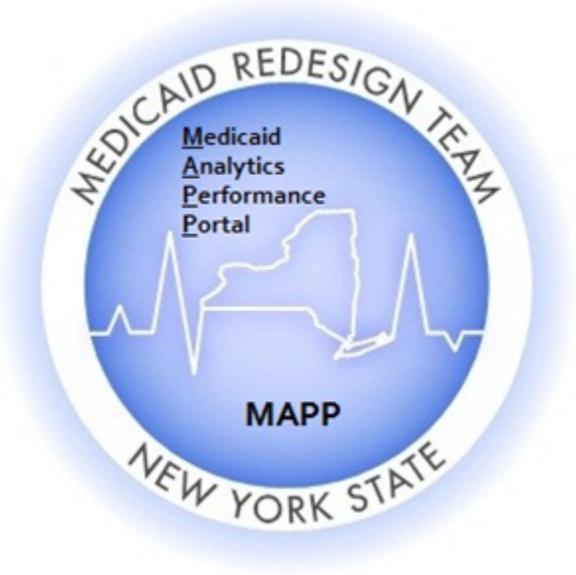
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Montefiore Hudson Valley Collaborative

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

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

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

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

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

Currently Uploaded File: **19_SEC000_DSRIP PPS Lead PPS Lead Financial Stability Test Excel Tool_10302014 as of 11.10.pdf**

Description of File

File Uploaded By: mmcjlam
File Uploaded On: 12/22/2014 09:49 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: lrichmon
Last Updated On: 12/22/2014 04:31 PM

Certified By: lrichmon
Certified On: 12/22/2014 04:33 PM
Lead Representative: Lynn Richmond

Unlocked By:
Unlocked On:

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

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Develop a more integrated system, better able to take on risk and deliver value	New York State is seeking to transform the health care delivery system at both the system and the state level and to develop integrated systems of care able to take on financial risk. As a PPS, we are firmly committed to the transition to an integrated and coordinated system of care across provider sites, able to engage in value based arrangements. Montefiore has deep expertise in system integration, community-based care and managing financial risk for a population. We will leverage this expertise with the unique strengths of our partners, including our payer partners, to bring about regional system transformation. We will build on our existing analytic expertise to evaluate our effectiveness under value-based arrangements that incentivize improved quality and reduced costs across the performance period.
2	Pursue a more sustainable system, with care delivered locally in the right care setting	New York State is seeking to improve care by reducing avoidable hospital use, contain costs, and improve quality through the DSRIP program, while developing a sustainable model to support vital safety net providers at immediate risk of closure. As a PPS, we seek to strengthen care in the community to ensure more care is delivered locally, set up seamless mechanisms to ensure that patients with complex needs are connected to ongoing disease management and care coordination resources that sustain and improve health. In addition, where possible, we will coordinate with our partners to regionalize services to deepen expertise and promote efficiencies. Our goal is ensure that the local delivery system thrives and becomes more sustainable, more patient-centered and better coordinated. We will leverage the support of the DSRIP program to create a bridge to long-term sustainability through the advancement of new services and payment arrangements required to thrive in a value-based world
3	Create a more patient-centered system, with access to services tailored to community needs	New York State is seeking to advance health by ensuring access to services aligned with the unique challenges of each community. Through our Community Needs Assessment, we identified a wide range of community needs and gaps, and have outlined them elsewhere in the application By refreshing our Community Needs Assessment, we will assess our success at expanding availability of services and transforming the services so they are better coordinated and patient-centered. We are committed to patient activation and engagement and will evaluate our effectiveness through regional feedback and patient satisfaction surveys, and are exploring approaches for promoting patient voices within the HVC's Leadership Steering Committee, through strategies such as the

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#	Goal	Reason For Goal
		establishment of a Consumer Advisory Council.
4	Align the workforce with the evolving needs of a rapidly changing delivery system	New York State is seeking to develop a strong, progressive and nimble health care workforce for the future. To achieve that goal, professional and non-professional health care systems must invest in transformation. As a PPS, we are committed to the vision that a well managed population requires more of the right kind of care and therefore, we are committed to the goal of 'no net reductions' in workforce. In the process of transformation, many may be displaced and yet others will need to develop new skills as their roles change and the approach to care changes. We believe the entire healthcare workforce will need to begin to see themselves as part of a broader system of care, and work to break down silos between disciplines and organizations that have stymied change in the past.

***Formulation:**

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

There are three important components to how we formulated our PPS to meet community needs and address health care disparities.
First, we conducted a comprehensive community needs assessment (CNA), working collaboratively with the other PPSs in the region to identify the areas of need and drivers of avoidable hospital use across the region through surveys, focus groups, and data analysis. These findings became the foundation for our work, providing us with focus.
Second, we developed a robust partnership network, beginning with a set of organizations that are leaders in their region. We looked to them for recommendations for partners, to help develop a naturally integrated network. We identified additional providers dedicated to serving the Medicaid population, made presentations to consortiums to spread the word, and fielded inbound requests. Our over 200 partners span the care continuum.
Third, working collaboratively with our partners and informed by the CNA, we selected projects to maximize results against the state's goals. We developed project plans with stakeholders across provider types to illuminate roles, and tested the plans with our PACs to ensure local relevance.

***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.

For patients, care will feel different: more coordinated, easier to access, and prevention-focused. The initial emphasis will be on the chronically ill, but all patients will benefit.
For providers, there will be greater accountability. Some providers will see roles enhanced; others may see roles change. Care will be more collaborative, with shared IT and care plans, and fewer regulatory barriers. VBAs will provide stability and prompt innovation.
For workers, there will be greater visibility into patient needs, connections across disciplines, and access to training, making work more rewarding. There will be an expansion of ambulatory jobs, but some workers will be impacted. We will strive for 'no net reductions'.
For payers, there will be closer alignment with providers, with both directed toward the same outcomes. Shared savings will benefit payers, and allow investment to bolster the safety net.
For communities, there will be a more responsive system and better integration between providers and social services.
Lastly, taxpayers will receive more value, through prudent use of publically supported programs, both under DSRIP and Medicaid value-based payment arrangements.

***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

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- 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	Introduction	The HVC has outlined the following areas of needed regulatory relief. As the HVC will engage in even more detailed planning in the coming months, we request the ability to refine and expand upon the items discussed herein and to engage in dialogue with state agencies about regulations that appear to be relevant based upon projects described in this application submission. Through these discussions, the HVC may wish to extend individual waiver requests to other projects not otherwise outlined. Of note, many of these requests are made because state agencies have not yet articulated an expedited review process for DSRIP activities. If such processes are made available, the HVC may withdraw some of the waiver requests discussed below.
2	Title 10, 83.2(a)	We seek a waiver of 10 NYCRR 83.2 (a), which defines shared health facilities, for projects 2.a.i.; 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. We may supplement this request with additional information during the implementation phase; in particular we anticipate needing relief from the requirements set forth in Part 83, particularly sections 83.4 and 83.5. In this application, we seek relief from 83.2 (a) to permit co-location of medical providers and behavioral and substance use treatment providers in the same settings. Given the explicit aim of DSRIP to foster integrated delivery systems that seamlessly coordinate behavioral health, substance use treatment, medical care, and palliative care for patients, we believe it is key to remove or limit impediments to service co-location. The alternative is to comply with the regulations applicable to shared health facilities, which will cause delays in DSRIP project implementation and may increase costs. We believe that there are no risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing state patient safety provisions related to the services that will be co-located to the maximum extent possible. Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
3	Title 10, 86-4.9	We seek a waiver of 10 NYCRR, 86--4.9, which establishes that the basis of payment for most clinic services provided in hospital outpatient departments and diagnostic and treatment centers under Article 28 of the Public Health Law is the threshold visit. We seek this waiver for projects 2.a.i.; 2.a.iii.; 2.a.iv.; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. We also request an examination of the policies and procedures that prohibit Federally Qualified Health Centers from being reimbursed for more than a single service in a single day. We believe that the reimbursement policy that stems from this regulation and policy stance will significantly undermine efforts to deliver coordinated, comprehensive care to patients. As an example, many of the patients we serve may require a primary care oriented visit and a visit to address mental

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#	Regulatory Relief(RR)	RR Response
		illness in the same day; the current billing architecture does not permit reimbursement beyond single threshold visit. We anticipate that many of the patients we serve face significant transportation and logistical barriers to accessing care. To the extent that the HVC in the execution of all project activities outlined above can promote streamlined access to services available in a single location on a single day, we believe patients with complex needs will benefit significantly and the DSRIP vision of integrated service delivery will be achieved. Put simply, we request an enabling reimbursement structure to support this vision. As an alternative, the HVC will need to continue to comply with current reimbursement practices, which we suggest fragment care and undermine the potential for true service delivery integration. We contend that there are no risks to patient safety in the waiving of the regulation noted above and a revision of the general FQHC reimbursement policy. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals
4	Title 10, 401.2 (b)	We seek a waiver of 10 NYCRR 401.2 (b), which notes that an operating certificate shall be used only by the established operator at the designated site of operation. We seek this waiver for projects 2.a.i.; 2.a.iv.; 2.b.iii.; 3.a.i., and 3.a.ii. Specifically, we seek this waiver to permit: (1) behavioral and/or substance use providers to operate primary care under the oversight of their regulatory agency in place of DOH and its attendant facility standards; (2) Article 28 providers to operate primary care at additional locations within space of a different provider who is separately licensed by a state agency and; (3) Article 28 staff to conduct reimbursable home visits in a patient's home. For these activities, we would want approval from DOH to relocate services or add on additional locations beyond the designated site of operation with no further certificate of need activity; ideally this approval would be conferred concurrent with or as part of the DSRIP project application approval process. This waiver will enable the PPS to promote rapid system reconfiguration and service integration. As an example, authorizing patient homes as a site of service eligible for the provision of care and reimbursement will promote ease of access and reduce reliance on ED and inpatient settings as sources of primary care or behavioral health services. The PPS will work with service providers and community based organizations to reduce barriers to access and this may necessitate patients being evaluated and treated in their residences. As an alternative, the PPS will consider compliance with integrated certification regulations. Alternatives for this waiver do not exist to permit (3), home visits. We contend that there are no risks to patient safety in the waiving of the regulation noted above and a revision of the general FQHC reimbursement policy. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other

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#	Regulatory Relief(RR)	RR Response
		state DSRIP goals
5	Title 10, 401.3 Changes in existing medical facilities	We seek a waiver of 401.3, which requires the submission of written changes to existing medical facilities to the Department of Health and approval prior to implementation. The projects we seek this waiver for include: 2.a.iv; 2.b.iii.; 3.a.i. and 3.a.ii. All of the projects above require either expanding capacity, modifying existing services, and/or relocating services. As an example, under project 2.a.iv, the HVC intends to optimize current regional inpatient delivery system by evolving excess hospital capacity (as determined through the community needs assessment activity and conversations with PPS partners) to serve other purposes such as respite behavioral health services, housing, and pharmacy services. Through this project, several of the hospital facilities the HVC is working with will transition excess capacity to make way for services identified as critical to HVC communities, namely urgent care, resuscitation services, and a rapid assessment zone to enable ED triage. As another example, under project 3.a.i, the HVC will cultivate three models: (1) the integration and co-location of behavioral health into primary care clinics; (2) integration and co-location of primary care into behavioral health clinics; and (3) the collaborative care model (telephonic behavioral health services) at sites where physical co-location is not possible. Pursuing these models will require the modification of physical facilities to meet service integration goals. We request a waiver because the regulation, as currently constructed, could significantly delay the timeline for activities such as those listed above and undermine the likelihood of meeting DSRIP project milestones. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 401.3, which may in turn diminish the extent of system transformation feasible. We also submit for consideration the idea that DOH would confer approval for these project activities concurrent with or as a part of the DSRIP Project application approval process. We believe that there are no risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
6	Title 10, Part 405; specifically 405.2(e)(3) and §405.4(c)(5)	We seek a waiver of 10 NYCRR Part 405; specifically 405.2(e)(3) and §405.4(c)(5) pertaining to projects 2.a.i.; 2.a.iii; 2.a.iv; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. in order to streamline the credentialing process within the PPS. This waiver will allow the HVC PPS to establish a shared credentialing process and standards to: (1) conduct primary source verification; (2) screen for Medicare and Medicaid exclusion; and (3) assure consistent standards to promote quality and patient safety, relying on data available to partner organizations and to the PPS through its own monitoring and data collection. The waiver would reduce the cost and administrative burden of credentialing by each partner organization, and would allow health care professionals to practice in different settings as needed for care coordination without duplicative credentialing. The waiver is also requested to permit certain practices that may be necessary to implement coordinated care models, such as allowing a physician in private practice to supervise more than two physicians' assistants (10 NYCRR 94.2). The only alternative would be to continue the existing process for

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		credentialing which as noted above will be highly demanding and labor and cost intensive, and will not provide the same degree of oversight or operational coordination based on a single set of credentialing standards and criteria. The HVC will use a single set of credentialing standards, criteria, and centralized review process to improve patient safety by assuring that consistent, sound standards are adopted and uniformly applied for health care professionals across partner organizations. Centralized credentialing would still entail collecting and relying upon information from each partner organization about health care professionals practicing under their license and supervision. It will also allow for a more objective evaluation by professionals who are not peers of individual practitioners. Moreover, the PPS will be able to use its own quality data and observations based on project participation to inform the review process.
7	Title 10, 405.1 (c)	We seek a waiver of 405.1 (c), which requires that any person, partnership, stockholder, corporation or other entity with the authority to operate a hospital to be approved for establishment by the Public Health Council. We seek this waiver for projects 2.a.i.; 2.a.iii.; 2.a.iv.; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to exempt the PPS from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements, and approving protocols that impact the delivery of services. There are no alternatives if DOH believes that the activities of the PPS would require establishment as an operator. The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols that influence how care is provided. This concern is mitigated in our view, however, by several facts. First, the PPS will have clinical experts develop the protocols and clinical pathways embedded within project plans, based on evidence-based practice and standards of care. The HVC participants will not only be monitored on their fidelity to these protocols through a robust quality monitoring and reporting infrastructure that the HVC will advance, but also through DOH oversight of the DSRIP program. Finally, DOH will also have ample time to review these pathways and protocols at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
8	Title 10, 405.19 (g) (2,5(b))	We seek a waiver of 10 NYCRR 405.19 (g) (2,5 (b)) for projects 2.a.i and 2.b.iii to (1) add observation unit beds without prior review under section 10 NYCRR 710.1(c)(2) or (3), regardless of project cost; (2) to waive the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of 10 NYCRR for construction projects approved or completed after January 1, 2011; and (3) to waive the physical space and location requirements applicable to placement of observation beds. In order to reduce avoidable hospital admissions, readmissions, and ED visits; to facilitate the proper assessment and treatment of patients who may be able to be cared for in the community, or, in accordance with a care transitions program, returned to a community setting following a short stay in the hospital as an outpatient, providers will need to expand capacity of observation beds and to have flexibility in the location of the beds. Alternatives to this waiver would be to comply with the applicable regulations but this will cause delays in implementation of DSRIP project plans and will likely increase cost and may be unable to be carried out due to constraints of physical space. We believe that there are no risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety

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		standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
9	Title 10, 405.9 (b)(2) and (f)(7)	We seek a waiver of 10 NYCRR 405.9 (b)(2) and (f)(7) for projects 2.a.i.; and 3.a.ii. to permit providers to implement PPS-approved protocols for care transitions and care pathways when making admission decisions and conducting discharge planning and placement of Medicaid and Uninsured patients. There are no alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and quality. We believe that there are no risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
10	Title 10, 600.9	We seek a waiver of 600.9 for projects 2.a.i.; 2.a.iii.; 2.a.iv.; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to exempt the PPS from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements, and approving protocols that impact the delivery of services. There are no alternatives to this if DOH believes that the activities of the PPS would require establishment as an operator. The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols that influence how care is provided. This concern is mitigated in our view, however, by several facts. First, the PPS will have clinical experts develop the protocols and clinical pathways embedded within project plans, based on evidence-based practice and standards of care. The HVC participants will not only be monitored on their fidelity to these protocols through a robust quality monitoring and reporting infrastructure that the HVC will advance, but also through DOH oversight of the DSRIP program. Finally, DOH will also have ample time to review these pathways and protocols at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
11	Title 10, 600.9 (c)	We seek a waiver of 10 NYCRR 600.9 (c) for projects 2.a.i.; 2.a.iii.; 2.a.iv.; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to ensure that DSRIP-related distribution of revenue and collaborative arrangements among providers do not violate this regulation, which prohibits regulated entities from fee-splitting or sharing in gross revenues of non-established entities. This regulation has been identified as a potential impediment to DSRIP flow of funds. We seek a waiver to ensure that any financial components of agreements or other processes providing for the DSRIP flow of funds among PPS partners for the purpose of DSRIP project execution is permissible. It is important to distinguish this critical PPS function in a manner that it does not constitute illegal fee-splitting with non-established providers. There are no alternatives to waiver if this would be considered to implicate the prohibition on fee-splitting.

