts, clinical projects, funding flow methodology, implementation governance structure and workforce strategy. The PAC members represent workers from a diverse group of the Brooklyn health care workforce including primary care physicians, FQHCs, D&TCs, long term care facilities, home health care agencies, labor organizations, and social service agencies, among others. In addition to these PAC and partner meetings, the PPS regularly releases updates through its partner email listserv. The PPS also held a borough-wide stakeholder meeting on December 12, 2014 to provide an update on DSRIP planning efforts and to educate and engage stakeholders on expected changes to the healthcare workforce. Finally, the PPS conducted a survey of partners during its project plan application development on existing workforce and workforce needs related to DSRIP implementation.

***Engagement 2:**

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



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

Page 57 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

The PPS identified 1199SEIU as an important strategic partner in all aspects of DSRIP planning, specifically in the development of its workforce planning and implementation strategy. 1199SEIU was a member of the PPS's PAC and sat on the Executive Committee during the planning phase. 1199SEIU will continue to have a seat on the Executive Committee and Clinical Sub-Committee during PPS implementation. The Executive Committee will oversee and approve all clinical projects, financing decisions, IT implementation, and workforce policy development during implementation. During the application development process, PPS leadership met with 1199SEIU to discuss opportunities to collaborate in the planning and development of the PPS workforce strategy, including training and redeployment activities. As a result of these consultations, TEF was identified as a primary workforce vendor for the PPS. The PPS also will work closely with the New York State Nurses Association and the United Federation of Teachers.

*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 began frontline worker engagement through an existing Labor Management Partnership meeting at Lutheran as well as multiple discussions with 1199SEIU. The PPS will continue to work with 1199SEIU as an essential partner in workforce gap assessment, training plan development, redeployment needs assessment, and hiring protocols. The PPS will work with its partners to engage their workers through a Workforce Advisory Group (WAG). The WAG will consist of up to 15 representatives of partner organizations, reflecting appointments by PAC representatives to ensure inclusivity of diverse partner organizations. The WAG will meet periodically to inform and advise the PPS on workforce strategy development and implementation. The PPS will leverage existing and new communication channels to outreach to the community, including frontline workers, regarding the transformative changes as a result of DSRIP. Our partner communication will be deployed through a new PPS website, webinars and stakeholder meetings, email listserv updates, and a social media strategy, to engage frontline workers in a transparent and open dialogue regarding employment changes and opportunities as a result of DSRIP.

*Engagement 4:

Describe the steps the PPS plans to implement to continue stakeholder and worker engagement and any strategies the PPS will implement to overcome the structural barriers that the PPS anticipates encountering.

The PPS communication strategy and WAG, described above, will be essential to ongoing stakeholder and worker engagement. To overcome structural barriers to stakeholder and worker engagement and to ensure effective communication and responsive action to managing DSRIP workforce impact in the coming years, the PPS will develop a Workforce Rapid Response System that includes the following activities:

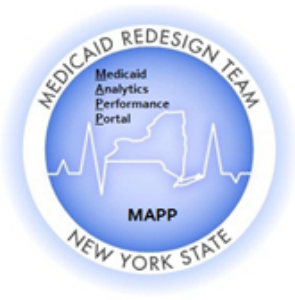
- * A comprehensive plan to assist workers in identifying redeployment and retraining opportunities;
- * Close collaboration with labor unions to assist the PPS in providing or facilitating career counseling, job search assistance, employment workshops, and transitional support;
- * Policies and procedures that support rapid response assistance to connect workers to training, redeployment, and other supportive resources; and
- * A communications strategy across PPS partners and labor organizations to ensure widespread knowledge of PPS workforce strategy, programs and opportunities.

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



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

Page 58 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

Independent Assessor.



Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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.

To achieve the goals of improving the quality of health care for patients and populations while reducing health care costs, the PPS partners must be equipped to share clinical information and communicate securely about shared patients. The PPS will foster clinical collaboration and data sharing to the greatest extent possible while carefully adhering to federal and State laws that protect health information and privacy. The IT Sub-Committee will oversee data sharing compliance.

The PPS's experience with data sharing in the RHIO and Health Home will guide its approach. Lutheran and NYULMC have both played significant roles in the Healthix RHIO for several years, including serving on the Healthix Board. NYULMC has experience operationalizing its own HIE with partnering community providers, skilled nursing facilities, and home health agencies. This experience will be invaluable for developing a strategy to protect patient information while promoting information exchange.