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		Patient safety is not impacted because the HVC governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers, regardless of funds flow within the PPS.
12	Title 10, 670.1 (a-c)	We seek a waiver of 10 NYCRR 670.1 (a-c) for projects 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. to facilitate the addition or expansion of services and capacity to meet DSRIP goals. Through this waiver, the HVC will promote rapid system reconfiguration, to better integrate and align service delivery across the continuum, and to situate services such as behavioral health treatment in alternative locations like primary care sites and elsewhere in the community, thereby reducing reliance on ED and inpatient hospital care. All of the projects listed above will require the expansion of capacity or adding or changing existing services. For example, under project 3.a.i, the HVC will cultivate three models: (1) the integration and co-location of behavioral health into primary care clinics; (2) integration and co-location of primary care into behavioral health clinics; and (3) the collaborative care model (telephonic behavioral health services) at sites where physical co-location is not possible. Pursuing these models will require the modification of physical facilities to meet service integration goals. Project 3.a.ii will involve increasing or adding crisis mobilization and stabilization services in the community. We seek relief from having to file new certificates of need, go through determinations of public need, and achieve approval prior to implementation, as these steps will significantly delay project activities. We also submit for consideration the idea that DOH would confer approval for these project activities concurrent with or as a part of the DSRIP Project application approval process. The alternative considered by the PPS is that if prior review is going to be required, to request that DOH only require limited review. We believe that there are no risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
13	Title 10, 709.1 Determination of Public Need	We seek a waiver of 709.1, which outlines a process for determining public need for health services and medical facilities as a part of applications for construction. The HVC seeks this waiver for project 2.a.iv, creating a medical village using existing hospital infrastructure, and 3.a.i, integration of primary care and behavioral health. Under project 2.a.iv, the HVC intends to optimize current regional inpatient delivery system by evolving excess hospital capacity (as determined through the community needs assessment activity and conversations with PPS partners) to serve other purposes such as respite behavioral health services, housing, and pharmacy services. Under project 3.a.i, the HVC will cultivate three models: (1) the integration and co-location of behavioral health into primary care clinics; (2) integration and co-location of primary care into behavioral health clinics; and (3) the collaborative care model (telephonic behavioral health services) at sites where physical co-location is not possible. To develop these three models, the HVC will need to undertake activities implicated under 709.1, such as construction to modify facilities to meet the objectives of projects 2.a.iv and 3.a.i. For example, under the auspices of 2.a.i, several of the hospital facilities the HVC is working with will transition excess capacity to make way for services identified as critical to HVC

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#	Regulatory Relief(RR)	RR Response
		communities, namely urgent care, resuscitation services, and a rapid assessment zone to enable ED triage, all of which will require construction and modification of existing facilities. We request a waiver because the regulation, as currently constructed, could significantly delay the timeline for these activities and undermine the likelihood of meeting DSRIP project milestones. Further, we suggest that the comprehensive analysis and community health needs activities embedded in DSRIP fulfill many of the objectives of the determination for public need process. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 709.1, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
14	Title 10, 709.2 Acute Care Facilities	We seek a waiver of 709.2, which outlines the process for certificate of need applications involving the construction or establishment of new or replacement beds in an acute care hospital and the need for acute care facilities and services The HVC seeks this waiver for project 2.a.iv, creating a medical village using existing hospital infrastructure. To develop these three models, the HVC will need to undertake activities implicated under 709.2, namely construction to modify acute care facilities to meet the objectives of projects 2.a.iv. We request a waiver because the regulation, as currently constructed, could significantly delay the timeline for these activities and undermine the likelihood of meeting DSRIP project milestones. Further, we suggest that the comprehensive analysis and community health needs activities embedded in DSRIP fulfill many of the objectives of the determination for public need process. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 709.2, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
15	Title 10, 710.1(c) Approval of Medical Facility Construction	We seek a waiver of 710.1(c), which concerns the erection, building, acquisition, alteration, reconstruction, improvement, extension or modification of a medical facility. The HVC seeks this waiver for projects 2.a.i.; 2.a.iii.; 2.a.iv.; 2.b.iii.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. As an illustration, five of the seven DSRIP counties in the HVC are designated Health Professional Shortage Areas (HPSAs); in these areas in particular, the HVC will build up primary care access and in some cases, construct new primary care facilities as a part of project 2.a.i. Further, all of the projects noted above require the expanded use of HIT technologies and interoperability, which will require investment in new EHR technologies, outlay of capital and the provision of vendor services. The reasons for the waiver request is to relieve the PPS and all partners from having to submit

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		new certificate of need applications and receive prior review and approval for all DSRIP activities, including the physical modifications described above and HIT acquisition, installation, modification or outlay of capital. We request a waiver because the regulation, as currently constructed, could significantly delay the timeline for activities such as those outlined above and undermine the likelihood of meeting DSRIP project milestones. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 710.1(c), which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals. Finally, the HIT activities noted above would not risk patient safety since HIT systems that will be utilized will meet all prevailing EHR standards and be certified to promote meaningful use objectives of providers.
16	Title 10, 711.1 – General Standards of Construction	We seek a waiver of 711.1, which notes that an applicant seeking approval to construct a new health facility or alter or renovate an existing health facility shall submit a completed application and functional program to the Department of Health. The HVC seeks this waiver for project 2.a.iv, creating a medical village using existing hospital infrastructure and project 2.a.i, the creation of an integrated delivery system based on evidence-based medicine. To develop this project, the HVC will need to submit applications to the Department of Health for the development of new facilities or alterations or renovations to those facilities. As an illustration, five of the seven DSRIP counties in the HVC are designated Health Professional Shortage Areas (HPSAs); in these areas, the HVC will build up primary care access and in some cases, construct new primary care facilities as a part of project 2.a.i. We request a waiver because the regulation, as currently constructed, could significantly delay the timeline for these activities and undermine the likelihood of meeting DSRIP project milestones. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 711.1, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
17	Title 10, 712-1.11 Standards for General Hospital Construction Projects Approved or Completed Prior	We seek a waiver of 712-1.11, which proscribes physical parameters that hospital outpatient facilities must meet, such as size and types of structures and rooms included in the facilities. The HVC seeks this waiver for project 2.a.iv, creating a medical village using existing hospital infrastructure. To develop this project, the HVC will likely modify outpatient hospital facilities to meet new purposes; for example, within an outpatient setting, the HVC may incorporate telephonic care management services, perhaps obviating the need for sterile supply storage. We seek a waiver because it

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		is conceivable that project objectives, as determined through the community needs assessment and discussions with PPS partners, require a departure from the strict physical parameters proscribed in 712-1.11 such as in the instance above. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 712-1.11, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
18	Title 10, 86-1.31	We seek a waiver of 86-1.31, which outlines activities related to mergers, acquisitions, and consolidations. The HVC seeks this waiver for project 2.a.iv, creating a medical village using existing hospital infrastructure. As it stands 10 NYCRR 86-1.31 allows facilities to apply for "temporary adjustment to the non-capital components of rates calculated pursuant to [such] Subpart for eligible general hospitals." Currently eligible general hospitals under this regulation must undergo a full asset merger in order to receive such adjustment. Montefiore believes that, in order to achieve truly transformational change under project 2.a.iv, disruptions and consolidations in the provider community are inevitable and, in order, to facilitate such changes, assistance must be available to those providers that acquire, consolidate or otherwise restructure provider systems. The restrictions of 10 NYCRR 86-1.31 stand as a barrier to such changes. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 712-1.11, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
19	Corporate Practice of Medicine	The prohibition on the corporate practice of medicine raises concerns since corporations may not employ licensed professionals to practice medicine. While we understand that this is not a state regulatory matter, we request that the Department of Health acknowledge, in consultation with Department of Education, that all PPS activities within HVC projects do not constitute the corporate practice of medicine under (1) Educ. Law 6522 which provides that only a person licensed or otherwise authorized under Education Law shall practice medicine and (2) Educ. Law 6527, which provides that a non-profit medical or dental expense indemnity corporation or a hospital service corporation may employ licensed physicians. There are no alternatives and patient safety is not impacted because physician fees for professional services will not be shared with non-physicians who are affiliated with the provider and the governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers regardless of funds flow within the PPS.

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20	Title 14, Chapter XIII, 551.6	We seek a waiver of 551.6, which outlines projects related to Office of Mental Health services that are subject to prior review before implementation. The HVC seeks this waiver for project 3.a.i, integration of primary care services and behavioral health, and 3.b.iii, behavioral health crisis stabilization. Under project 3.a.i, the HVC will cultivate three models: (1) the integration and co-location of mental health services into primary care clinics; (2) integration and co-location of primary care into mental health service providers; and (3) the collaborative care model (telephonic behavioral health services) at sites where physical co-location is not possible. To execute this project, we will need to in some cases modify primary care facilities to incorporate mental health services and vice versa. Under project 3.b.iii, we will expand crisis stabilization services where they exist and develop needed outpatient and inpatient mental health services. We intend to develop mobile crisis units staffed with clinical and peer staff to actively outreach to members in the community and provide urgent services. We are very concerned that the regulatory application and review process set forth in 551.6, including initial notification of local government units (LGUs), associated with the delivery of OMH-related services will delay the timeline for these activities and undermine the likelihood of achieving DSRIP milestones; we therefore request a waiver of this provision. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 551.6, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
21	14 NYCRR 599.4 (ab)	We seek a waiver of 14 NYCRR 599.4 (ab) for projects 2.a.i., 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. to permit Article 28 licensed providers to operate mental health services either within the general hospital or in an outpatient hospital department in amounts which exceed the current limits of visits annually. This exemption from requiring OMH licensure, regardless of the number of patients served, will help transform the method of delivering services and increase access to behavioral health and primary care. As an alternative, the PPS will consider compliance with integrated certification regulations. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
22	Title 14, 85.4	We seek a waiver of 14 NYCRR 85.4 for projects 2.a.i; 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. to permit DOH-regulated providers to operate mental health services under the oversight of the agency regulating them (DOH) and to forgo the requirements of an operating certification from OMH. One of the primary goals of DSRIP is to achieve better integration of

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		primary care, behavioral health and/or substance use services. In some instances, this goal will best be accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to expand their scope of services in the context of integrated care models. As an alternative, the PPS will consider compliance with integrated certification regulations. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
23	Title 14, 600.2	We seek a waiver of 14 NYCRR 600.2 for projects 2.a.i.; 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. to permit behavioral and/or substance use providers to operate primary care under the oversight of the agency regulating them (OMH, OASAS or OPWDD) without the requirement of DOH approval. One of main DSRIP priorities is to stimulate the integration of primary care, behavioral health and/or substance use treatment services. This integration vision may be most efficiently accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to expand their scope of services. As an alternative, the PPS will consider compliance with integrated certification regulations. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
24	Title 14, 679.5	We seek a waiver of 14 NYCRR 679.5 for projects 2.a.i.; 3.a.i.; and 3.a.ii, to permit clinic treatment staff to conduct home visits and be eligible for reimbursement for services rendered within a patient's home. The reason for this request is that in order to promote mental health services and reduce the reliance on ED and inpatient use, innovative methods of ensuring that patients receive necessary treatment are needed; one such strategy may include the provision of such services within the patient's home, recognizing transportation and physical mobility barriers. Alternatives to this waiver that would permit such home visits do not exist. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.

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25	Title 14, Chapter XXI, 810 Establishment, Incorporation, Certification	We seek a waiver of 810, which outlines the establishment, incorporation, and certification of services related to Office of Alcoholism and Substance Abuse Services (OASAS) The HVC seeks this waiver for project 3.a.i, integration of primary care services and behavioral health, and 3.b.iii, behavioral health crisis stabilization. Under project 3.a.i, the HVC will cultivate three models: (1) the integration and co-location of OASAS services into primary care clinics; (2) integration and co-location of primary care into OASAS providers; and (3) the collaborative care model (telephonic behavioral health services) at sites where physical co-location is not possible. To execute this project, we will need to in some cases modify primary care facilities to incorporate mental health services and vice versa. Under project 3.b.iii, we will expand crisis stabilization services where they exist and develop needed outpatient and inpatient OASAS services. We intend to develop mobile crisis units staffed with clinical and peer staff to actively outreach to members in the community and provide urgent services. We are very concerned that the regulatory application and review process set forth in 810, including initial notification of local government units (LGUs), associated with the delivery of OASAS-related services will delay the timeline for these activities and undermine the likelihood of achieving DSRIP milestones; we therefore request a waiver of this provision. As an alternative, the HVC will need to revisit detailed project plans and potentially alter activities to no longer implicate 810, which may in turn diminish the extent of system transformation feasible. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to facility modifications, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
26	Title 14, 814.7	We seek a waiver of 14 NYCRR 814.7 of projects 2.a.i; 2.a.iv.; 2.b.iii.; 3.a.i. and 3.a.ii. to permit partner organizations who locate services in shared space with OASAS providers flexibility in the physical requirements of the space provided there is adherence to federal regulations One of the main DSRIP priorities is to transform patient care through integrating primary care, mental health services, and substance use treatment services. In order to collaborate and integrate, OASAS providers need to have flexibility to collaborate with other provides in their space and in the course of providing treatment. We seek to remove or limit impediments to the provision of integrated services. As an alternative, the PPS will consider compliance with integrated certification regulations. We believe that there are not substantial risks to patient safety in the waiving of this regulation. First, the HVC will seek to align with existing patient safety provisions related to service delivery, as articulated in state regulation, to the maximum extent possible Further, DSRIP performance metrics ensure that all PPSs will be held accountable to the highest of patient safety standards in the execution of project activities. Finally, DOH will also have ample time to review HVC project implementation plans at a high level before any activities commence – we believe this review step will ensure that all planned activities are in accordance with patient safety and other state DSRIP goals.
27	Title 14, Parts 822 and 841	We request that the Department of Health work with the Centers for Medicaid and CHIP Services on a state plan amendment (SPA) to move

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		OASAS services to the rehabilitation option of the SPA. This modification would permit Medicaid reimbursement of off site providers to provide home visits. Once OASAS is authorized, we will request waivers of relevant sections in 14 NYCRR Parts 822 and 841 to request OASAS to authorize home visits for substance use treatment.
28	Other	As the HVC engages in more extensive planning, we will request additional waivers that tie to more detailed project components. Potential future areas of inquiry include but are not limited to the following: Title 10: Part 83 Shared Facilities (parts beyond sub-part 83.2(a)); 715 Freestanding Ambulatory Care Facilities; 415.38 Discharge (Ventilator Dependent Persons) Title 14: 590 Comprehensive Psychiatric Emergency Programs; 590.5 Certification; 590.9 Services; 599 Clinic Treatment Programs; 599.1 Integrated Services; 599.5 Certification; 36.4 Discharge of Inpatient Patients into Community Settings; Part 77 Physical Plant Standards for Behavioral Health Facilities; 504.5 Placement of Individuals Leaving Transitional Care Funding; Part 521 Financial Assistance for Construction or Acquisition of Behavioral Health Facilities; Part 573 Issuance of OMH Operating Certificates; Part 587 Standards for Operating Behavioral Health Outpatient Programs; Part 592 Governing Comprehensive Outpatient Programs; Part 595 Governing Operation of Adult Residential Programs Title 14, Chapter XXI: 810.5 Full Review; 810.6 Administrative Review; 814 General Facility; 814.2 Building Code Requirements; 814.3 Requirements of all Facilities; 814.6 Additional Requirements for OP Facilities; 840.8 Full Review Process; 810.9 Administrative Review Process; 816 Chemical Dependence Withdrawal and Stabilization Services; and 822 General Service Standards for Chemical services and Dependence Outpatient and Opioid Treatment; Part 321 Regarding Financing & Construction of OASAS Facilities; 815.7 Discharge from OASAS Services; Part 816 Inpatient and Outpatient Chemical Dependence Withdrawal and Stabilization; Part 819 Standards for Chemical Dependence Residential Services; Part 822-2 Outpatient Chemical Dependency and Opioid Treatment; Part 822-4 Staffing and Treatment Plans for Chemical Treatment Programs; Part 822-5 Opioid Treatment Programs

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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

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

This section is broken into the following subsections:

- 2.1 Organizational Structure
- 2.2 Governing Processes
- 2.3 Project Advisory Committee
- 2.4 Compliance
- 2.5 Financial Organization Structure
- 2.6 Oversight
- 2.7 Domain 1 Milestones

Scoring Process:

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

- 2.1 is worth 20% of the total points available for Section 2.
- 2.2 is worth 30% of the total points available for Section 2.
- 2.3 is worth 15% of the total points available for Section 2.
- 2.4 is worth 10% of the total points available for Section 2.
- 2.5 is worth 10% of the total points available for Section 2.
- 2.6 is worth 15% of the total points available for Section 2.
- 2.7 is not valued in points but contains information about Domain 1 milestones related to Governance which must be read and acknowledged before continuing.

Section 2.1 - Organizational Structure:

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

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

Building on the structure we established for the planning phase, the Montefiore Hudson Valley Collaborative (HVC) selected Model 1 (collaborative contracting) for implementation planning. We intend to investigate Model 2 in implementation, and may develop a new IPA for this purpose.
Under Model 1, Montefiore will be the fiduciary, and we put in place a multifaceted organizational structure, similar to the structure used to date.
First, we will evolve our Leadership Steering Committee to broaden representation. This committee sets overall direction, ensures HVC is on track to achieve goals, validates implementation plans, and makes recommendations on strategic decisions such as collaborations and the process for member removal.
Second, we will evolve our Transformation Teams, which were created to set PPS-wide standards across the region. For the implementation period, we will put in place four Transformation Teams:
1) Finance & Sustainability: Provides input into funds flow model, budget, and approach for value-based arrangements.

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2) IT Infrastructure: Informs approach for data collection and reporting, EHR deployment, care management platforms, other IT enablers, and approach for driving adoption and connections with RHIO/SHIN-NY.
3) Care Management & Coordination: Aligns on common approach for care management and coordination, determines mechanism to balance central support vs. partner-based infrastructure, and identifies additional requirements for system & practice transformation.
4) System & Practice Transformation: Defines and implements change management strategy, assesses current capacity and future need of delivery systems, defines common clinical models, and identifies supports required for implementing evidence-based, coordinated and integrated care delivery.
Third, we will evolve our four Regional PACs, which will remain a forum for partner engagement and collaboration. In addition to acting as a vehicle for the PPS to facilitate individual partner implementation planning, the PACs will define an approach for local learning collaboratives during the implementation period, and will be asked to provide input on the PPS-wide support functions cross-PPS initiatives like public health campaigns. Lastly, the PACs will inform investments in regional resources for projects like 3.a.ii., Crisis Stabilization Services.
As stated above, we expect our governance model to continue to change to meet the changing needs of our PPS. As we move toward implementation, the HVC will leverage Montefiore's experience and legal standing as NYS's only Pioneer ACO to support value-based arrangements to support ongoing transformation and to ensure the long-term stability of the integrated healthcare system.