***Confidentiality 2:**

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

As a condition of joining the PPS, each partner will sign a data sharing agreement that requires adherence to federal and State privacy requirements, including that: 1) data only be used for permitted uses under HIPAA; 2) PPS attributed patients have consented to the disclosure of their information; 3) information related to certain diagnoses including alcohol/drug abuse and HIV is only exchanged in accordance with 42 CFR Part 2; and, d) data storage complies with HIPAA security standards.

Acting through its IT Sub-Committee, the PPS will establish a formal program for data sharing compliance. The PPS will provide privacy-law trainings, monitor partner compliance, and require corrective actions when necessary. The PPS will implement an IT system that allows for dynamic tracking of patient consent to ensure privacy law compliance. The IT Sub-Committee will ensure data sharing compliance through the use of partner surveys and audits.

***Confidentiality 3:**

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

NYS Confidentiality – High



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

Page 60 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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

The PPS will make the Healthix RHIO the central platform for sharing patient information. Partners that already utilize EMR systems will be required to connect to the RHIO to facilitate timely information exchange during the early stages of DSRIP. Partners that do not have EMRs will be given access to RHIO data through a portal—in accordance with federal and State privacy laws. In addition, the PPS will work with Medicaid managed care (MMC) plans to obtain claims and care management data to supplement clinical data. The PPS will also provide trainings to participants on how to use the RHIO and how to use both clinical and claims data to improve patient care, as necessary.

Although the Patient Navigation Center (PNC) will rely on the ability to access complete and timely utilization and clinical data, the PNC will also be a valuable source of additional information from patients about their health status, social risk factors, and service utilization. Community health workers, working centrally through telephonic outreach and on-the-ground in the community, will collect and share important patient information. This information will be collected in the EMR and available to partners through HIE.

Section 6.2 – Rapid-Cycle Evaluation:

Description:

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

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

***RCE 1:**

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

The PPS will include a robust and integrated rapid cycle evaluation (RCE) unit, led by NYU's Center for Health Innovation and Delivery Science and supported by the PPS's IT Sub-Committee, that will capture data consistently and timely, rigorously evaluate project redesign work, make results available to implementers, providers and other partners, and make recommendations to iterate interventions regularly to ensure continuous quality improvement.

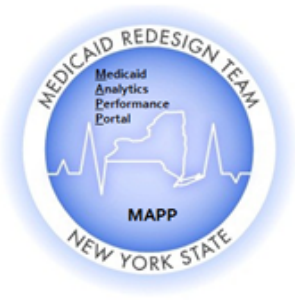
The PPS's will form a Quality Council, which will be part of the PPS's governance structure. On a monthly basis, the Quality Council will meet to address critical components of the RCE plan and communicate recommendations and progress against performance metric objectives to the PPS Clinical Sub-Committee and PPS partners. The Clinical Sub-Committee will review the Quality Council's recommendations and act to accept, reject, or further analyze each. The Quality Council will implement recommendations by disseminating new or revised protocols, changing operational procedures or workflows, changing systems' rules or workflows, contacting non-performing PPS partners, or by other means.

***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.

In accordance with standard RCE principles, the evaluation unit will employ a variety of data collection methods, including interviews or focus groups with partners and patients, surveys, direct observation, and review of clinical and claims data, to evaluate the performance of PPS partners. Additionally, the unit will conduct evaluation in concert with intervention work, rather than at the conclusion of work, to continuously update and refine interventions. The unit will analyze and categorize qualitative data into themes to provide useful feedback for improvement and summarize quantitative data using quality improvement analytic strategies to identify and analyze changes over time. The unit will review data for population-level trends that may suggest additional protocols, projects, interventions, or other approaches to improving the health of attributed and targeted populations served by the PPS.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

***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).

In order to ensure timely and ongoing feedback, the Quality Council will establish an evaluation schedule for each project. Feedback using administrative claims data or extractable clinical data will be automated and conducted monthly (i.e., for readmission rates or patient satisfaction surveys), quarterly (i.e., for diabetes screening or cardiovascular monitoring), or annually (i.e., for percent of PCPs meeting PCMH certification or year-long adherence to antipsychotic medications). More labor-intensive evaluation work will be conducted ad hoc at key intervention moments in consultation with each project team – for instance, 1-2 months after implementation of a new workflow, protocol, or process. The Quality Council will share results in writing with the PPS Executive Committee and Clinical Sub-Committee and with PPS partners through reports posted to a PPS portal. The PPS will provide alerts and will consider the use of a dashboard for reporting updates to partners.

***RCE 4:**

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

The PPS's evaluation plan aligns with the Institute of Medicine's definition of a Continuously Learning Health Care System, which is well-demonstrated to improve the success of local improvement work. A Continuously Learning Health Care System provides real time access to knowledge, makes maximal use of electronic data, engages and empowers patients, is transparent about safety, quality, cost, and outcomes, has leadership committed to a culture of learning, and provides ongoing feedback, team training, skill building, and analysis promoting system improvement. The PPS's Quality Council is central to all of these activities, and will be an important contributor to the development of a highly functioning PPS, one responsive and committed to using data to positively impact the health and well-being of the PPS's attributed and target populations. With each RCE, the PPS will adjust clinical and process standards and expectations to drive improvements in order to achieve project goals.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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.

Brooklyn is a culturally, ethnically, and linguistically diverse borough, with populations including, but not limited to, African American and Caribbean people, Latinos (originating from multiple countries), and Chinese, Russian, Polish, South Asian, and Arab populations. More than 50% of Brooklyn residents are non-White, and approximately 17% of residents are non-citizens, compared to New York City (18%) and New York State (11%). About 35% of Brooklyn residents are foreign-born and more than 22,000 residents report having migrated to the United States less than one year ago. Approximately one in four people in the borough report speaking English "less than very well." Nearly half (46%) speak a language other than English at home. Approximately 17% speak Spanish or Spanish Creole, approximately 7% speak Chinese, and approximately 5% speak Russian. Health care disparities are pronounced for the borough's low-income neighborhoods and for communities of color and immigrant populations as well as LGBTQ people. Each community in Brooklyn has unique needs related to their culture, language, education, economic status, and unique health and social needs.

The CNA's primary data analysis suggests that Brooklyn lacks culturally and linguistically competent primary care providers and specialists to meet the demands of the borough's diverse population. Improving cultural and linguistic competency is essential to the success of the PPS and to ensuring active patient engagement and support self-management of chronic diseases.

***Competency 2:**



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

Page 63 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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

The PPS will leverage strengths and experience of its partners in cultural competency to establish standards and develop expertise across the PPS network. The PPS will incorporate rigorous competency standards in the design and implementation of clinical projects and central services including the Patient Navigation Center (PNC). Lutheran and many PPS partners have a longstanding presence in the diverse communities of Brooklyn and as such, cultural competency is engrained in their mission and daily operations. Several of Lutheran's FQHC sites focus specifically on the health care needs of Latino, Chinese, and Caribbean communities. Lutheran has a mosque, Bikor Sholim room, and Sabbath elevators. Units where staff speaks Chinese are located within the Lutheran inpatient facility and nursing home.

Dedicated Lutheran staff, working with the Vice President of Cultural Competence, have developed best practices to ensure cultural sensitivity, including: recruiting staff from the local community; new hire and annual refresh trainings on cultural competency as well as brief trainings conducted as part of morning "huddles;" monthly discussion groups; bilingual-bicultural patient advocates; and a rigorous medical translation program supported by unified standards and policies. Multi-lingual staff are required to pass an oral fluency test to ensure competency, and a language bank is actively maintained to ensure access to any needed language.

The PPS intends to socialize these best practices to its partners, informed by a network-wide strengths and gap analysis of cultural competency to identify priority areas for intervention. Implementation of an action plan to address gaps may include the creation of additional culture-specific centers of excellence within the PPS network as well as training on the relationship between cultural values and health beliefs, the role of alternative medicine, and culturally-rooted concepts of health, illness, pain, and healing.

*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 engage with many community-based organizations who have already developed expertise in reaching into the diverse neighborhoods of Brooklyn including, but not limited to, the Caribbean Women's Health Association, Brooklyn Perinatal Network, and Ridgewood Bushwick Senior Citizen's Council. Engagement of community-based organizations will occur on two levels to strengthen and maintain cultural competence throughout Brooklyn Bridges' integrated network. First, all community-based organizations within the PPS network will agree to cultural competency hiring and training standards as part of the Master Services Agreement (MSA) that will be established with PPS partners. Milestones reflecting adherence to these standards will be phased in and measured over the course of the DSRIP project period.