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: **19_SEC021_C:\Users\Razili Stanke-Koch\Documents\0. Montefiore\Application\Organizational application\Montefiore HVC Organizational Structure.pdf**

Description of File

Montefiore Hudson Valley Collaborative Organizational Structure

File Uploaded By: mmcjlam

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***Structure 2:**

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

We believe the structure outlined above will ensure adequate governance and management of the DSRIP program for the implementation planning phase. As we represent a broad and heterogeneous partnership group and geography, effective management will require (1) cross-regional committees to promote alignment, guidance, and oversight across the PPS, particularly for financial management and analytic activities; balanced by (2) regional committees to allow for a distributed, regional processes that provides local adaptability and autonomy in project implementation.
As described above, HVC's cross-regional committees include a Leadership Steering Committee (LSC) with two subcommittees and four Transformation teams. We will describe how these teams will promote alignment and oversight for the PPS.
The strong engagement and collaborative nature of our LSC to date has been crucial to our success to date. Moving into implementation planning, the LSC will continue to provide input on the crucial decisions required to set the PPS on a path for success in implementation planning. As partners that drive meaningful attribution, their involvement in setting a direction that works for their organizations and communities ensures we are setting the PPS up to maximize impact on our attributed population. As implementation plans are developed, the LSC will validate those plans, and then will demonstrate commitment and traction toward implementation.
During implementation planning, we will introduce two sub-committees of the LSC. First, a Legal & Compliance subcommittee charged with: creating PPS participation contracts to align with implementation plans; providing input on the next evolution of our governance structure (e.g., Model 2); identifying regulatory waivers; and advising on the compliance function. Second, a Capital subcommittee charged with: developing an approach for evaluating capital requests from partners; prioritizing those requests; and validating the capital application to be submitted in February.
The LSC will be supported in the execution of the above activities through the Transformation Teams. These committees include representatives from the PPS more broadly, and are responsible for defining (1) which services will be delivered centrally by the PPS and locally by partners; (2) what resources (i.e., financial, technical, professional) are expected to be required for each project; (3) which services are to be delivered by partners and the common standards and guidance for partners as they develop their implementation plans;

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(4) an approach for funds distribution that supports implementation (particularly in the early years), and rewards performance (particularly in the later years).
The committees described ensure consistency across the PPS, but as described above, success in the implementation planning phase will require that the plans are responsive to local realities and partner input. Our four Regional PACs will be the vehicle for local input, and will be vital for the planning for regional resources, public health campaigns, and to support individual partners as they develop implementation plans for their organizations.

***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.

In the planning period that is concluding with this application, we clustered our clinical Transformation Teams by DSRIP Domains, and had them led by subject matter experts within our PPS. These experts helped us shape our project plans to reflect the most current thinking and best practices.
As we look toward the implementation planning phase, we will need to (1) set more specific clinical standards for care, and (2) establish mechanisms for partner accountability against those standards. To facilitate this, we have maintained the same general committee structure, but have evolved the concentration of our teams to focus on the highest impact areas required for implementation.
As described above, we have two committees that will give input on which services will be provided by partners vs. centrally, and the quality standards and metrics required to set implementation expectations. First, our Care Management & Coordination committee, with its emphasis on the Domain 2 projects, will align on a common approach for care management and coordination, building off of Montefiore's extensive experience. Second, our System & Practice Transformation committee will evaluate current capacity and future needs of the delivery system to assess specific investments, and, with its emphasis on the Domain 3 projects, will identify the supports needed to implement agreed upon evidence-based practices.
These inputs will be important for the Finance and Sustainability committee as it develops the funding protocols and incentive payment standards that will be critical to holding partners accountable for the clinical outcomes required to hit project metrics. Additionally, the LSC will develop mechanisms for handling partner underperformance as revealed by standard and transparent reporting, including coaching and, if necessary, a partner removal process.

***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.

As it relates to the governance committee structure, we expect to maintain a central/regional framework throughout the performance period, but will continue to evolve the committee structure and specific charges to meet the needs of our PPS.
As it relates to the legal governance structure, we believe Model 1 is sufficient for the purposes of the near term work, but we will continue to reevaluate as our PPS matures toward value based models. The Leadership Steering Committee has evaluated possible options for Model 2 that would facilitate more comprehensive regional planning, and ease administrative burdens in contracting with payers for shared risk. This could include the development of a new IPA structure connected with Montefiore's existing structures for engaging payers and community partners, like Montefiore Pioneer ACO.

Section 2.2 - Governing Processes:

Description:

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

***Process 1:**

Please outline the members (or the type of members if position is vacant) of the governing body, as well as the roles and responsibilities of each member.

Montefiore is the fiduciary and lead applicant. We established a Leadership Steering Committee, established based on attribution, scope of services provided, and cross-regional presence, includes representatives from the following organizations: Coordinated Behavioral Health Services, Greater Hudson Valley Family Health Center, Greater Hudson Valley Health System, HealthQuest, Hudson River Health Care, Hudson Valley Care Coalition, Hudson Valley Regional County Department of Health, Hudson Valley Regional County Mental Hygiene Directors, Middletown Community Health Center, Montefiore Medical Center, Montefiore Mount Vernon, Montefiore New

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Rochelle, Nyack Hospital, Rockland Psychiatric Center, St. Luke's Cornwall Hospital, St. John's Riverside Hospital, St. Joseph's Medical Center, White Plains Hospital, and 1199SEIU.
We asked these organizations to identify members whose responsibilities would be to share their expertise and knowledge of their communities, represent the viewpoints of their organizations, identify and commit resources to address action items and contribute to a collaborative, innovative and constructive discussion.
Moving into the next phase, we will be adding repr

***Process 2:**

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

The HVC PPS Leadership Steering Committee was: charged with realizing the HVC's vision, representative of a range of provider types and geographies, made up of regional leaders demonstrating clinical excellence, able to contribute meaningfully to DSRIP planning, and was nimble and effective. We established this group by identifying members who had a broad scope of services, broad reach (e.g., multiple county presence; sole or one of few provider(s) of type in area, sizable attribution) as well as key leadership stakeholders (e.g., local commissioners, 1199). We will continue to do so throughout the DSRIP period.

***Process 3:**

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

The 26 members of our LSC represent all 7 counties in the HVC catchment area. FQHCs, health homes, hospitals, SNFs, DOH/DMH, CBOs, labor organizations are all included. Outside of the LSC, our Transformation Teams include 151 members from 73 organizations. There are a total of over 200 organizations in our 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.

We reached out proactively to CBOs and invited them to join the PPS. We also presented to local coalitions like the JMHCA in Orange County, to educate CBOs on DSRIP and the HVC, and to give them an opportunity to join our PPS. Through word of mouth, additional organizations reached out; we welcomed every request to join.
In terms of structure, all CBOs are members of the PPS and have the opportunity to join regional PACs for which they feel best suited. They also joined our Transformation Teams, adding critical input into project design. For instance, our PPSs strong commitment to peer-based services was a direct consequence the involvement of CBOs like the Empowerment Center in our committee structure. As these committees will continue forward into implementation planning, we anticipate continued involvement by CBOs.
In terms of contracting, we will contract with CBOs for various components of project implementation as necessary to accomplish the goals of DSRIP. HVC PPS is open to d

***Process 5:**

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

When we instituted our original governance structure, we aligned on a set of guiding principles to inform overall strategy and decision-making. We said we would:
Ground decisions in data, robust analytics, and evidence-based practices
Approach decisions collaboratively, transparently and with input from multiple perspectives (including stakeholders beyond PPS);
Adopt approaches that are centered around the voice and needs of our patients
Have a shared PPS vision
Promote local ownership of regional transformation
Focus on DSRIP requirements and long-term financial sustainability of integrated systems of care
To date, Montefiore remains the ultimate fiduciary and decision-maker for the HVC, but has sought input on decisions regarding major issues like governance models, funds flow, project selection, project design, etc., to be transparent and collaborative. As decision-making will become more complex moving into the implementation planning phase, and having selected the Collaborative Contracting Model, we will work with our partners through the LSC's Legal and Compliance committee to develop provider participation agreements that outline partnership responsibilities, and bylaws that detail formal voting protocols going forward.

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***Process 6:**

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

In our guiding principles, we commit to grounding decisions in data, robust analytics, and evidence-based practices. By adopting a fact-based approach, we hope to mitigate some potential conflicts and look to data to inform discussions and decisions. However, as in any diverse, multi-stakeholder environment, conflicts will most certainly arise. When this happens we will seek the input of outside experts and advisors to help facilitate discussions and provide additional perspective. Further, the participation agreements and bylaws noted above will outline standard processes for coming to resolution on decisions where not all PPS members are in alignment.

***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.

We are committed to maintaining a transparent process. All materials will be disseminated and are posted to a HVC SharePoint site, which can be accessed by all PPS members.
The DSRIP office has put in place a number of forums for communication. We soft-launched a website (http://www.montefiore.org/hudson-valley-collaborative), and have a contact email address (MontefioreDSRIPPlanning@montefiore.org) for DSRIP-related matters. We continue to host 'office hours' and Q&A sessions for partners, local government officials, etc., to provide garner feedback outside of the existing committee structure.
As we move into the next phase, we will host forums where partners, patients, families, and community members can ask questions and give input about the overall strategy and progress of the HVC. This could be in the form of presentations to community or organizational boards, sessions with local interest groups like the Central Westchester Geriatric Board, or town hall meetings.

***Process 8:**

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

We have created a variety of forums to engage local stakeholders and ensure robust level of community engagement. In the planning phase, we conducted surveys and focus groups to better understand our communities and inform our engagement strategy. We created specific committees within the Transformation Team and PAC structure charged with helping to identify local stakeholders and develop communications and engagement strategies. We hosted meetings in each of our four regions to share findings from the CNA and solicit input from our PAC members on the underlying drivers behind the data. We will continue to leverage the PAC structure as a forum for input and stakeholder engagement as we transition to implementation planning. We have also engaged a broad range of community stakeholders in our process, including local Departments of Health, Departments of Mental Hygiene, Department of Social Services, along with various associations and coalitions focused on improving health. We will cont

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.

Given the size of our PPS and breadth of our network, we decided to adopt an alternative PAC structure (as described in Section 2.1). As part of our overall organizational structure, we created four regional Project Advisory Committees (Westchester, Rockland, Orange /Sullivan, Dutchess/Ulster/Putnam), which were formed in June 2014. We analyzed regional healthcare utilization patterns to understand where residents were receiving care and where natural referral partnerships were already in place. After identifying the appropriate geographies, we invited our PPS members to join the regional PACs. Partners were encouraged to join one or more PACs based on their current footprint and service areas. To support the planning process, we also developed two PAC sub-committees in each region. Throughout the planning process, we had >250 people from 65+ organizations join one or more of our PAC committees. We continued to adapt the frequency, forum and format of our meetings to meet the needs of our partners and to adequately inform project planning.

***Committee 2:**

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

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We view our PACs as a critical forum for partner communications and for facilitating "matchmaking" among PPS partners in support of joint project development and implementation. As we shift to planning and implementation, the PACs will be charged with defining the approach for local learning collaboratives and informing the central PPS support function. The PACs will also provide input to collaboration efforts with other PPSs in the region, such as alignment on public health campaigns.

***Committee 3:**

Outline the role of the PAC in the development of the PPS organizational structure, as well as the input the PAC had during the Community Needs Assessment (CNA).

The PACs played a formative role in helping to define the PPS organizational structure. At the start of the planning phase, we hosted a webinar to seek input on a proposed structure. Our PAC members provided thoughtful feedback and recommendations on how to identify participants.
The Community Needs Assessment was jointly developed with the other PPS in the region. The CNA and Stakeholder Engagement Committee was a sub-committee within each of the four PACs. We hosted meetings in each of our four regions to share preliminary findings from the CNA and solicit input from our PAC members on the underlying drivers behind the data. We have also engaged our PAC members and broader community stakeholders in completing the healthcare and community resource assessment and in collecting the primary data in the form of surveys and focus groups.

***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 described above, participants were identified based on geography and functional alignment, with >250 people from 65+ organizations out of a total of 200+ organizations participating over the past 6 months. These 65+ organizations include all provider types in our PPS, as well as community based organizations, local government officials, and frontline workers from three of the largest unions in our PPS: 1199SEIU, NYSNA, and CSEU.

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.

HVC will create a series of functions to support compliance efforts. For the implementation planning phase, we are establishing a Legal/Compliance sub-committee to support the Leadership Steering Committee. This sub-committee will be staffed by one or multiple individuals charged with formulating and formalizing HVC DSRIP compliance and program integrity activities. This sub-committee will build upon the compliance function that already exists within Montefiore, in order to ensure proper governance and oversight. Montefiore also will bring to bear expertise in compliance associated with state and federal risk-taking programs (e.g., Pioneer ACO, MLTCP) carried out through the Montefiore IPA and Montefiore Care Management.

***Compliance 2:**

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

As lead applicant, Montefiore will generate regular performance reporting to help identify potential compliance problems, and will institute a process for regular audit and review of operations. Montefiore will also establish a compliance contact that allows PPS members, community members, and others to easily raise potential compliance issues. The Legal & Compliance committee will also review regular performance reports & provide feedback on an approach for interventions.

***Compliance 3:**

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

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HVC will develop compliance training for PPS partners that covers relevant fraud and abuse laws, a PPS hotline, and other relevant policies to be developed by the Legal & Compliance sub-committee. We will leverage training programs that exist within Montefiore, partner organizations and from the state and other associations to support training needed across the provider network. New training will be developed as needed to address circumstances that arise particularly with organizations that have limited existing programs. Partners will be required to certify that staff training has occurred for all appropriate staff. Further modifications will be determined as needed by the HVC's compliance official.
Additionally, all safety net providers are required, in accordance with their agreement to accept Medicaid reimbursement, to attest that they are in compliance with applicable rules and regulations.

***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 described in the sections above, we will utilize a series of tools, such as a compliance hotline, direct access to Montefiore's DSRIP office and web forums to provide a channel for community members, Medicaid beneficiaries and uninsured community members to file a complaint. We will work with the local commissioners and other community stakeholders to incorporate this information into broad based communications materials regarding DSRIP efforts.

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.

As lead applicant, and under collaborative contracting model, Montefiore will have fiduciary responsibilities. However, recognizing the success of the PPS relies on the contributions of a broad coalition of partners, Montefiore has engaged the LSC and the Finance Transformation Team to provide input to key financial decisions. HVC partners have contributed to decisions regarding the distribution of funds, aligned with overall PPS objectives set by the LSC. The re-formed Finance and Sustainability Committee will create transparent, easy-to-understand, reproducible criteria for funds distribution.
As part the DSRIP office, Montefiore will ensure that financial controls are established and maintained. Generally accepted accounting principles will be utilized as well as transparency and accountability to ensure that all participating providers are clear about the expectations, eligible uses and consequences associated with inappropriate use of DSRIP funds.
Additionally, we recognize that the long-term success of our PPS requires that our partners be financially sound. We have completed an initial financial assessment across PPS partners and will institute mechanisms to enable ongoin

***Organization 2:**
Please provide a description of the key finance functions to be established within the PPS.

Funds will be received by Montefiore and distributed to organizational partners, vendors and others based on criteria developed in partnership with PPS members through the Finance and Sustainability Transformation Team. As lead applicant, Montefiore will be responsible for expense management, financial reporting and analysis, audit, budgeting and funds flow forecasting, initiation of payroll and other expense processes, accounts payable, payroll, accounts receivable, financial controls and compliance. Within the DSRIP office, there will be a Finance function that will support the full range of functions required over the duration of the DSRIP period, connecting back to core services at Montefiore.

***Organization 3:**
Identify the planned use of internal and/or external auditors.

Montefiore has strong internal controls to assure achievement of its operational objectives, reporting and compliance, and has extensive experience managing flows of funds from external sources to external partners. The internal control system is reviewed and assessed annually by Montefiore's finance leadership and is review and assessed by external auditors.

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***Organization 4:**

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

Montefiore has an existing compliance program in accordance with New York State Social Services Law 363-d and will ensure that any HVC PPS compliance activities also accord with the relevant state law.

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 LSC, informed by the Transformation Teams, and with the guidance of the DSRIP office, PACs and broader PPS partners, will align on metrics and performance levels and ensure that process and evaluation criteria are transparent to the entire PPS. Through experience managing risk, Montefiore has strong capabilities to monitor performance and provide support to participating providers. Building from this experience and existing infrastructure, Montefiore, as lead applicant, will develop a robust reporting structure to track key clinical and financial metrics and milestones. We will provide regular reporting to the LSC and all PPS partners so they can understand their own performance, as well as the overall performance of the PPS. Montefiore will provide technical assistance and resources to ensure that the best outcomes and the highest quality and experience of care are delivered across the PPS.

***Oversight 2:**

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

We will establish a system for early identification of lower performing members and once members are flagged, we will provide immediate intervention support, including but not limited to the consultant capabilities of Montefiore's CMO, centralized change management support, learning collaboratives/peer support or connecting with New York's existing Quality Innovation Networks. In addition, learning collaboratives and/or technical assistance will be available to assist members in meeting the DSRIP goals. Performance data will regularly be shared with members and venues for high-lighting best practices and overcoming challenges will be available through a variety of delivery methods including regional meetings, webinars and on-site assistance.

***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.

As described above, Montefiore will take a series of actions to both identify underperformers, follow-up with support and technical assistance and develop a clear performance improvement plan. We maintain that removal would be a last resort, and only as agreed upon by the defined metrics and in accordance with the LSC criteria. We recognize that our wide network of partners reflects a variety of readiness stages. Some practices have been on the leading edge of recent health care transformations (e.g., have achieved Meaningful Use and Level 3 PCMH) and others are just beginning that journey. Therefore, we will invest significantly in tools & training in order to ensure all PPS partners achieve an acceptable level of performance.

***Oversight 4:**

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

As described in previous sections, we are committed to an open and transparent process. We will create multiple forums for Medicaid beneficiaries and their advocates to provide feedback to the PPS, such as community meetings and outreach as well as making available direct contact with the DSRIP office and the use of web-based technologies.

***Oversight 5:**

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

As part of our ongoing network management, we will implement systems and processes to track partners' performance over the DSRIP

period, and will create transparent network lists so that both partners, members and advocates are aware who is currently in the PPS. We also maintain close relationships with the Medicaid plans, allowing for information transfer between our DSRIP office and their members services departments.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

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

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

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

In July 2014 the CNA leadership of the PPSs in the Hudson Valley Region partnered to undertake an extensive regional assessment of community needs. We were guided by the CDC's Community Health Assessment and Group Evaluation (CHANGE) toolkit. We actively engaged our community; we have received over 4,700 responses from our resident survey, conducted 3 mini-groups of consumers to discuss barriers to access and health behaviors, conducted 7 focus groups with over 60 participants representing over 30 organizations, met with a group of 20 providers of mental and behavioral health, substance abuse and related services in Putnam County, and received 45 provider responses for surveys on HIT and/or cultural and health literacy. The needs and opinions of community stakeholders across sectors were gathered in a systematic way that included compilations of data into workbooks, chart books, and map books; surveys; focus groups, key informant interviews; and a public comment period. Rigorous analysis of extant health, socio-demographics, and built environment data enhanced our ability to identify DSRIP projects that focus interventions on individuals and communities most in need. To ensure broad representation across all community sectors, we met with and sought input from local teams established by each county DOH. All data analyses and chart-, map- and work books were shared as they were developed with providers and stakeholders across the region through public meetings with county health commissioners and project team meetings conducted by the PPS in the region.

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

needs assessment was designed within a geographic information science (GISc) framework. Detailed-level Statewide Planning and Research Cooperative System (SPARCS) data provided by Iona College, Medicaid claims data accessed through Health.NY.Gov dashboard, and Census information, were mapped to identify community needs by prevalence indicators for major diagnostic categories. Using SPARCS, we identified ER visits, hospitalizations and readmissions and analyzed trends over the past 3 years to identify negative quality indicators. We worked with the other PPS partners in our region and county health department teams for local surveys on capabilities to supplement secondary website information.
We reviewed information available to us through the DSRIP Dashboard, OpenHealth NY, and the OMH website. In addition, we undertook a comprehensive evaluation based on SPARCS for 2008-June 2013 for patients from the Hudson Valley, irrespective of the particular facilities at which these services were rendered, recognizing patient migration across various geographies. We identified the number of unique individuals served across the many service silos and across competing providers. We were then able to measure the number and frequency of readmissions over an extended period of time.
Prevalence rate information was analyzed using hotspot identification via the SatScan statistic. Perinatal data are from the NYSDOH Vital Statistics Program (2010-12).
We analyzed patient volume and disease burden by zip code using data from the Medicaid Chronic Conditions file available on OpenHealth NY (Appendix D1). The chronic health categories represented in the data file are: Diabetes Mellitus, Diseases and Disorders of the Cardiovascular System and Respiratory systems, HIV Infection, Mental Diseases and Disorders, Newborn and Neonates and

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Substance Abuse. Data tables are available in Appendix D2. Medicaid beneficiaries were mapped as raw counts and by densities (beneficiaries/sq mi).

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	51	30
2	Ambulatory surgical centers	685	81
3	Urgent care centers	13	5
4	Health Homes	14	12
5	Federally qualified health centers	66	30
6	Primary care providers including private, clinics, hospital based including residency programs	5048	2050
7	Specialty medical providers including private, clinics, hospital based including residency programs	43640	5900
8	Dental providers including public and private	366	80
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	129	70
10	Behavioral health resources (including future 1915i providers)	786	483
11	Specialty medical programs such as eating disorders program, autism spectrum early	133	60
12	diagnosis/early intervention	470	81
13	Skilled nursing homes, assisted living facilities	88	79
14	Home care services	177	87
15	Laboratory and radiology services including home care and community access	146	81
16	Specialty developmental disability services	22	8
17	Specialty services providers such as vision care and DME	253	30
18	Pharmacies	402	42
19	Local Health Departments	35	24
20	Managed care organizations	8	0
21	Foster Children Agencies	1	0
22	Area Health Education Centers (AHECs)	2	0

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

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

In order to best meet the needs of our community and to advance the goals of our PPS of decreasing avoidable ER/inpatient hospital use and improving overall care to members in our community, we intend to expand the number and availability of outpatient care services, including increasing the number of urgent care centers in the region (only 13 identified in the Hudson Valley), increasing the hours of availability of FQHCs, and expanding primary care capacity, particularly in regions of shortages, including Ulster County (through

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increased hours, recruiting of primary care providers, and using telehealth capabilities where feasible). Additionally, we believe expanded care management capabilities will be required to ensure improved care coordination for patients, particularly those with complex medical or social needs. As such, we will look to expand care management capacity within the Health Homes in our region and build additional care management capacity beyond the Health Homes as needed. Additionally, given that our partners have cited a frequent reason for non urgent ER visits to be access to lab/radiology services, this will also be an area for development, possibly within our medical village (particularly noting areas of shortages in Delaware and Sullivan counties). In order to address the behavioral health needs of the community, the high ER/inpatient utilization for behavioral health needs, and the consumers' health concerns about behavioral health issues as noted in the resident survey, we will expand the number of emergency/crisis intervention programs within the region (from the 21 existing) to best address and triage urgent behavioral health needs.

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	120	7
2	Food banks, community gardens, farmer's markets	48	4
3	Clothing, furniture banks	7	2
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	27	10
5	Community outreach agencies	252	80
6	Transportation services	13	3
7	Religious service organizations	71	0
8	Not for profit health and welfare agencies	123	0
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	22	11
10	Peer and Family Mental Health Advocacy Organizations	123	62
11	Self-advocacy and family support organizations and programs for individuals with disabilities	41	10
12	Youth development programs	92	3
13	Libraries with open access computers	142	0
14	Community service organizations	100	0
15	Education	650	3
16	Local public health programs	7	5
17	Local governmental social service programs	8	2
18	Community based health education programs including for health professions/students	126	0
19	Family Support and training	194	4
20	NAMI	8	2
21	Individual Employment Support Services	9	2
22	Peer Supports (Recovery Coaches)	16	8
23	Alternatives to Incarceration	8	0

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
24	Ryan White Programs	5	3
25	HIV Prevention/Outreach and Social Service Programs	50	35

***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.

As identified in the housing project summary by Karl Bertrand, homelessness and inadequate housing is a key issue in the Hudson Valley; there are 120 housing agencies available, but from our meetings with stakeholders and partners within our PPS, these resources are sparsely distributed (and often unavailable in rural counties) and are beyond capacity . In order to best meet this need, we will expand upon the housing services available. In our focus groups and in our resident surveys conducted in the Hudson Valley, transportation was highlighted as a key issue in accessing appropriate care. Given the sparse number of transportation services (13 identified), we will expand these services in order to improve access for our community members. Given that behavioral health issues are among the top 5 issues noted by residents in our resident survey in all counties in the Hudson Valley, expanding peer based community resources will be critical (e.g., only 7 recovery coaches in the Hudson Valley). As we are also planning to improve care and access for populations with special needs, developing the specialty community based and clinical services for individuals with developmental disabilities will also be a priority. Given that there are no Ryan White programs in the Hudson Valley, we will work with existing community based resources (HIV prevention/outreach programs, self-advocacy, community outreach, and community service organizations) to serve the HIV/AIDS population.

Section 3.4 – Community Demographic:

Description:

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

***Demographics 1:**

Age statistics of the population:

The median age for the region is roughly 42 years; however, the population is shifting. The aging population (≥65) in the region is expected to increase by 28.5% by 2020, outpacing NYS's projected growth of 22.4%; Orange and Rockland counties are comprised of younger populations, with median age of 36 years.

***Demographics 2:**

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

Although the majority population is White, the region has seen increases in minority populations. Mount Vernon (Westchester County) has New york's highest urban concentration of African American residents (60%). Hispanic and Asian populations are the fastest-growing minority populations, with 74% and 64% growth respectively across the region since 2000. Foreign-born residents represent a quarter of the population of Rockland and Westchester counties. Although most speak English, 19% in Westchester speak Spanish. .French and Spanish Creole, Portuguese and Yiddish are dominant languages in some of our communities with high levels of health needs. Health literacy challenges, as reported in a survey of over 50 providers in the region, are most prominent in communities where English is not the main language and is compounded when individuals are not literate in their native language. A major unmet need in the area is bilingual health educators, translators, and staff.

***Demographics 3:**

Income levels:

A microcosm of the U.S., the Hudson Valley has pockets of great wealth and pervasive poverty; median household income ranges from $40-93,000. In cities across the region fully one third of households spend two thirds of their income on housing costs. 6% (Putnam County) to 15% (Sullivan County) of households in the Hudson Valley had income of less than $15,000/year. 7% (Sullivan County) to 26%

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(Westchester County) of households had incomes over $150,000/year.

***Demographics 4:**

Poverty levels:

There are widely varying poverty levels across the counties, ranging from 6% in Putnam county to 19% in Sullivan County. Childhood poverty ranges from 6% in Putnam to 28% in Sullivan; there are cities within each county where childhood poverty rates exceed the national average. Approximately 46,000 grandparents live with grandchildren under 18 years of age and in over 25% of these households the grandparents have financially responsibility for care of the children.

***Demographics 5:**

Disability levels:

Approximately 10% of residents in the region are living with a disability. Disability among children and adults vary, from a low 7% to a high of 15% of the population within a county. Distinct disabilities such as hearing, vision, cognitive, ambulatory, self-care, or independent living difficulty, each affect 3-4% of the population.

***Demographics 6:**

Education levels:

Educational achievement varies but on average nearly half of adults have completed high school or college; dropout rates range from 8%-15% of adults 25 years or older. Unemployment for those 16 years plus has averaged 32-40% in the past few years in some cities, including Mt. Vernon, Spring Valley, Swan Lake, and Kingston.

***Demographics 7:**

Employment levels:

There are also widely varying levels of employment, which also mirror the poverty levels across the counties. Employment rates in the region varied from 53% (in Sullivan County) to 62% (in Putnam County) for those individuals over the age of 16, with 32% (Putnam County) to 40% (Sullivan County) of the population not in the workforce.

***Demographics 8:**

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

There are three psychiatric centers that provide comprehensive programs for those who require institutionalized care in the region, including one forensic center; one psychiatric hospital exclusively for children and adolescents; and one for adults 18 and older with serious mental illness. County jails have a total capacity of 2500 inmates and there are 12 state correctional facilities in the region. Conservative estimates indicate there are 3500 homeless. (Please refer to Appendix for a full report on homelessness and housing needs.)

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
19_SEC034_ECommunityProfiles_IncludingHealthOutcome.pdf	12/22/2014 03:53:43 AM	
19_SEC034_B2HousingStudy.pdf	12/22/2014 03:50:29 AM	
19_SEC034_B1CommunityProfiles-SESBuiltEnvironment.pdf	12/21/2014 08:05:49 PM	

Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

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Please describe the health of the population to be served by the PPS. At a minimum, the PPS should address the following in the response.

***Challenges 1:**

Leading causes of death and premature death by demographic groups:

Based on Vital Statistics data the 5 leading causes of death are heart disease, cancer, chronic lower respiratory diseases (CLRD), stroke, and unintentional injury. Among minority populations diabetes replaces CLRD. The top causes of premature death are cancer, heart disease, unintentional injury, CLRD, and stroke or suicide. On average, the ratios of Black non-Hispanics and Hispanics to White non-Hispanics percentage of premature death for the Mid-Hudson region are 1.99 and 2.29, respectively. A closer look at each county indicates a wider range of 1.92 – 3.01 for these groups compared to their White non-Hispanics counterpart.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

SPARCS data indicate that among Medicaid inpatient discharges, the top 5 conditions are maternal/child, behavioral health, digestive, respiratory, and heart disease. Age-adjusted preventable hospitalizations were below the 2017 objective of 133.3 per 10,000, with significant variation in rates ranging from 93.8 (Rockland)) to 128.1 (Delaware). Ratios of Black non-Hispanics to White non-Hispanics in Dutchess and Westchester are 2.01 and 2.22, respectively, significantly higher than the 2017 objective of 1.85 for these groups.

***Challenges 3:**

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

Based on the Medicaid Inpatient Prevention Quality data, risk-adjusted ambulatory care sensitive condition rates are 90% and higher for all 8 counties. Dutchess, Putnam, and Westchester are above 100%; Westchester has the highest rate of 117.4%. Specific PQIs are listed in the table in the attached CNA PDF report.
Information on Medicaid beneficiaries with behavioral health diagnoses by number of ambulatory care visits in the last 12 months; number of chronic conditions (diabetes, asthma, cancer, and child-birth related claims) and service utilization in our counties of interest is presented in Table 3 of the attached PDF CNA document.

***Challenges 4:**

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

CVD inpatient patterns revealed a large cluster in the Catskill region spanning most of Sullivan and Ulster, approximately half of Orange and zip codes in western Dutchess. There were geographically smaller isolated clusters scattered throughout Westchester. Clusters for CVD-related ER visits showed a different spatial pattern, with a large hotspot in Poughkeepsie and the Middletown/Monticello area. There were smaller clusters in Westchester and eastern Rockland.
When diabetes is examined by volume of Medicaid beneficiaries, large counts are seen in southern through northwest Westchester County, western Rockland, Orange County, western Dutchess, and the Kingston area in Ulster County. Highest volumes in Sullivan County are in Monticello and Liberty.
Both COPD and pneumonia hospitalization clusters had similar distributions to CVD,. Asthma, however, showed a different spatial pattern. There was no apparent large Catskill hotspot; there were clusters of elevated risk appearing around Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester.
Clusters of cancer hospitalization rates demonstrated different patterns than the previous diagnoses, with rates of total cancer patients showing a large hotspot in northern Ulster (including Kingston), much of Rockland (from Nyack to Stony Point), and a cluster in lower Westchester ranging from the Bronx border in the south up to Hartsdale. Cervical cancer clusters revealed a large hotspot in Ulster County, and smaller clusters around Yonkers/Mt. Vernon and in Bedford Hills. Breast cancer had a large cluster in Ulster and a large area of elevated risk in most of Westchester and Rockland counties (excluding Yonkers and Mt. Vernon). Colon cancer revealed two clusters in Ulster (Pine Hill and Kingston) and a relatively large hotspot in southern Westchester and southern Rockland. Respiratory cancer hospitalization rate clusters were similar to that for colon cancer, with a hotspot centered in Kingston, a cluster in southern Westchester, and a small cluster around Somers.
Behavioral health, mental health, and substance abuse clusters followed similar patterns described. Alcohol abuse rates showed smaller, more discrete hotspots around Kingston, Monticello, and Poughkeepsie, and clusters in northern Rockland, Nyack, and southern Westchester.
According to the NYS DOH, the number of HIV cases has consistently decreased over the last several years. Data from 2009-11 indicate

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that the region has an adjusted rate of 8.6 per 100,000, slightly higher than the central and northeastern regions but about average for upstate New York and significantly lower than NYC and NYS overall rates (36 and 20 respectively). Notably, Westchester County has the highest rate (11.6) among all counties. The region has a rate of 10.6 per 100,000 for syphilis, generally higher than upstate NY, but lower than NYC and NYS overall. The region has a rate of 34.2 per 100,000 for gonorrhea, lower than any region in NYS, including NYS overall rate. For chlamydia, the region has a rate of 238 per 100,000, lower than upstate NY and significantly lower than NYC and NYS overall rates.

***Challenges 5:**

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

The general area of western Orange and southern Sullivan revealed elevated risk for both pre-term and low birth weight births, which was also consistent with higher risk for late or no prenatal care. Lower Westchester also revealed consistent elevated risk for these same outcomes, particularly in Yonkers, Mount Vernon and Bronxville. The proportion of births covered by public insurance was also elevated in the Yonkers-Mt Vernon area and the entire Catskill region.

The proportion of total births delivered by C-section (primaries plus repeats) was highest in lower Westchester County; C-sections for both total births and those covered by public insurance revealed other clusters with lower risk but still statistically significant.

The five leading birth defects for the counties (birth data 2002-2004) are hypospadias & epispadias, obstructive defects of renal pelvis and ureter, ventricular septal defect, congenital hypertrophic pyloric stenosis, and undescended testicle. Delaware, Orange, Rockland, and Sullivan all reported Down Syndrome cases.

***Challenges 6:**

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

Common risk factors across the region (except Westchester) include childhood obesity, adult smoking, and adult obesity in Northern counties. Putnam and Delaware report high adult binge drinking. Age-adjusted suicide death rates per 100,000 range from 6 in Rockland to 18 in Delaware. In Orange and Westchester counties, hospitalization rates for violence from Black non-Hispanics to White non-Hispanics is above average. Similarly, that of Hispanics to White non-Hispanics is higher in Westchester.