Second, community-based organizations within the PPS network already possess a wealth of cultural competence expertise within specific communities. Therefore, as part of its initial cultural competence strengths and gap analysis, the PPS will identify best practices and centers of excellence among the existing community-based organization partners and contract with leaders in cultural competence to assist in content development and delivery of specialized cultural competency training services across the PPS.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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

*Literacy:

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

- Describe the PPS plan to improve and reinforce the health literacy of patients served.

NYS Confidentiality – High



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

Page 64 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

- 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.

Plan to Improve and Reinforce Health Literacy:

To achieve a sustainable reduction in avoidable hospitalizations and ED visits, the PPS must actively engage patients in care. For this reason, improving the health education and literacy of patients will be integrated into all PPS clinical projects. The PPS is committed to working with patients to provide the education and coaching necessary to make them proactive and confident participants in their health care, as well as effective self-managers of their health-related behaviors.

The PPS will identify health literacy enhancement strategies based on industry best practices. These strategies will be deployed through clinical project plans and through the PNC. Many of these strategies will leverage existing standards in place at Lutheran and partner organizations. For example, since 2006, all new patient education materials at Lutheran undergo health literacy review to ensure they are accessible at appropriate literacy levels in English and other languages.

Recognizing the challenges that many patients face due to low educational attainment and limited English language proficiency, Lutheran has also operated an Adult Education and Training program since 1976. The program offers classes in English for Speakers of Other Languages (ESOL), basic education, high school equivalency preparation, and workforce training. The PPS will leverage this existing resource as part of its approach to reinforcing health literacy.

PPS Initiatives to Promote Health Literacy:

Core strategies to be incorporated as standards across PPS clinical projects will include:

- * An assessment to determine which programs and interventions are most sensitive to health literacy gaps;
- * Segmentation of target audiences for all written and verbal communications;
- * Pre- and post-testing of written communications to gauge audience understanding and to evaluate effectiveness of key communication protocols or campaigns; and,
- * Training on the principles of "plain language," "teach-back" and "show-back" methods, and tactics to maximize patient self-efficacy in communication.

The PNC will serve as the primary customer service hub of the PPS, tasked with helping patients to access the right care at the right time, and it will provide a vehicle for the dissemination of best practices around health literacy improvement across PPS partners. For Brooklyn Bridges' community health workers, supporting health literacy via dissemination of easily understandable, patient-centered health education will be a core outcome measured alongside increases in patient activation, management of referrals to community-based services, and improved care transitions.

Community-Based Organizations and Health Literacy:

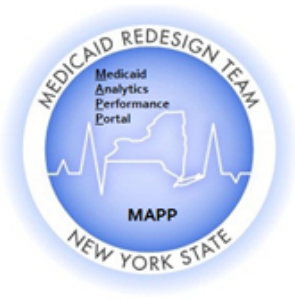
As with cultural competency, the PPS will engage with community-based organizations on two levels as part of its efforts to enhance health literacy throughout the PPS patient base. First, all community-based organizations within the PPS network will agree to health literacy standards as part of the MSA that will be established with all PPS partners. Examples of these standards are outlined above. Milestones reflecting adherence to these standards will be phased in and measured over the course of the DSRIP program.

Second, to the extent that community-based organizations within the PPS network already employ successful programs and practices to improve health literacy within specific communities, the PPS will identify best practices and centers of excellence contract with leading community-based organizations to assist in content development and delivery of specialized health literacy training services across the PPS.

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



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

Page 65 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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

Page 66 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

Description:

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

This section is broken into the following subsections:

- 8.1 High Level Budget and Flow of Funds
- 8.2 Budget Methodology
- 8.3 Domain 1 - Project Budget & DSRIP Flow of Funds Milestones

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

*Budget 1:

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

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

The PPS funds flow methodology promotes DSRIP goal achievement by balancing upfront implementation investments with performance incentives that encourage the sustainable transformation of the health care delivery system to improve health outcomes and reduce costs. DSRIP payments received from DOH will be allocated into the following budget categories: project implementation, provider bonuses, revenue loss, and contingency funds.