With the exception of Westchester and Delaware counties, few have supermarket access, leaving many with inadequate access to fresh foods; with the exception of Westchester, few residents are served by community water systems with optimally fluoridated water, and 4 of 8 counties reported a high percentage of third graders with evidence of untreated tooth decay. Access to clean air for the region's residents who live in areas that adopted the Climate Smart Communities pledge (Dutchess, Putnam, and Delaware) report lower figures than the 2017 objective. Across all 8 counties, ~25% of workers use alternate modes of transportation to travel to work, compared with the 2017 objective goal of 49%.

***Challenges 7:**

Any other challenges:

According to NYS Vital Statistics data for Early Entry into Prenatal Care by County, in 2007 there was a decline in the number of women receiving care during the first 3 months of pregnancy in Orange, Ulster, and Sullivan Counties over a ten-year period. Orange County reported the lowest rate of 54.8% compare to NYS rate of 69.2%. Data from the same source (2010-2012) continue to show problematic areas at the zip code level for Percent of Births with Late or No Prenatal Care: 6 zip codes in Ulster County, 7 zip codes in Orange County, 14 zip codes in Sullivan County, and 8 zip codes in Westchester County have rates higher than NYS overall.

An analysis of the Prevention Agenda indicates 30 health status areas that are still in need of improvement including high adult un-insurance rates, low rates of adults who have a regular health care provider, and low percentage of children with the recommended number of well child visits in government-sponsored insurance programs. Orange County has multiple risk factors and low rates of adults who receive colorectal cancer screening, children with immunization series, and percent of children and woman with any health insurance

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Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

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

***Gaps 1:**
Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

The region has slightly fewer hospital beds per 100,000 than New York State (29.07 and 30.48 beds per 100,000, respectively). While these numbers may be similar to the state as a whole, the types of beds differ. The region has a higher proportion of physical rehabilitation, psychiatric and chemical dependence beds than the rest of New York State and fewer pediatric, pediatric ICU and general medical surgical beds. These differences are driven by regional specialty facilities. The region also lacks certain types of beds altogether such as hospice, transitional and swing beds. At a regional level, bed occupancy was 67.9% based on licensed beds and 74.2% based on staffed beds, suggesting the availability of a large amount of capacity for potential repurposing. As of 2012, all hospitals in the region were operating below optimal capacity (assuming an 85% occupancy benchmark) with the occupancy ranging from 32-83%.
Of the 9 hotspot zip codes identified by the PPS, 7 of them fall within defined MUAs (total population: 344,100). Designated MUA and HPSA by definition are areas with significant service gaps. Additionally, 5/7 counties in the Hudson Valley (covered by HVC) have primary care HPSAs (Orange, Rockland, Sullivan, Ulster and Westchester) and 6/7 have mental health HPSAs (Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester).
A noticeable gap is the availability of alternatives to the ER, including urgent care centers (only 13 identified in the region; many of our PPS partners have indicated at stakeholder engagement that the few urgent care centers available are not well distributed geographically). Our focus groups noted significant inconvenience in availability of outpatient healthcare appointments. Consumers indicated they are resigned to a 2-3 week wait time for an appointment and more if you are new patient, waiting 2-3 hours to see a doctor even when you have an appointment, limited weekday-only hours and, in more rural areas, traveling to areas closer to or in New York City to get proper care.

Primary care capacity is notably lower in Ulster County, with a low of 400 primary care providers per 100,000 in Ulster County (and a high of 2,100 in Westchester County). In these rural counties, outpatient provider shortages exist; our PPS partners note that these shortages impact poor health outcomes of members and drive increased ER utilization.
According to the DSRIP dashboard, there are 146 laboratories in the region, with a range of 3 or 4 providers in Delaware and Sullivan counties to about 50 providers in Westchester County. Given the relative shortage of these services in rural Delaware and Sullivan, these gaps are likely driving ER utilization, as our partners have cited a frequent reason for non-urgent ER visits to access to lab/radiology services. Given the high ER utilization and inpatient hospitalization for behavioral health needs, there is a noticeable gap in the number of emergency/crisis intervention programs; 21 exist in the region.

***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.

Our hotspot zip code areas have health professional shortages and most are in designated MUAs, which means availability of and accessibility to care is challenging and stressful. Causes for gaps in care in these areas encompass broader social determinants including higher poverty rates, lower levels of education, and a language other than English spoken in the household. All of these areas have higher levels of depression and mood disorders.
Discussions with community stakeholders and focus group participants indicate that households are disproportionately stressed due to long waits for care; limited transportation options; and interaction with providers who are often insensitive to language and cultural challenges and needs.
From our resident survey, 29% of members who visited the ER in the past year did so because of accessibility and availability gaps of outpatient providers, with 19% citing their physician's office not open at time of need, 6% indicating the ER was the closest provider, and 4% indicating there was no other place to go.
Within our focus groups, language barriers were cited as reasons for difficult doctor/patient communication, limiting access to proper information. Communication on many different levels is a barrier to optimal care, including difficulties in accessing help from insurance companies. Many of these consumers indicated in focus groups that they do not know whom to call, email, or visit, and they do not know where to turn for support. A few have case worker advocates who help navigate the healthcare maze, but most are unaware of such

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services.

Transportation was a barrier to care by our focus group members. Taxis are not affordable, and bus services often do not run at the later hours for doctor or hospital visits. Where transportation services do exist, focus group members indicated many show up late so the patient is late for their appointment and/or having to wait 2 hours or more to be driven home.

Financial concerns are an overarching issue in consumers accessing appropriate healthcare. In our focus groups, low income Medicaid patients indicated they are struggling to keep up financially and health-wise, with day to day living expenses superseding healthcare 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.

In order to develop sufficient outpatient primary care and behavioral health capacity, we will work with current partners in our PPS to expand current hours/days of services for and will ramp up staffing according to our workforce plan. Where needed (due to scarcity of providers) we will develop telehealth options for accessing scarcer/specialty health resources (e.g., child psychiatrists).
We will develop our medical villages to be "one stop shops" for patients and will bridge the gaps of lack of sufficient resources (e.g., lab/radiology services), that of insufficient transportation (as members will need less frequent trips to get all care performed), and that of insufficient communication between providers, as the providers will be in one village, facilitating communication.
Overwhelmingly we have identified the social determinants as being large drivers in prohibiting adequate healthcare for members. As such, we will develop a far reaching care management platform within project 2.A.III to address not only medical issues but the social determinants of health. Additionally, within project 2.A.I, we will develop an integrated delivery system to involve providers and community organizations to address all member needs and improve health outcomes.
To bridge the gap of insufficient culturally competent care, we will develop PPS-wide guidelines for culturally and linguistically appropriate services and allow partners the freedom to determine what will have the greatest impact for their specific communities (as outlined in our Cultural Cultural Competency and Health Literacy section).
To address financial concerns of our consumers, we will develop our PPS into an integrated delivery system and will work with payors in the region to increase coverage of needed services (both medical and social), thus decreasing out of pocket costs for members.

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).

We partnered with county and mental health departments of health and community services to establish teams to identify resources and provide outreach to groups affected by DSRIP. Working with county teams has assured representation from special population groups, healthcare participants not in our PPS, and critical sectors such as schools and work sites.
As part of the CNA, the PPS conducted a survey of Hudson Valley consumers on demographics and community health needs. The survey was drafted at a 6th-grade reading level and approved by health literacy experts. Available online and in paper form in 5 languages as of 12/01/14, the survey received >4,700 responses representative of the demographics of the region. We conducted 3 mini-groups to discuss barriers to access and health behaviors.

We conducted 7 focus groups with over 60 participants representing over 30 organizations, and explored behavioral health topics including perceptions of current use of services, suggestions on services integration, and perceptions of current use of ERs. We interviewed experts from organizations that have experience working with vulnerable populations and met with a group of 20 mental and behavioral health providers, substance abuse and related services in Putnam County. Forty-five providers responded to surveys on HIT and/or cultural and health literacy including (1) specific challenges that the PPS must address for success; (2) potential solutions; and (3)

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approaches to address the challenges.

Three mini-groups were conducted among Medicaid, uninsured and insured consumers from a mix of 7 counties: Dutchess, Putnam, Orange, Rockland, Sullivan, Westchester and Ulster. Two groups/12 individuals represented the Medicaid and uninsured population and 1 group/5 individuals comprised a mix of privately insured, Medicare and 1 Medicaid respondent. The objective was to provide input into community needs/gaps in the regional healthcare system, develop a program to address Medicaid patient needs, and transform the delivery system to better serve all populations.

The CNA, all meeting materials, workbooks and chartbooks were shared with our PPS partners. On a public website, http://www.montefiore.org/hudson-valley-collaborative, the entire CNA, the resident survey, healthcare and community-based resource chartbooks, and community profiles are available for review by the community.

***Community 2:**

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

We conducted 7 focus groups with over 60 participants representing over 30 organizations. Topics related to behavioral health included perceptions of current use of services and ERs, and suggestions about how to better integrate services. We interviewed experts from organizations like Gateway Community Industries and Hudson Link who have experience working with vulnerable populations. We met with a group of 20 providers of mental and behavioral health, substance abuse and related services in Putnam County.

Three mini groups were conducted among Medicaid, uninsured and insured consumers from a mix of 7 counties: Dutchess, Putnam, Orange, Rockland, Sullivan, Westchester and Ulster counties. Two groups/12 individuals represented the Medicaid and uninsured population and one group/5 individuals comprised a mix of privately insured, Medicare and one Medicaid respondent. The objective of this research was to provide input into a broader assessment of community needs/gaps in the regional healthcare system in order to develop a comprehensive program to address Medicaid patient needs and transform the delivery system to better serve and have impact on all populations.

***Community 3:**

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

There is a need to focus on care management and integrated care, "one stop" sites for care, involvement of peers in care, adequate IT connectivity between organizations, improved training for providers, improved care transitions, increasing the number of health care providers and accessibility, increasing urgent care outpatient appointments, increasing crisis mobile unit services/availability and respite beds, improving availability of transportation and housing services, and improving and working with external stakeholders to address behavioral health needs.
Residents often use the ER for care that may be handled on an outpatient basis; 20-30% of residents do not know how to access healthcare in the region.
Health literacy and cultural competency challenges included an inability to communicate in patients' native languages and an over-reliance and emphasis on written care documentation.
The IT survey indicated key areas for development: connecting to an HIE/bidirectional exchange of patient data from a RHIO, integrating primary care and behavioral health systems, interoperability among EHRs, and access to patient registries.

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.

[Montefiore Hudson Valley Collaborative] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	County Departments of Health	The 7 County (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester) Departments of Health and Health Commissioners	The County Departments of Health and Health Commissioners provide advice and guidance on evidence based strategies for project design and implementation, aid in outreach

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[Montefiore Hudson Valley Collaborative] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			and engagement of the community and stakeholders, and provide access to vital health data.
2	County Mental Departments of Health	The 7 County (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester) Mental Departments of Health and Health Commissioners	The County Departments of Health and Health Commissioners provide advice and guidance on evidence based strategies for project design and implementation, aid in outreach and engagement of the community and stakeholders, and provide access to vital health data.
3	County Departments of Social Service	County Departments of Social Service across the Hudson Valley provide social service needs to the poor and the near poor, as well as those who are unable to care for and protect themselves.	The County Departments of Social Service aid in outreach and engagement of the community and stakeholders and identify areas in which we can collaborate.
4	Joint Membership of Health and Community Agencies (JMHCA)	Health and Community Agencies across Orange & Sullivan counties	JMHCA is a great example of existing collaboration across providers in the Hudson Valley region, and has been a great source of input for project design and community engagement strategy
5	Ulster County Care Transitions	Community based organizations working together to improve care for residents in Ulster county	The Ulster County Care Transitions network highlights areas for collaboration of projects as well as provide a means for stakeholder and community engagement
6	Departments of Corrections and Probation	Departments of Corrections and Probation across Hudson Valley counties	We have engaged leaders in numerous counties to get input on project design and overall strategy for implementation. We plan to continue and increase engagement with these important stakeholders and we shift to implementation.

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.

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[Montefiore Hudson Valley Collaborative] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for an integrated delivery system	Health and community resources are currently very fragmented and operate in silo. Community members do not know where to turn for many services and desire a single point of contact to help navigate behavioral health, medical health, and support services. Community members need integrated care across the continuum to prevent potentially avoidable ER and hospital admissions.	PPS primary data collections, surveys, and focus groups Potentially avoidable ER visits and readmission PQI suite-composite of all measures-AHRQ PDI suite-composite of all measures-AHRQ
2	Need for effective IT connectivity between all provider types, including community organizations	Providers feel the critical IT capabilities they are missing include: the ability to connect to an HIE/bidirectional exchange of patient data from the RHIO, the integration of primary care and behavioral health information systems, and the interoperability of EHRs among organizations. Indeed, only ~40% of our partners are connected to the local RHIO, ~20% of our PPS partners are PCMH level 3 2014 (compared with the State average of 25%), and ~30% receive Meaningful Use incentives. This lack of sufficient information sharing and lack of accessibility of information may lead to potentially preventable ER and hospital admissions and suboptimal care for members.	PPS primary data collection and IT survey, focus groups, and stakeholder engagement meetings Potentially avoidable ER visits and readmission PQI suite-composite of all measures-AHRQ PDI suite-composite of all measures-AHRQ New York State Innovation Plan report, Dec. 2013
3	Need for Improved outpatient care for patients with cardiovascular diagnoses	Based on vital statistics data, cardiovascular disease was the primary cause of death and the second leading cause of premature death in the Hudson Valley, indicating a greater need to improved diagnosis and treatment. This is also a condition that weighs heavily on the residents in the Hudson Valley, as they indicated cardiovascular disease as an area of health concern (ranked #3/17) in the resident survey.	NYS DOH (2014). Leading causes of death in NY state. PPS primary data collections, surveys, and focus groups NYS DOH. (2014). Vital statistics of NYS. NYS DOH. (2014). NYS prevention agenda dashboard. Salient interactive miner, 3/2013-2/2014 PQI # 7 (HTN)—AHRQ PQI # 13 (Angina)—AHRQ
4	Need for improved screening and early detection of breast, cervical, and colon cancer	Based on vital statistics data, cancer is the primary cause of premature death and the second leading cause of death in the Hudson Valley, indicating a greater need to improve preventative screening. Preventative screening for breast, cervical, and colon cancer, some of the most common cancers, are lower in the Hudson Valley than State average. This is also a condition that weighs heavily on the residents in the Hudson Valley, as they indicated cancer as their top area of health concern (ranked #1/17) in the resident survey.	NYS DOH. (2014). Leading causes of death in NYS. PPS primary data collections, surveys, and focus groups NYS DOH. (2014). Vital statistics of NYS. NYS DOH. (2014). NYS prevention agenda dashboard. Salient interactive miner, 3/2013-2/2014
5	Need for improvement in disparities in	The ratios of Black non-Hispanics and Hispanics to	NYS DOH. (2014). Vital

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[Montefiore Hudson Valley Collaborative] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	health outcomes for minorities	White non-Hispanics percentage of premature death span up to 3x for these minority groups compared to their White non-Hispanics counterparts in the Hudson Valley. These statistics highlight the need for improved healthcare and outreach for minorities within the Hudson Valley.	statistics of NYS. NYS DOH. (2014). NYS prevention agenda dashboard. NYS DOH. (2012). NYS minority health surveillance report.
6	Need for improved access to quality outpatient providers as an alternative to the ER	Five of our 7 PPS counties have primary care HPSAs and 6 counties have mental health HPSAs; for primary care, staffing levels are much lower in medically underserved areas (which exist in every county except Putnam) in the Hudson Valley. There is a noticeable shortage of alternative sites for urgent care within the Hudson Valley, with only 13 urgent care centers identified. These shortages lead to insufficient access to outpatient care and increased utilization of ER and inpatient services. In fact, residents cite the primary reasons for traveling outside their county is for better care and because there are no providers in the county.	PPS primary data collections, surveys, and focus groups The NYS DOH, (2014). Provider List - October 1, 2014. The NYS Education Department, Office of the Professions, (2014). NYS Licensed Professions. Health Resources and Services Administration (HRSA). Guidelines for MUA and MUP
7	Need for expanded community services, including transportation and housing	Lack of transportation and lack of information on where to seek assistance in accessing transportation is a major barrier to proper healthcare, particularly in rural Hudson Valley counties. Indeed, only 13 transportation agencies were identified across the Hudson Valley, indicating a distinct shortage. Residents note that the few services that are available are often unreliable and have excessively long wait times. Housing is also an area of need in the community, with homelessness and housing instability being prevalent conditions. The agencies that provide these services, however, are unevenly distributed and often unavailable in rural counties.	Housing project summary, Karl Bertrand PPS primary data collections, surveys, and focus groups Guidestar, Up-to-Date Information on Thousands of Non-profit Organizations Idealist, Up-to-Date Information on Thousands of Non-profit Organizations, Retrieved
8	Need for integrated care delivery between primary care and behavioral health	SPARCS data demonstrate that behavioral health disorders are one of the top five Medicaid inpatient conditions in the Hudson Valley. In our PPS, 32% of members had both a behavioral health and non-behavioral health diagnosis, suggesting the magnitude of the opportunity in improving integrated care for patients with both behavioral and medical needs.	Salient interactive miner SPARCS database PPS primary data collections, resident surveys, focus groups, stakeholder engagement meetings Health.NY.Gov dashboard NAMI of New York State, (2012). NAMI NYS Affiliates. NYS DOH, (n.d.). Mental health program directory
9	Need for increased integration and access to behavioral health peer resources	Behavioral health issues are among the top 5 issues noted by residents in our resident survey and area top reason for ER utilization in the Hudson Valley, indicating the importance of this health issue. There is a desire for increased usage of peers in	Health.NY.Gov dashboard Salient interactive miner PPS primary data collections, surveys, and focus groups

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[Montefiore Hudson Valley Collaborative] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		integrating behavioral health with primary care and in transitioning patients between levels of care and providers.	NAMI of New York State, (2012). NAMI NYS Affiliates. NYS DOH, (n.d.). Mental health program directory NYS OMH (2014). County capacity and utilization data book
10	Need to improve health disparities in areas of poverty in the Hudson Valley	There are widely varying poverty levels across the counties, ranging from 6% in Putnam county to a high of 19% in Sullivan County. There are hotspots of disease in this region as well, including cardiovascular hospitalizations, beneficiaries with diabetes, and tobacco use. Improving these disparities and health outcomes is imperative to building healthier communities.	Health Data NY PPS primary data collections, resident surveys, focus groups, stakeholder engagement meetings DSRIP NY Dashboards Salient interactive miner NYS DOH. (2014). New York state prevention agenda dashboard
11	Need for "one stop" shop for health and community services	Given the difficulty in obtaining convenient and adequate transportation and the often large distances members must travel for different types of care (particularly in the rural counties), residents indicated the desire for "one stop" service sites, offering an array of services. Unused space within hospitals provides an ideal opportunity to meet the needs of the community while optimizing resource use.	Medicare cost reports, 2009-2012 AHA survey 2011, 2012 SPARCS database PPS primary data collections, resident surveys, focus groups, stakeholder engagement meetings
12	Need for increased behavioral health crisis stabilization services	Based on Salient interactive miner, the top utilizers in our PPS had inpatient admissions most frequently for behavioral health diagnoses, including substance related disorders, alcohol related disorders, mood disorders, and schizophrenia. Many of these diagnoses are amenable to outpatient urgent care and could have been diverted from unnecessary ER and inpatient utilization. However, only 21 crisis intervention programs were identified in the Hudson Valley, which have limited availability and breadth in geography. This presents an opportunity to expand upon crisis stabilization services to better serve the community and provide more efficient care.	Salient interactive miner PPS primary data collections, resident surveys, focus groups, stakeholder engagement meetings Health.NY.Gov dashboard NAMI of New York State, (2012). NAMI NYS Affiliates. NYS DOH, (n.d.). Mental health program directory NYS OMH(2014). County capacity and utilization data
13	Need for improved evidence based practices for asthma	In 2012, the second highest ER diagnosis for the Hudson Valley was asthma (8%). With appropriate outpatient care, nearly all of the ER visits were potentially preventable. Although there are pockets of providers actively engaged in evidence based practices for asthma, these need to be instituted more broadly.	Health.NY.Gov dashboard PQI #15 (Younger adult asthma)—AHRQ PDI #14 (Pediatric asthma)—AHRQ Asthma med ratio (age 5-64)—NCQA Med mgmt for people with asthma (5-64)-50% of treatment days covered--

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DSRIP PPS Organizational Application

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[Montefiore Hudson Valley Collaborative] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			NCQA Med mgmt for people with asthma (5-64)-75% of treatment days covered--NCQA
14	Need for increased smoking cessation efforts	Smoking rates in the Hudson Valley range up to an astonishing 29% (in Sullivan County), much greater than the New York State Prevention Agenda goals. Despite the high smoking rates, there is low utilization of smoking cessation tools in our region, with only 17% of smokers using the smoking cessation benefit (vs. State target of 40%). Given the morbidity and mortality associated with smoking, increased efforts must be made in our region.	2010 New York State expanded behavioral risk factor surveillance system New York State Department of Health. (2014). New York state prevention agenda dashboard. Salient interactive miner

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
19_SEC038_GCommunityBasedOrganizationsWorkbook.pdf	12/22/2014 06:12:29 AM	
19_SEC038_F_Health Care Resources_120814.xlsx	12/22/2014 06:11:06 AM	
19_SEC038_D3CRHI-Community-Needs-Assessment-Lower-Hudson-Valley-Seven-County-Disease-Prevalence-Clusters.pdf	12/22/2014 06:10:20 AM	
19_SEC038_D2Bene_Summary_Tables_COUNTY_and_ZIP_PLUS_CANCERS_100214.pdf	12/22/2014 06:09:21 AM	
19_SEC038_D1Mapping Methodology for Medicaid Beneficiaries for Selected MDC_EDC VolByZip.pdf	12/22/2014 06:08:25 AM	
19_SEC038_CPrevalence Rate Mapping Methodology_SatScan Statistic.pdf	12/22/2014 06:07:43 AM	
19_SEC038_A4HIT_HIE SurveyofCapabilities_InstrumentandResults.pdf	12/22/2014 05:55:33 AM	
19_SEC038_A3DSRIP Organization Input Sheet_FINAL_CulturalCompetency.pdf	12/22/2014 05:54:21 AM	
19_SEC038_A2CommunitySurvey_InstrumentandResults.pdf	12/22/2014 05:52:51 AM	
19_SEC038_A1Focus Groups_Recruitment ProcessGuidesandResults.pdf	12/22/2014 05:52:00 AM	
19_SEC038_Complete CNA.pdf	12/22/2014 05:50:45 AM	

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **Montefiore_Section4_Text_Montefiore HVC - project template FINAL.docx**

Description of File

Project plan application

File Uploaded By: mmcjlam

File Uploaded On: 12/22/2014 11:12 AM

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

Currently Uploaded File: **Montefiore_Section4_ScopeAndScale_DSRIP Project Plan Application _Scale & Speed 20141222 v2.xlsx**

Description of File

Scale and speed

File Uploaded By: lrichmon

File Uploaded On: 12/22/2014 03:42 PM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

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

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

The economic vibrancy of the PPS region is crucial to good health outcomes. DSRIP will have wide-ranging impacts on many of the 75,000-100,000 employees in our PPS. Despite reductions in IP/ED volumes that will lead to reductions in workforce, plus natural attrition and turnover, we expect a parallel increase in outpatient and community-based care, care management, and administrative functions, and anticipate hundreds of new opportunities will be created across our PPS. We will strive for no net reductions in workforce unless staff is unwilling or unable to be retrained or redeployed.

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The Hudson Valley Collaborative (HVC) includes organizations across the continuum of care, and staff that span the breadth of functions in these organizations. A categorization of roles allowed us to develop a detailed understanding of the anticipated impact of DSRIP initiatives. We anticipate the following positions will be affected:

1) Acute care clinical staff (Inpatient/ED)
- Physicians/PAs/NPs/APRNs
- Nurses (e.g. RNs, LPNs,)
- Non-professional patient care (e.g., NAs, PCTs)
- Patient Navigators
- Allied Health professionals (e.g. Physical therapists, respiratory therapists, nutritionists, social workers)

These staff are likely to be affected by an acceleration in already declining volumes in these care settings. These staff members will need support moving to new care settings, and training to prepare them for new roles.

2) Ambulatory care staff (Medical and behavioral health)
- Physicians/PAs/NPs/APRNs
- Nurses (e.g., RNs, LPNs)
- Non-professional patient care (e.g., NA, PCTs)
- Chronic Care RNs
- Referral Coordinators
- Patient Service Reps
- Allied Health professionals (e.g. Physical therapists, respiratory therapists, nutritionists, Dental technicians)
- Dentists
- Mental health specialists, psychologists, MD psychiatrists, Psychiatric NPs
- Population Management experts
- Case managers
- Social Workers
- Home health workers
- Nutritionists
- Healthcare Counselors
- Paramedics and Emergency technicians
- Ambulatory Care practice managers

The ambulatory care system will see an increase in volume, and will require an expansion in workforce, to be filled through retraining or new hires. Training will be required to increase familiarity with community-based care integration and coordination, and the implications the transition to value-based payment models.

3) Community-based care delivery staff
- Visiting nurses/Home health aides
- Patient educators/community health workers
- Peer coaches/ Peer support staff
- Crisis intervention professionals

Community-based care settings will see an increase in volume, and will require an expansion in workforce, to be filled through retraining or new hires. Training will be required to increase familiarity with community-based care integration and coordination, and the implications the transition to value-based payment models.

4) Healthcare-related administrative and supporting staff
- Data analysts and statisticians

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■ Human Resources Professionals
■ Training and development staff
■ Registration clerks
■ Financial counseling staff
■ Translators/foreign language speakers
■ Communications and media experts
■ Marketing professionals
■ Managers/Supervisors
■ Ancillary workers
■ IT staff

Administrative and support staff will experience a change in the nature of care they are supporting, as care increasingly shifts to outpatient and community settings, and becomes more integrated, with a greater focus on coordination.

5) Staff to support transition
■ DSRIP program office staff
■ Process redesign experts
■ Human Resource / labor experts

These will be DSRIP-specific roles critical to ensuring a smooth rollout of DSRIP projects and achieving the goals of the DSRIP program

***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.

The 'HVC 2020' workforce strategy has the following key components:
1) Recruitment and redeployment: We will focus on partners under financial distress and partners most susceptible to volume reductions (e.g., hospitals). We will develop mechanisms to identify new roles that can be filled on a voluntary and "fit-for-role" basis (aligned with contractual guidelines where applicable), provide support for trainings for displaced employees to build skills required for new roles, facilitate the identification of comparable positions across the PPS for those with limited training options, and support education of staff choosing to leave or retire. Redeployment and staff retraining will be a top priority, and will be facilitated by our planned PPS job posting board and complementary employment tools, like a redeployment pool.
2) Training: We anticipate that many employees, even those staying in their roles, will require some form of training. We will leverage the 1199 Training and Education Fund, and their long-standing collaborators, the Montefiore Learning Network and Care Management Learning and Innovation Center, for existing and custom modules to support workforce needs. In addition to technical skills required to implement DSRIP projects, training will be aligned with the broader goals of DSRIP, with a focus on systems understanding, skills, mind-sets and behaviors to enable coordinated, integrated and evidence-based care.
3) Rapid response services: While we anticipate minimal net job loss, professionals and paraprofessionals in acute-care settings are most likely to have the least opportunity for redeployment. We intend to pursue rapid response services, in conjunction with existing labor unions and directly with non-union workers, as an early intervention to these workers. Rapid response case management includes: career counseling, job search assistance for non-union workers, employment workshops and support to help employees cope.

As one of our chief workforce vendors, 1199 SEIU Training and Employment Fund (TEF) brings deep experience in retraining, redeployment and worker engagement strategies, and is skilled at developing and implementing approaches for both unionized and non-unionized organizations. Because frontline supervisors have difficulty creating the system change needed to transform care delivery, TEF's labor management project creates a team-based approach to redesigning systems.

Moreover, as evidenced by its retention track record during a decade of network expansion, has extensive experience with managing workforce issues through restructuring, bolstered by proven training and career development practices. Montefiore Care Management now

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employs over 1,000 employees, many of whom previously held positions in acute care settings. A clear strategy, commitment to employee advancement and retention, and strong union partnerships have been key elements of success.

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The HVC identified current shortages in both health professional resources and community-based personnel as part of our CNA:

a) Health professional shortages: Using data from the Center for Health Workforce studies, we identified 38 Health Professional Shortage Areas (HPSAs) across our 7 counties, and assessed the number of members eligible for care management. Across clinical and support staff, we anticipate the need to create 200-250 new FTEs to account for these shortages.

b) Community-based resource shortages: We identified key community resources that need to be fortified before DSRIP programs can be fully implemented, including peer staff for coaching and crisis intervention, mobile crisis teams, and respite facilities staff.

Future demands for ambulatory and community-based services upon successful implementation of DSRIP projects will necessitate additional expansion of staff beyond what was identified by our analysis of current shortages.

***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	.49%
Retrain	.35%
New Hire	.76%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

Please outline the expected workforce retraining. Describe the process by which the identified employees and job functions will be retrained. Please indicate whether the retraining will be voluntary.

We will begin by profiling the types of retraining and education required and the number of individuals requiring each type of retraining. For the purposes of this section, retraining is expected when training for and/or movement to a new role is anticipated.

Retraining needs are anticipated to fall into four categories:
1) New site of care: Employees expected to transition from inpatient to outpatient sites of care will require orientation to responsibilities and to the community being served.
2) New function: Many will assume new roles ranging from a modest change (e.g., discharge planning social worker to community-based social worker) to a major up-skilling (e.g. administrative professional to social worker).
3) New process or workflow: Staff with the technical skills and qualifications to perform new work processes will need training, including but not limited to formal operational efficiency training (e.g., Lean or Six Sigma).
4) Cultural competency: Beyond training for new roles, across all functions and staff, the HVC will support training programs aimed at creating culturally competent organizations and services.

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To ensure the effectiveness of the training and education programs, we will employ adult learning methods, and leverage a broad range of forums (e.g., in-person, online, web-based modules, on the job, skills training).

We have identified two vendors with a longstanding collaboration: Montefiore Learning Network and the Care Management Learning and Innovation Center, and the 1199 Training and Education Fund (TEF). TEF and its partners will leverage state and federal grant funding to provide training and education in: community health, care management, interdisciplinary team work, advanced skills for home health aides, cultural competency, and other areas identified as DSRIP planning continues.
We intend to support training for incumbent workers and community members in the early years of DSRIP implementation, creating a larger talent pool and minimizing negative impacts to the workforce in the later stages of implementation. As lead applicant, Montefiore has extensive experience developing these programs; as evidence of leadership's commitment to education, Montefiore's President and CEO, Dr. Steven Safyer, serves on the board of the Josiah Macy Foundation, which is active in inter-professional education. This commitment has emerged in a number of forms. For instance, in addition to Montefiore's strategic partnership with the Albert Einstein College of Medicine, Montefiore has partnered with the TEF in a learning collaborative that offers career pathways that facilitates entry-level staff advancement through training and educating, and has partnered with colleges and high schools to prepare young people for the skills needed in health care. Building off of these successful models, the HVC intends to partner with community colleges (e.g., through the Phipps Neighborhood Career Network) to develop academic curricula for students leading to internships.
Montefiore's partnership with Albany Medical Center will also allow the HVC to leverage their capabilities as a leading educational institution.

At-risk employees will have the option to determine whether they intend to seek retraining to support a transition to a new role, and thus will be voluntary, but highly encouraged. Other forms of training will be less optional. For instance, newly recruited staff will receive mandatory training to orient them to their new organization, and staff redeployed to different departments/ locations are expected to require retraining commensurate with the change. Existing employees whose current roles are changed by DSRIP will require training to succeed in their position . Where new credentials or skills are needed for specific incumbent job titles (e.g., asthma certification), the training or credential may be mandatory.

***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.

Even as we seek to maintain no net reductions in workforce, we expect to see changes in the skill sets required across the PPS, and this is likely to have an impact on wages and benefits.

We anticipate that employees who will be retrained and transitioned to a new role will more often be moving to an ambulatory or community setting where pay is historically lower. Compensation will be at the discretion of the individual partner and their policies/procedures. However, the HVC has established a commitment to a fair Living Wage. Where possible, redeployment of staff will take place to positions of equivalent compensation, which will be partially achieved by providing voluntary redeployment opportunities. In situations where re-deployment would result in a decrease in wages, we will encourage policies such that employees will be presented with the option of retraining to maintain wage parity.

For employees remaining in their current department, we expect no change in compensation, unless roles change substantially to meet new work requirements. As above, compensation will be at the discretion of the individual partner and their policies/procedures.

***Retraining 3:**

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

We believe every effort should be made to identify individuals on a voluntary basis. Partners will be expected to follow protocols and collective bargaining agreements (if applicable) for informing employees of possible retrenchments/layoffs, bumping and seniority rights, and other considerations. If individuals refuse assignment, effort should be made to find roles consistent with training and goals. Additionally, mechanisms like the job posting board will allow employees to seek more suitable jobs, and a redeployment pool will allow hiring entities to identify candidates.

We expect that individuals who refuse will be given finite time to pursue the alternative opportunities outlined above. The HVC will make public employment counseling opportunities, through TEF or other entities.

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***Retraining 4:**

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

The HVC involved representatives from the largest unions represented among our PPS partners – including 1199 & the TEF, NYSNA, CSEU – to jointly develop this workforce strategy. Representatives participated across our Planning Period governance structure, from the Leadership Steering Committee, to the Workforce Transformation Team, to our regional PACs.

We anticipate increasing labor involvement in planning during the DSRIP performance period. Labor representatives and the TEF will play a key role in the identification of training needs, provide input on curricula and provide training in some cases.

***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	82%
Partial Placement	18%

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.

To maintain our commitment to a fair and living wage and our intention that our work result in no net workforce reductions, redeployment is the fastest and most cost-effective method of filling key staffing needs. For the purposes of this section, redeployment involves transferring staff to different entities that require hiring to fill the positions, but where the responsibilities are similar to current roles. Staff remaining in their home department but changing roles and/or job class are not considered to be "redeployed," and these changes will be coordinated between the department, HR, labor representatives, and the individual. While these changes are voluntary, the individual will understand that remaining in their current role and job class may not be an option.

Guided by a Workforce lead in the DSRIP office, and supported by a committee of partners focused on workforce issues, we will collaborate with our workforce vendors to innumerate the workforce implications of our implementation plans, which would include key aspects of redeployment: assessment of staff additions and reductions, and PPS-wide standard guidelines of competencies, skills and performance standards. The plan will be updated regularly to ensure it is consistent with facts on the ground.