Project implementation funds will be shared across PPS partner organizations and allocated to fund central services. Lutheran will serve as the administrative hub of the PPS and together with NYULMC will implement centralized project components for all PPS partners. A portion of project implementation funds will be provided to partners as upfront payments to initiate hiring and project development, while the rest will be distributed to pay for services for which partners are not currently reimbursed and for meeting specific project milestones. As most providers in Brooklyn are operating at break-even, significant upfront funding will be necessary to ensure that partners have the required infrastructure and clinical capabilities to support DSRIP projects. These funds will be distributed across all 5 years, with the majority of funds allocated for DY 1 and 2 distribution.

To protect against potential expenditure overages, 10% of all DSRIP funds will be held in a contingency fund. If these contingency funds are not needed for project implementation, they will be used for internal PPS provider bonus payments.

Revenue loss funds will be distributed on an as-needed basis to partners to offset net revenue loss related to successful implementation of DSRIP projects. These funds will be utilized most heavily in DY 2–4 as the PPS achieves DSRIP goals, but has yet to transition to value-based contracting. The PPS will require partners to submit business plans to repurpose assets to ensure that ongoing support for revenue loss will not be required.

Partners' performance relative to established clinical and quality metrics will be rewarded through incentive-based provider bonus



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

payments. All partners will receive a portion of the bonus payment funds based on overall PPS performance; the balance of bonus funds will be proportionately allocated to partners who demonstrate meaningful achievement of DSRIP goals. Performance goals will be standardized across partners by provider type. Bonus payment distribution will begin in DY 2 and will increase through DY 5, when they will become the main source of PPS partner payments.

The PPS is a broad network of hospitals, outpatient clinics, physicians, behavioral health providers, nursing homes, home care agencies, and community-based organizations spanning clinical specialties. All PPS partners, regardless of clinical specialty or organization type, are eligible to receive implementation funds, bonus payments, and revenue loss mitigation funds, proportionate to their level of involvement in DSRIP projects, the task-specific budgets of those projects, and the partner's achievement of performance goals.

Finally, the PPS governance structure is fundamentally linked to the funds distribution process. The Executive Committee will authorize partner bonus funding amounts. The Finance Sub-Committee, in consultation with the Clinical Sub-Committee, will define and draft project task-specific budgets, performance obligations, milestones, costs associated with implementation, and revenue loss mitigation amounts. The Executive Committee will review and approve all aspects of the funding methodology.

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.

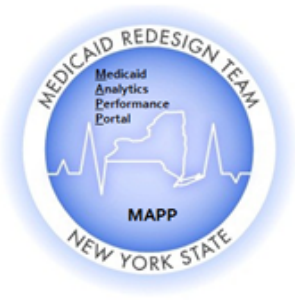
#	Budget Category	Percentage (%)
1	Cost of Project Implementation	40%
2	Revenue Loss	20%
3	Internal PPS Provider Bonus Payments	30%
4	Contingency Fund	10%
Total Percentage:		100%

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.



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

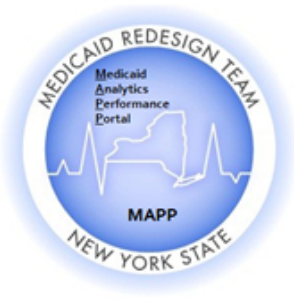
Page 68 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)



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

Lutheran Medical Center (PPS ID:32)

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:

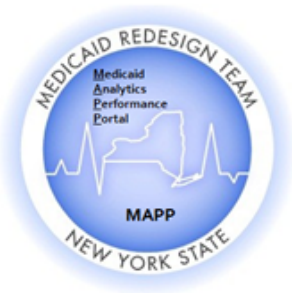
*Assessment 1:

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

Understanding the overall financial health of the PPS and its network partners is critical to PPS sustainability. Recognizing this, the PPS created a survey to evaluate the financial stability of its partners and to identify any organizations potentially at risk of financial failure. To encourage a high response rate, the PPS streamlined the survey to a limited number of questions designed to verify financial stability. The survey was distributed to all partners and included the following questions based on DOH's criteria for safety net hospitals to receive IAAF funding:

- * Does the organization have 15 days cash and equivalents on hand?
- * Does the organization have assets that can be monetized other than those vital to operations?
- * Does the organization have access to resources from foundations and other affiliated entities that can be accessed if required to sustain operations?
- * Will successfully achieving the required metrics for DSRIP projects have a negative financial impact on the organization?

According to the survey results, the vast majority of respondent partners are financially stable with more than 15 days cash on hand. Approximately 20% of partners are moderately financially frail with fewer than 15 days of cash on hand – although the majority of this group has assets to monetize or access to resources from affiliated entities. Only three non-provider partners (with zero combined attribution) qualify as financially frail based on the IAAF criteria; the PPS will work closely with any partners that may require financial sustainability plans during DSRIP implementation.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

*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.

Successful implementation of DSRIP projects may have a negative financial impact on certain PPS partners, as the projects make substantial transformations to health care delivery models. Input to our financial stability survey and discussion among the Finance Workgroup participants identified how successful implementation of DSRIP projects could cause negative financial outcomes for partners, including:

- * A reduction in hospital FFS payments for inpatient admissions, readmissions, and emergency department visits;
- * A reduction in hospital revenue related to emergency department visits due to redirection of Medicaid patients to primary care and other appropriate ambulatory care settings, and also due to increased care management, coordination, and monitoring of Medicaid patients discharged from hospitals;
- * An increase in care management, home visits, or other expenses not currently reimbursed through FFS payment arrangements;
- * Increased workforce expenditures to retrain and/or recruit staff to support an increase in outpatient services; and,
- * Potential loss of support payments, bridge money or debt guarantees from the State through the Distressed Hospital Pool, grant programs, and other sources of funds.

The majority of revenue loss will likely occur in hospitals and other inpatient settings. Lutheran, the primary hospital partner operating in the PPS's service area has already demonstrated its financial stability. The PPS has developed estimates for the potential negative financial impact of DSRIP projects on Lutheran and its affiliate centers, including the reduction of approximately 40 long-term care beds at Lutheran Augustana Center for Extended Care and Rehabilitation. These estimates have been incorporated into the allocated funding amounts for revenue loss discussed in Section 8.

DSRIP funding alone will not save otherwise vulnerable institutions. However, through DSRIP, it will be possible to identify when essential partners are at risk and to help plan for the continuation of the services they provide so that the PPS fulfills its mission. The PPS's approach has the following elements:

- * Early identification of financial and programmatic issues through continual monitoring. The PPS plans to continue annual partner financial surveys in addition to the quarterly performance and financial monitoring being implemented as part of the DSRIP projects;
- * Proactive work with local organizations and parent companies. The PPS will continue to work with both entities to ensure that access to essential services can be sustained;
- * Leverage the Finance Sub-Committee for restructuring. The Finance Sub-Committee will work together with financially fragile participants to collect information and develop restructuring plans for failing institutions. The estimated financial impact will be considered in the budgeting for revenue loss mitigation discussed in the Section 8 (flow of funds); and,
- * Commitment to using DSRIP funds to sustain needed services in the most efficient possible manner. Use of DSRIP funds for revenue loss will be provided only upon demonstration of a negative financial impact caused by DSRIP and assurance that DSRIP funds will be used as a short term stop gap in a manner that will enhance the overall viability of the sponsoring institution.

Section 9.2 – Path to PPS Financial Sustainability:

Description:

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

*Path 1:

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

The PPS views DSRIP incentive payments as essential to the transformation of the current delivery system and has designed a funds flow methodology to maximize the value of DSRIP payments. However, if new ambulatory services and payment methodologies do not transition to value-based payments rapidly, all participating partners, especially the financially fragile, will be negatively impacted when DSRIP funding ends. To sustain delivery system changes during the five years of DSRIP implementation and beyond will require the PPS and its partners to develop a strong governance structure; employ evidence-based clinical programs and HIT to improve health outcomes and manage the ongoing cost of health care; and successfully transition all PPS partners to value-based payment arrangements.



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

The PPS and its partners currently have limited value- and risk-based arrangements. Lutheran has limited capitation agreements and shared savings arrangements. Most other partner experience is with FFS arrangements with quality bonuses. The PPS recognizes that a singular approach for entering into value-based contracts on behalf of all partners across specialties and organization types may not be feasible nor desirable; the PPS is committed to creating a strong organizational and clinical foundation to ensure it is prepared to pursue value-based and alternative contracting arrangements with managed care organizations.