With guidance from the DSRIP office, HVC partners will identify the staffing implications as it relates to the projects undertaken, including vacancies and transitions, existing staffing level and capabilities, and an assessment of employee willingness to be redeployed. We expect partners will work with department managers to conduct a review of individuals (including shift, skill set, and job title), and confer with HR to determine if individuals on the list belong to a protected class. In the case of poor performance, individuals will be performance-managed or released and will not be eligible for redeployment.

We intend to develop mechanisms match needs with the availability of redeployment-eligible individuals. Chief among these mechanisms will be a PPS-wide job posting board and complementary employment tools, like a redeployment pool.

The redeployment approach outlined above will support DSRIP goals and involve transitioning employees at inpatient and acute care sites to ambulatory and community-based settings. This redeployment will also imbue the skills and mind-sets necessary for our employees to thrive in a system where value-based payment models are the norm. The approach we have designed acknowledges the risks inherent in this transformation, including salary and geographic displacement, and skill and cultural mismatches. Multiple mechanisms, outlined below, exist to mitigate these risks. In brief, these mechanisms provide for multiple options for individuals affected by temporary displacement during this necessary transformation.

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***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.

Every effort will be made to keep employees "whole" and the HVC has articulated a commitment to maintaining a fair Living Wage. Before individual is offered or selected for redeployment, we expect partners will prepare a position packet with a detailed comparison between the current position and the future position, including location salary, benefits, role, responsibility, and training requirement in terms of time. We have recommended guidelines such that, if new compensation is ≤5% lower than current compensation, compensation will not change. We estimate 80% of employees identified for redeployment will have no change to compensation, and 20% will have compensation between 75% and 95% of their current compensation.

Since retraining often goes hand-in-hand with redeployment, we are working with training vendors outlined above to scale up existing training infrastructure to support DSRIP-related needs.

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

We believe every effort should be made to identify individuals on a voluntary basis. Partners will be expected to follow protocols and collective bargaining agreements (if applicable) for informing employees of possible retrenchments/layoffs, bumping and seniority rights, and other considerations. If individuals refuse assignment, effort should be made to find roles consistent with training and goals. Additionally, mechanisms like the job posting board will allow employees to seek more suitable jobs, and a redeployment pool will allow hiring entities to identify candidates.

We expect individuals who refuse assignment will be given a finite amount of time to pursue the alternative opportunities. The HVC will make public employment counseling opportunities, through TEF or other entities.

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

The HVC involved representatives from the largest unions represented among our PPS partners – including 1199 & the TEF, NYSNA, CSEU – to jointly develop this workforce strategy. Representatives participated across our Planning Period governance structure, from the Leadership Steering Committee, to the Workforce Transformation Team, to our regional PACs.

We anticipate increasing labor involvement in planning during the DSRIP performance period. Labor representatives will play a key role in the continuing to advance our redeployment plans, including guidance and standards from the HVC to partners.

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.

Redeployment and staff retraining will be the first priority. We anticipate that new hiring will support further unmet needs after these interventions have been put in place, and will be driven chiefly by the need for integration of care, and transition of services from inpatient settings to ambulatory and community-based care. The roles we anticipate hiring for include:

1) Ambulatory care clinical staff (medical and behavioral health)
■ Physicians/PAs/NPs/APRNs: to fill the need for expanded primary care services.
■ Nurses, Nurses Assistants and PCTs: to staff-expanded primary care services, multi-specialty clinics and co-located ED primary care services, and provide patient education.

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■ Allied Health professionals (e.g., physical and respiratory therapists, nutritionists, paramedics and emergency technicians, dental technicians): to support critical interventions required to reduce preventable utilization.
■ Dentists: to staff new or redesigned multi-specialty clinics and medical villages.
■ Mental health specialists, psychologists, MD psychiatrists and psychiatric nurse practitioners: to fill the need for expanded primary care services as behavioral health and primary care integrate.
■ Population Management experts: to help with care coordination strategy, and resource and data management.
■ Case managers/social workers: to create care plans, bring in other providers as needed, and serve as the patient's single accountable point of contact.
■ Healthcare counselors: to work with care coordinators as patients navigate the new care delivery system.

2) Community-based care delivery staff
■ Visiting nurses/home health aides: Critical staff to stabilize members with medical needs in community-based settings and prevent unnecessary admissions, especially readmissions.
■ Peer coaches/peer support staff: Critical care team members drawn from local communities who can fully engage members in their care plans; will also serve critical roles in behavioral health crisis stabilization units.
■ Crisis intervention professionals: Clinical staff including social workers, nursing staff, and physicians/PAs/NPs/APRNs required to deliver and oversee crisis intervention services.

3) Healthcare-related administrative and support staff
We will expand a range of administrative functions to support the rollout of new projects.
■ Data analysts and statisticians
■ Human resources professionals
■ Registration clerks
■ Financial counseling staff
■ Translators/foreign language speakers
■ Communications/media experts
■ Marketing professionals
■ Managers/supervisors
■ Ancillary workers
■ Ambulatory Care practice managers
■ IT

4) Central staff to support transition
■ DSRIP program office staff: Lean operating team to coordinate operations and services provided by the PPS to its partnership. The team will coordinate governance and operating committees and oversee shared services.
■ Process redesign experts: Temporary hires or consultants to bring the latest operations expertise to PPS's new model; develop and implement new processes
■ Training staff (e.g., job coaches, process coaches)

Many of these growth jobs, such as navigators and care coordinators, EMTs, financial counseling personnel and others, are potential areas for incumbent healthcare workers. Efforts will be made to provide training opportunities for these workers. We have agreements with local educational institutions (e.g., Montefiore School of Nursing, St. John's Riverside Hospital's Cochrane School of Nursing, Mercy College and other private colleges, high schools, City University of New York, State University of New York, the 1199 Training and Education Fund) to expand training capabilities and facilitate student placement, and are exploring the creation of a nurse practitioner community health center residency program.

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	151

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Position	Approximate Number of New Hires
Physician	55
Mental Health Providers Case Managers	250
Social Workers	52
IT Staff	33
Nurse Practitioners	28

Section 5.5 - Workforce Strategy Budget:

In the table below, identify the planned spending the PPS is committing to in its workforce strategy over the term of the waiver. The PPS must outline the total funding the PPS is committing to spend over the life of the waiver.

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	1,198,457	1,492,682	2,116,682	1,454,950	1,701,207	7,963,978
Redeployment	224,908	221,883	221,883	56,450	193,658	918,782
Recruiting	59,475	56,450	56,450	56,450	28,225	257,050
Other	126,750	253,500	253,500	253,500	125,750	1,013,000

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.

Our strategy pulls on HVC partners' experience with city, state, and federal programs to support training, and create a pipeline to meet current and future needs. This strategy is focused on meeting the workforce needs of our PPS, keeping care local, supporting health workforce professionals at their highest level of licensure, career advancement, and expanding training/mentoring to address areas of high unemployment.

Our partners have experience across a wide range of state programs. For example: Doctors Across New York to support physicians via loan repayment in underserved areas; NYS Hospital Medical Homes Grant to support training of faculty and residents in skills needed for transformation to Patient Centered Medical Homes; National Health Service Corps loan repayment and other programs encouraging practice in Health Professional Shortage Areas; NYS Health Foundation grants to support training in new roles, including care transitions and data analytic roles that are embedded in inpatient care to reduce readmissions; CMMI Innovation grants to train analysts to extract data from regional health information organizations; NYC Department of Education and CUNY program to expose high school students to careers in healthcare and mentorships, resulting in a high school diploma, a 2 year associate's degree in a health related field and career network; and NYS ECRIP to train physicians as clinical researchers to advance biomedical research in NY. Montefiore was involved in the Governor's Unemployment Strikeforce and created programs to train young people for jobs in high demand, to mentor for success, and ensure career development via workplace education programs.

Our collective expertise in working with all levels of government, unions, education, and non-profit organizations to create effective programs will be beneficial as we advance our workforce strategy. The HVC will leverage this experience, as well as that of TEF, to ensure that all resources are maximized.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

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

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The governance structure established during the planning process ensured engagement of stakeholders across our partner organizations and local communities, and included representation from labor representatives at all levels. 1199SEIU was a member of the HVC Leadership Steering Committee (LSC), and TEF was a core member of the Workforce Transformation Team which developed and blessed the strategy outlined above. In addition to the TEF, management and frontline staff across 20 organizations participated in the Workforce Transformation Team. Once developed, the HVC sought input from four regional PACs, made up of 200 representatives from over 65 organizations, including 1199, NYSNA, and CSEU members.

As the largest labor union representing employees within the PPS, 1199 was particularly influential, as was TEF. Both will continue to drive the strategy, with 1199 maintaining its role on the LSC, and TEF acting as a primary workforce vendor.

***Engagement 2:**

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

The HVC invited representatives from the largest unions represented among our PPS partners – including 1199 & the TEF, NYSNA, CSEU – to co-develop this workforce strategy. Representatives participated across our Planning Period governance structure, from the Leadership Steering Committee, to the Workforce Transformation Team, to our regional PACs.

***Engagement 3:**

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

The HVC has placed strong emphasis on transparency and close communication with all members of the PPS in the form of frequent updates and communication of developing plans so that input from the full breadth of our membership can be included. Moreover, we believe that if frontline workers are part of solutions, they will be more likely to be effective. As we move forward, there will be more opportunities to engage frontline workers in the transformation. Our PACs will continue to be the key vehicle for frontline involvement, as they are the setting for translating system-wide implementation plans to individual partner plans. Additionally, we will invite frontline members of our Workforce Transformation Team to join one our System and Practice Transformation and Care Management & Coordination Transformation Teams, to imbue frontline wisdom into the plans. Lastly, the DSRIP office will develop specific education materials designed for frontline audiences, to support our partners ongoing engagement with DSRIP planning and implementation.

***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.

As noted above, we will continue to engage stakeholders and workers through frequent communication, participation on governance committees and PAC meetings. In developing our approach, we considered potential structural challenges imposed by the breadth of our network (over 200 organizations and over 1,000 entities) and the geographic diversity (across 7 counties). We have used two strategies to overcome this, a) frequent communication involving remote interactions such as email updates, web-based sharing and conference calls, and b) regionalization of the planning process with the creation of four PACs representing distinct geographies based on the historic flow of patients, with central coordination facilitated by the DSRIP office.

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.

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- Supporting documentation to validate and verify progress reported on the workforce strategy, such as documentation to support the hiring of training and/or recruitment vendors and the development of training materials or other documentation requested by the Independent Assessor.

☑ Please click here to acknowledge the milestones information above.

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Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

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

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

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

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

Scoring Process:

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

Section 6.1 – Data-Sharing & Confidentiality:

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

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

To enable real-time data sharing across our PPS, HVC plans to increase the number of providers that are actively sharing data with the local RHIO, HealthlinkNY where ~40% partners have participation agreements in place today. We plan to rapidly increase level of connectivity and data exchange over the next 3 years
1- ADT integration and secure DIRECT messaging will be implemented in major hospitals and key ambulatory providers as a stepping stone to meet SHIN-NY/RHIO integration and e-prescribing requirements by Y3
2- Montefiore will help facilitate an EHR adoption process for paper based partners, and educate them on EHR alternatives. Montefiore has been responsible for installing, configuring and training for EHR integration for >2000 providers within and external to our network over the past 10 years.
3- Exchange of targeted patient information by determining "minimum use" for data exchange and bringing all participants up to Stage 2 MU over time

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

HVC will follow the outlined principles to ensure data security and privacy with partners.
Sign Participation Agreement, explaining the nature of partnership, Business Associate Agreement, containing the elements specified at 45 CFR 164.504(e), use, disclosure and data protection and Data Use Agreement, for scope of data use, and additional safety regulations.
Hold webinars to ensure all are aware of and comply with HIPAA Privacy and Security Rules, and fair data sharing practices set forth in the Nationwide Privacy and Security Framework
Montefiore will host reporting and performance tracking systems at its data center,a SOC II Secure Facility for Hosting.
HealthlinkNY also will offer training on consent, privacy and security to each participant as their connections are made
The Leadership Steering Committee and IT&HIE Transformation Team will have oversight of overall strategy and DSRIP compliance officer will have responsibility for ensuring data sharing protocols are enforced

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***Confidentiality 3:**

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

Over 80% of the PPS providers have made the transition to EHR. This as a critical enabler for real-time data sharing and universal integration to HealthlinkNY, which could
Enable our partners to receive real time alerts at time of admission and discharge
Collect and exchange core data elements of clinical quality measures, that is compliant with relevant privacy protocols. We will also encourage our partners to leverage DIRECT messaging.
In addition to the data exchange enabled through HealthlinkNY, we are exploring options for a common, integrated care management platform that will allow multiple providers to access a single integrated platform, and will provide more advanced alerts to facilitate execution of the care plan. This system will ideally interface with the RHIO and other tools necessary to facilitate reporting and data sharing in an environment patient privacy protocols are adhered to. We will strive to provide technical assistance for partners lagging behind DSRIP goals.
While increasing connectivity is a primary objective, we recognize an interim solution will be required to support reporting and data sharing in DSRIP Years 1 & 2. As such, Montefiore plans to leverage its experience with data collection and reporting (through Pioneer ACO and Health Homes) to launch a portal that will enable partners to share important information to inform overall PPS performance, and allow Montefiore to share back performance reports and other important data to inform care delivery.
We believe that an Opt-Out model or a SHIN-NY consent will be a critical enabler for data exchange between partners.

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.

HVC performance management efforts will jointly be driven by Clinical, Financial, and IT Transformation Teams in strong collaboration with our Project Advisory Committees. These teams all provide input to the Leadership Steering Committee LSC, our governing team that has ultimate responsibility for ensuring the PPS is on track and meeting collective performance goals.
The LSC will drive change by covering all critical elements:
Creating the performance driven culture for continuous improvement and immediate action taking. This will be done via awarding success, and best practice sharing
Ensuring the processes are aligned with goals
Clear divisions of roles and responsibilities of staff, and making sure their incentives are aligned with the change aimed with DSRIP.
As lead applicant, Montefiore will ensure partners understand the requirements, and take the corrective measure to meet the goals. This will be done by a reporting and performance tracking web portal developed and managed by Montefiore. Montefiore will also make sure that collected data is analyzed and results are fed forward to HVC partners to inform care decisions.

***RCE 2:**

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

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

Data will be collected from multiple sources and integrated into Montefiore's Enterprise Data Warehouse, which creates potential for cross-domain analytics (e.g. claims, care processes, outcomes, patient satisfaction, healthcare utilization and cost etc.). These analytics,

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combined with continued updates to the CNA will help HVC understand the health needs of the community and design activities that improve health care. Patient stratification will be a critical tool to meet this goal. HVC will leverage Montefiore's current experience and capabilities within the Care Management Organization to stratify the population based on level of need and potential risk factors. This will enable targeted outreach and communication to emphasize primary and preventive care, linked with community prevention services. HVC will also work to integrate systems as appropriate with managed care plans, building off Montefiore's experience through the CMO, to enable regular data exchange and reporting.

***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).

Summary dashboards and reports will be made available for regular (e.g., quarterly or monthly) performance reviews. Collective performance against targets will be overseen by the Leadership Steering Committee and the compliance function with the DSRIP office. Performance results and ways to improve performance will be discussed at all committee meetings. Montefiore will also hold webinars upon receipt of results and feedback from State. These webinars ensure that the activities of the different workgroups towards DSRIP goals remain aligned with one another, and that each group is clear on corrective actions and deliverables. Montefiore will also continue to explore other web and software tools to facilitate communication and collaboration among PPSs and other stakeholders.

***RCE 4:**

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

HVC will build a highly functioning PPS by leveraging RCE through:
Immediate action and correction: RCE will help HVC to address improvement opportunities while identifying best practices and success cases. Success will spread across the PPSs by having superior performing partners play a role in coaching partners that are lagging behind.
Claims-based analytics with real time inputs: HVC will leverage the claims data provided by DOH and any available clinical and patient data to perform patient risk stratification and provider performance analytics in Y1 and Y2, and transition to advanced performance analytics across PPSs afterwards.
Continuous improvement: RCE will help HVC to quickly determine whether an intervention is effective, and enable program administrators to continuously improve their programs by experimenting with different interventions.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

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

Scoring Process:

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

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

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

As part of the CNA, the PPS undertook surveys and focus groups to develop a better understanding of providers' perceptions of their ability to provide culturally competent care and to communicate effectively with patients. The Hudson Valley region is increasingly diverse, with fast growing Hispanic and Asian populations, and a wide range of languages spoken besides English (Spanish, Portuguese, French Creole, and Yiddish), particularly in communities with a high level of social, economic and health needs. Many areas have significant populations of foreign-born and/or temporary migrant workers. Beyond language barriers, cultural differences account for variations in health care use, patient outcomes and engagement and ability to adhere to treatment.

The health literacy and cultural competency challenges identified by our surveys and focus groups were as follows:
• Providers and staff often do not speak patients' native languages such as Spanish, Portuguese, French Creole, and Yiddish
There is a dominant reliance and emphasis on written care documentation (vs. verbal or picture-based instruction)in communities where there is limited baseline literacy even in native languages
•There is a paucity of education/health literacy courses
•Providers and staff do not demographically represent the target patient population and may not have a sufficient understanding of the communities in which they are working

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•Providers lack awareness of the particular competencies and accommodations needed for special needs patients and those from diverse cultures.

For the LGBTQ population, additional steps must be taken to create welcoming environments and support groups.