The PPS through the Finance Sub-Committee will continue detailed sustainability planning in parallel with the development of the PPS implementation plan. The sustainability plan will further define the distribution of DSRIP funding to support sustainability of PPS partners in the context of the DSRIP projects. It will define the required financial measures and expectations to be monitored along with clinical quality measures. It will detail the shift to value-based contracting, including the expansion and/or development of existing risk-bearing entities and contracting infrastructures.

There are currently no known restructuring efforts required. Lutheran will work with the three organizations identified as financially frail during the implementation planning process to determine the appropriate role, funding, performance measures, and oversight required to ensure services critical to success of the DSRIP projects.

*Path 2:

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

As described above, the PPS created and administered a financial stability survey to all of its PPS partners to obtain an initial baseline understanding of the PPS's overall financial stability. A similar survey will be administered annually to continuously monitor the PPS's financial stability. The survey will be adjusted to account for learnings from the initial survey, evolving DSRIP project needs and recommendations from the financial sustainability plan.

In addition to the annual survey administered across all PPS partners, the Executive Committee and the Finance Sub-Committee will continuously monitor a set of operational and financial metrics and meet regularly with the most vulnerable partners to confirm that DSRIP project funds have been properly invested and timelines met. An emphasis will be placed on monitoring and working with safety net partners who are, or may become, financially fragile. Where indicators or activities are not in line with expectations, the PPS will work with these organizations to develop transition plans which may include distribution of revenue loss funds.

*Path 3:

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

DSRIP will lead to further development of care management infrastructure, providing capabilities that are beyond Medicaid managed care (MMC) plans' current capabilities. The result of this integration will include lower costs, improved quality, and better health for the community. PPS partners will be clinically, financially, and technically integrated, creating a high-performing provider network that will reflect a fundamental transformation of today's disjointed, episodic system.

Sustainability beyond DSRIP involves partnerships with MMC plans to establish new value-based contracts that will sustain health care transformation. In preliminary conversations with MMC plan partners, the PPS has begun to identify data sharing priorities, "high value" care management functions that may be most effective if provided by the PPS, and MMC plan functions that are complementary to and can be leveraged by the PPS to meet the needs of the community. Core components of contract negotiations will include funding the PPS's expanded care management infrastructure and agreements to avoid duplication of efforts with respect to care management, data sharing, network management, and other functions.

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:



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

Page 72 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

*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.

Value-based payment arrangements are critical to the long term sustainability of the PPS and the programs and infrastructure created through DSRIP. The PPS has defined three phases in the transition to value-based payment: Phase one, in late DY 1 and DY 2, will focus on implementation and demonstrated success of the PPS care model. Payment in this phase will relate to compensation for PPS care management services. In the second phase of the value-based payment approach, the PPS intends to transition to shared savings arrangements for clinical conditions being addressed through its DSRIP clinical projects. Specifically, the PPS plans to pursue shared savings for asthma and diabetes in DY 2 and DY 3, with shared savings arrangements for behavioral health programs in DY 4 or 5. In phase three, the PPS will initiate discussions with MMC plans related to up and downside risk based arrangements in DY 5 and beyond.

With its diverse provider partners, the PPS will need to support various types of value-based arrangements. The PPS will create new contracting structures as necessary to implement new payment arrangements. Initial conversations have begun with several leading MMC plans, including Healthfirst and Amerigroup, about the development of value-based contracting arrangements with the PPS and its partners. The PPS also intends to pursue a multi-payer risk contracting strategy to include Medicare and commercial payers; the multi-payer contracting strategy is key to the PPS's long-term financial sustainability.

*Strategy 2:

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

Payment reform will position the PPS on a path toward financial stability by transitioning partner financial relationships with payers from existing FFS arrangements to value-based arrangements which promote clinical and financial integration. The full scope of health care, population management, and social services that our community requires for optimal health and wellbeing is not currently supported by FFS Medicaid. Value-based payment will promote provider driven care transformation by giving PPS partners the resources and incentive to provide the right care, at the right time, in the right place. Value-based payment will shift the "pay for volume" culture in the health care delivery system to a "pay for value" culture that promotes population health management, improved outcomes, and lower costs.

The PPS plans to pursue shared savings arrangements based on the specific clinical conditions supported by DSRIP projects (asthma, diabetes, and behavioral health) before pursuing upside and downside risk sharing arrangements in order to introduce our partners to value-based arrangements with no downside risk at the outset. This will allow the PPS to stand up and strengthen its infrastructure, evaluate member performance, and test internal quality and cost reporting mechanisms to ensure it is equipped to gauge performance and appropriately structure future risk sharing agreements. Shared savings alone will not provide enough funding to support long term sustainability of the full scope and breadth of the programs created by DSRIP. In DY 4, 5, and beyond, the PPS will look to expand the level of risk and capitation it assumes as the capabilities of the PPS and its partners improve.

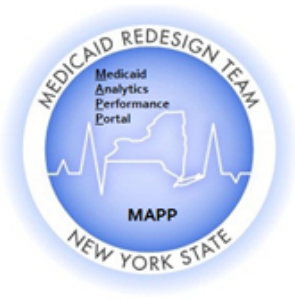
Payment transformation negotiations with MMC plans will be framed to help support financially fragile safety net providers whose performance meets or exceeds quality and cost goals, and whose services are critical to the PPS and its patients. The PPS will work with financially fragile safety net providers to optimize and improve workforce productivity through redeployment and retraining with the goal of aligning resources to community need and providing services in the most efficient manner possible.

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.



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

Page 73 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)



Please click here to acknowledge the milestones information above.



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

Page 74 of 75
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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.

LFHC has extensive and proven experience with population health management (PHM) with Medicaid patients. The LFHC's Community Case Management Program (CCMP) provides care coordination, patient navigation, and health coaching to high-risk patients within one of the largest FQHC networks in the country as well as affiliated members of the Southwest Brooklyn Health Home. Within the CCMP, which serves primarily Medicaid beneficiaries, high-risk patients are identified during care transitions, connected to a Level 3 Medical Home, provided a physician appointment within 48 hours of discharge, and offered four weeks of health coaching/education using motivational interviewing techniques to encourage self-management and promote adherence to medication and treatment protocols. Additional aspects of LFHC's PHM expertise include:

* LFHC uses clinical software, Azara, to identify patients at risk for readmissions; the Patient Navigation Center (PNC) will leverage Azara for risk stratification for enrollment of members into care management services of appropriate intensity;

* LFHC's existing community resource guide includes OASAS and OMH providers, adult day care, transportation, housing, workforce training, adult education, and food programs, and an established network of robust community based providers – a resource that will be leveraged and developed further to support the PNC.

NYU also brings tremendous population health assets to the PPS. NYU's Center for Health Innovation and Delivery Science (CHIDS), a division of NYU's Department of Population Health, will support the PPS through a robust rapid cycle evaluation unit to ensure continuous quality improvement.

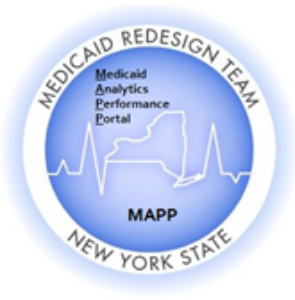
Proven Workforce Strategy Vendor (PWSV):

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 PPS will retain the 1199SEIU Training and Employment Funds (TEF) as its primary workforce development trainers. The TEF is the largest joint labor-management workforce planning organization in the United States and has a proven history of providing quality training and education that assists the workforce in meeting the challenges and changing demands of the health care industry.

The TEF has a broad range of on-going education programs and a vast network of educational providers. The TEF has the capacity and experience in customizing curricula to serve the workforce, including all allied health job titles and physicians and for new models of care (e.g., ACOs and PCMH). The TEF will, in collaboration with Brooklyn Bridges' leadership, screen and contract with the most suitable educational vendors to deliver high quality training. Training will be conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. In addition, TEF uses the City University of New York wherever possible to deliver training programs that offer college credit or where high quality workforce and certificate programs meet industry needs.

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



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

DSRIP PPS Organizational Application

Lutheran Medical Center (PPS ID:32)

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 Lutheran Medical Center that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Primary Lead Provider Name: LUTHERAN MEDICAL CENTER

Secondary Lead Provider Name:

Lead Representative:	Claudia Caine
Submission Date:	12/22/2014 01:03 PM

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