***Competency 2:**

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

Different cultural groups in the HVC are often concentrated in specific areas. Our strategic approach to creating culturally-competent integrated systems of care will be to develop PPS-wide guidelines for culturally and linguistically appropriate evaluation and services and allow partners to choose the approaches with the greatest impact for their communities:
Centralized PPS support and expertise
Self-assessment tools and technical assistance on considerations for cultural competency holistically and for their communities and specific DSRIP projects
Adoption of National Standards for Culturally and Linguistically Appropriate Services
Measure disparities in outcomes for different cultural groups; monitor progress on reducing these disparities; and publish to promote best practices
Identify staff representative of their patient population for more patient facing roles
We will provide comprehensive education to all staff – from front-line staff to senior management – about the healthcare-specific beliefs , values and religions of the different communities they serve and the impact on how services and should be designed and delivered. Our identified training vendors partners – Montefiore CMO and 1199 Training and Education Fund –have existing modules for this purpose. Cultural competency will also be assessed through evaluation of patient outcomes and satisfaction scores. For partners who struggle with patient engagement and treatment adherence, the role of cultural and linguistic competency as a barrier will also be evaluated and addressed. The stakeholder committees and the ongoing health needs assessment activities will seek to assess whether progress is being made. We will leverage the expertise of Montefiore's partner, Einstein College of Medicine with its Institute for Community and Collaborative Health and significant competencies in understanding health disparities.

***Competency 3:**

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

We will contract with community based organizations that are recognized for their ongoing commitment to Cultural and Linguistic Competence in key clinical areas – such as the Mental Health Association in Orange county and the Hudson Valley Asthma Coalition – to conduct initial assessments, develop the strategy, and assess and evolve it on an ongoing basis. We will partner with community-based organizations to seek outside funding to study the effectiveness of our cultural competency interventions.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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

***Literacy:**

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

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

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

Our CNA has identified several key health literacy considerations unique to the Hudson Valley. About half of the adults in the region have completed high school or college. The major language spoken is English, and it is closely followed by Spanish in most counties and in major cities in the region. French and Spanish Creole, Portuguese and Yiddish are dominant languages in some of our communities with high levels of health needs. Health literacy challenges, as reported in a survey of over 50 providers across the region, are most prominent in communities where English is not the main language and is compounded when an individual is not literate in their native language. One implication of this is a major unmet need in the area is for health educators and translators in addition to staff who are bilingual.

In order to address these challenges and keeping with our approach of PPS wide standards and local flexibility, we will:
Provide training and technical assistance to providers on the basis that everyone may have difficulty understanding and creating an environment where patients of all literacy levels can thrive
Measure disparities in effective access and healthy behaviors between cultural groups. For example, controlling for health literacy, testing if racial and ethnic disparities in health care quality and outcomes often disappear.
Create and share project specific best practices and targets for health literacy. For example, we would include percent of patients receiving education on Environmental triggers and Environmental tobacco exposure as a core process metric in Project 3.D.III. Key PPS partners with technical expertise in relevant domains, like the Asthma Coalition, would be tasked with leading this

Health literacy is key to patients' meaningful engagement with their own health and well-being. We will have a comprehensive plan that will include policies and procedures to identify the cultural and linguistic needs of the population served, as well as of the workforce and service providers. Key activities include:
Create dedicated workforce to address health literacy issues, with a focus on health educators and translators, in addition to recruitment and redeployment of staff that is representative of the patient population
Require providers to conduct assessments of their facilities & services, focusing on 1) environments where patients are not "blamed" for low health literacy 2) ease of use of forms and processes, with attention to format and reading level for non-English speakers; ensure a range of oral and written language assistance options 3) leveraging existing community groups (e.g. churches) to improve health literacy
Provide 'core' health promotion and system navigation literature in multiple languages that can be tailored by providers to meet their specific needs
Adopt National Standards for Culturally and Linguistically Appropriate Services
Ensure adequate focus on staff and patient/client health literacy – for example, even though over 90% of psychiatrists and nurse practitioners believe that helping patients to stop smoking is the role of the mental health professional, only 12% felt well prepared from prior education to treat tobacco use. As such, education for providers, particularly behavioral health providers will be a key component of our strategy for our project 4.B.1 on tobacco cessation.
There are several CBOs who have been recognized for their efforts in health literacy, such as the Mental Health Association in Orange County and the Asthma Coalition, who are part of the HDVC PPS and have played an active role in developing the approach towards health literacy. We will provide appropriate incentives to such groups to support planning and implementation of health literacy programs across the region and partner with them to seek outside funding to study the effectiveness of our interventions.

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

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

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

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care consistency and health literacy.

☑ Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

We plan to establish four main categories for distribution of DSRIP funds, as outlined in the table below. We will create a distribution model to support partners through the implementation period and compensate for project startup costs. While these funds will support overall system transformation, we are focused on creating a model that will allow our partners to be financially stable after the 5 year DSRIP performance period. Our approach to budgeting and funds flow also takes into account alternative funding sources that can be leveraged to complement DSRIP incentives and activities.
In order to establish an incentive structure that will position our PPS for success, distribution of funds will mirror the State's objectives and will be linked to achieving project milestones and performance targets. We also plan to leverage Montefiore's experience in administering incentive payments through the Pioneer ACO model and other value-based arrangements within the Montefiore IPA structure.
PPS partners spanning the care continuum will be eligible for PPS funding. The distribution of funds will be based on the following factors
•In the initial years, the funds will flow to support partners in program implementation and related financial needs in the process of delivery system transformation
•As the time progresses, the payments structure will shift towards performance payments. Therefore, the payments will be distributed based on
o Attribution share, based on the amount of population served and risk / severity of population
o Individual performance of individual partners compared to project-specific metrics and milestones
o Collective performance of partners within each project
The Leadership Steering Committee and Finance Transformation Team have provided significant input into the overall funds distribution model, and will continue to play an advisory role to ensure that the funds distribution is done fairly, in a manner that supports and rewards system transformation and achievement of overall DSRIP goals. PPS funding will focus on establishing a solid foundation for the financial sustainability of safety net and financially distressed providers.
The Leadership Steering Committee will also be responsible for analyzing projects goals and milestones and modifying funds flow over

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time to achieve optimum results.
Experience of existing ACOs (such as Montiefore's Pioneer ACO) will be used in establishing a link between governance structure and the distribution of funds in a manner that is fair to all participants and ensures long term sustainability.
Proposed funds distribution approach is designed with the goal of helping our PPS achieve its long-term DSRIP goals. Below are the components that will facilitate that:
• Focus on improving quality of care and efficiency and effectiveness of care delivery. Our mechanism for distributing funds is heavily based on performance metrics, progress towards achievement of DSRIP goals and achieving project milestones. While a portion of funds will be reserved to address provider impact (including revenue loss), the structure will not be geared to support the "status quo"; instead, it will focus on creating a more efficient health care delivery system.
• Time alignment. Our distribution schedule will mirror DSRIP and will evolve to performance model over time. This timing structure will help providers in the initial stages, when partners engaged in implementing the DSRIP projects and experiencing the impact of delivery system transformation. In later stages, when partners will start to discover other sources of revenue (including value based arrangements with health plans), funds distribution mechanism will shift to the pay for performance mode.

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	45%
2	Revenue Loss	10%
3	Internal PPS Provider Bonus Payments	40%
4	Other: Funds dedicated for continuous innovation and piloting new clinical programs; Discretionary funding to account for unforeseen expenses or underperformance	5%
	Total Percentage:	100%

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

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

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

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☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

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

We launched a comprehensive survey to assess financial strength of our partners, to fully scope the financial diversity of our PPS, and to identify the members that might be financially challenged and at risk of failure. To collect this information, we surveyed our PPS partners and leveraged publicly available data sources. In our analysis, we focused on the following four areas:
1. Sources of funding and safety net providers
77% of partners within our PPS are identified as safety net providers. This helps us better evaluate the financial condition to identify those which may be more vulnerable to DSRIP transformation.
In addition, 77% of inpatient providers, 74% of outpatient providers and 51% of other providers receive the majority of their revenue from Medicaid.
2. Liquidity. This helped identify partners that will be most sensitive to the immediate spending requirements of DSRIP. From this survey, ~30% of partners reported cash on hand <20 days (state threshold for lead agencies) and ~65% of partners reported cash on hand <40 days.
3. Solvency position. Our partners provided us with data on liquidity, profitability and debt and capital structure ratios, which showed that ~15% of partners have debt ratios>95% (state threshold for lead agencies) ~30% of partners have debt ratio >75%
4. Profitability: The responses helped understand diversity and identify partners that will be most vulnerable during the DSRIP period and beyond. For example, ~25% of our partners have operating margins lower than -6% (state threshold for lead agencies) and ~45% have negative operating margins. This will be important as we look to develop a financially sustainable model within DSRIP and beyond.

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***Assessment 2:**

Identify at a high level the expected financial impact that DSRIP projects will have on financially fragile providers and/or other providers that could be negatively impacted by the goals of DSRIP.

We expect DSRIP will have a significant impact on all providers, including those that are already financially fragile.
The impact will greatly depend on partners':

Current financial condition and pace of delivery model and payment changes

Current reliance on the service lines that will decline under DSRIP (inpatient care, ED care) and ability to transition to a financially sustainable model requiring, in some cases, restructuring and repurposing of care delivery resources and assets

Safety net status and whether they are recipients of state aid or otherwise financially distressed
Partners that have previously benefited from IAAF funding, will see heightened challenges as this source of funding will be discontinued.

The following are the major financial impacts we anticipate DSRIP projects will have on HVC partners:

A decline in IP and ED revenues from a reduction in preventable admissions. The magnitude of impact will vary by the level of reduction, repurposing opportunities and existing financial condition

Implementation costs. Majority of DSRIP projects will require upfront startup costs, and this factor absent PPS funding would present an added financial challenge to partners, particularly safety net and financially fragile partners.

An increase in revenues associated with outpatient and primary care. The improved care delivery model will include heavier reliance on primary care services, community-based services, ambulatory services and robust development of medical villages.

Increased revenue due to decreased outmigration of patients in the Hudson Valley

Reduction in variable costs associated with lower IP and ED visits

Reduction in fixed costs due to better resources utilization, rightsizing and restructuring

Improved operational efficiencies including leveraging care management and economies of scale available through certain PPS providers

The combination of these levers, and partners' ability to adapt to the new care delivery model will greatly impact both the successful transformation of care during the DSRIP period and the longer term financial viability of PPS providers.
We expect that providers across the continuum will contribute to and benefit from opportunities of DSRIP transformation as well as new, aligned value based arrangements with many health plans. For example:

Hospital partners will havesignificant opportunities to drive efficiencies and new sources of value as the DSRIP period progresses and they explore and develop value based arrangements and share in the benefits derived from a more efficient delivery system and associated payment reform

Non-hospital partners (ambulatory and community-based providers) will have an opportunity to improve access of care and realize increased revenue as they play major role in implementing the portfolio of DSRIP projects. In addition, there is also a great opportunity for those partners to seek ways of profit improvement, both from increased efficiencies and reduced costs, and from exploring new revenue sources.

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:

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***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.

1) Increasing access and the volume of primary care visits and reducing outmigration
Reducing preventable inpatient and emergency room visits will be a major outcome of DSRIP. As such, we will experience an increase in high quality outpatient and primary care services, to better manage chronic conditions, reduce acute exacerbations, increase access to preventative care and reduce the per capita demand for high cost services
By providing better coordinated, higher quality care, PPS partners will reduce outmigration of care, becoming more prevalent into the later years of DSRIP as the integrated care delivery model evolves and durable value based arrangements are forged with many health plans.
2) Focusing on continued operational efficiency: By coming together with ~750 participants in our PPS we create significant operational efficiencies and share best practices across a broad spectrum of functions and potentially shared administrative functions
3) Entering into value-based contracts with payers and enhancing care management: Transforming to value based arrangements will be a key lever to achieve financial sustainability of our PPS. It creates the flexibility to invest in continued transformation and compensate for services that may fall outside of FFS reimbursement streams. As medical science, technology and evidence based best practices develop, new ways of delivering efficient, effective and lower cost care will emerge. We will work with providers and payers to move toward outcomes based measures and sustainable value based arrangements. With an existing care management infrastructure and partner experience with value based arrangements, we expect to accelerate transformation to new payment paradigms with payers during the DSRIP period.
4) Fixed cost reduction through rightsizing, integration and potential merger: We will work to reconfigure facilities, develop medical villages and use care delivery capacity in the most efficient manner. We will rationalize and right-size our facilities, and seek to significantly reduce fixed costs of operations. This will include re-purposing idle resources and shared use of facilities. Montefiore has demonstrated expertise in bringing financially distressed hospitals to a more sustainable model, such as Westchester Square, where they successfully restructured an acute care facility to a functional Medical Village

***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.

Safety net providers will achieve a path toward financial sustainability by:
•Use of shared resources and creating operational efficiencies and economies of scale by joining a network of over 750 partners
•Entering into value based arrangements with payers that will be tied to performance and impact on quality of care rather than fee for service
•PPS wide implementation of care management capabilities, leveraging existing infrastructure
•Rationalizing, repurposing and right-sizing services and capacity
In addition to that, the HVDC budget and funds flow will be structured with the goal to assist safety net providers and other partners who might experience difficulties, especially during the first years of DSRIP projects implementation

***Path 3:**

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

To ensure that PPS will sustain outcomes after the conclusion of the program we will focus on the following initiatives:
•In the funds flow architecture, we will establish principles that promote continued operational efficiencies, encourage partners to reduce costs while maintaining performance
•By aligning payer / provider incentives under Value Based Arrangements, access to high quality, cost effective care delivery will provide our partners with flexibility of finding financially sustainable solutions that will be effective after the DSRIP source of funding discontinues
•We will work with the partners to make sure that shared payments from value-based agreements by year 5 of DSRIP program will be large enough to fully replace the program's incentive payments
•Finally, we will focus our activities beyond Medicaid, to all lines of business to make sure that our PPS achieves financial sustainability and adheres to the goals of DSRIP and the Triple Aim for all populations

Section 9.3 – Strategy to Pursue and Implement Payment Transformation to Support Financial

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Sustainability:

Description:
Please describe the PPS' plan for engaging in payment reform over the course of the five year demonstration period. This narrative should include:

***Strategy 1:**
Articulate the PPS' vision for transforming to value based reimbursement methodologies and how the PPS plans to engage Medicaid managed care organizations in this process.

Our vision for transforming to value based reimbursement methodologies builds upon the experience of Montefiore and many of the PPS partners and will focus on the following:
•Establishing value based arrangements, which reward PPS providers performance on quality of cost effectiveness, with the Medicaid Managed Care Plans serving the Hudson Valley region
•Engaging in value based arrangements with health plans which serve Medicaid, Medicare and Commercial members
•Already actively engaging payers in the Hudson Valley region to develop value based arrangements which benefit the member/patient, the health plan and PPS
•Introducing and expanding value-based arrangements during the DSRIP period
We will achieve alignment with MCOs by setting up network architecture for shared savings that would be transparent and fair to our partners, including:
- Attribution and performance baselines and trends
- Performance measurement covering cost of care, quality, access and patient experience
- Incentive payment distribution methodologies
We will implement principles for incentive distribution that will promote improvement in quality, cost effectiveness and health status of populations served
- Building on existing incentive distribution models
- Based on collective PPS performance while rewarding individual providers based upon their performance and contributed value
The lead applicant has actively engaged with many Medicaid and other payers in the region and will leverage its 20+ years of experience in risk based arrangements to help other partners' transition into new payment structures

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

Payment transformation will play a crucial role in the system's achieving financial stability beginning during the DSRIP incentive program. As described above, the value based arrangements will be an increasing source of financing in the later stages of DSRIP and into the future
Payment transformation will assist the PPS, and especially financial fragile safety net providers in the following ways:
•Provides a new sustainable source of funding long after the DSRIP program is over
•Helps align partners in PPS with DSRIP and Triple Aim goals which improve quality of care to patients, improve the health status of communities while reducing the overall cost of care
•Helps financially fragile providers find a way to sustainability by focusing on performance
•Provides flexibility beyond current FFS structure to invest in and deliver beneficial services that will meaningfully improve patient outcomes, and ultimately reduce total cost of care
We will provide flexible arrangements to allow providers to shift into value-based arrangements and for some, take on more risk-based arrangements, but only after they develop the capabilities and scale necessary to do so.

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

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allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

As lead, Montefiore brings population management capabilities that are unique in New York, and among the most advanced nationally. The HVC will use these capabilities to develop a more integrated and patient-centered system.
First, Montefiore is expert at structuring value-based arrangements (VBAs). Montefiore launched its first VBA in the 1990s, and established early relationships with Medicaid payers. Today, Montefiore has VBAs across lines of business, including with payers in the Hudson Valley, and has started discussions in the region with all major Medicaid payers. Montefiore has developed an Integrated Provider Network comprising 3,400 providers, including 1,500 in private practice. Montefiore will use its infrastructure and expertise to accelerate adoption of VBAs.
Second, Montefiore has established one of the nation's most progressive and successful approaches to managing care. One critical component is Montefiore Care Management, which supports nearly 300,000 beneficiaries, approximately 40% of which are Medicaid recipients, and is poised to serve the HVC's needs while building capacity within partner organizations. Montefiore provides essential wraparound services, seamlessly integrated with on-site clinical care. These resources are central services that assess patient needs, navigate across settings, work closely with physicians, support patients between visits, and are integrated with social services. As the network that Montefiore manages includes independent providers, Montefiore has experience executing in collaboration with community partners.
Third, Montefiore has developed a strong IT infrastructure, with robust data analytics, operations support, EMR implementation and data warehousing.
Montefiore is at the forefront of innovation, including as a lead Health Home, and as the operator of the state's first free-standing ED. Notably, Montefiore is New York State's only Pioneer ACO, and was top performing nationally two years running.

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 Hudson Valley Collaborative will leverage the synergistic capabilities of two key partners who have a strong track record of collaboration and who will work closely together to advance DSRIP goals:

1) 1199 Training and Employment Fund (TEF): The 1199 Training and Employment Fund brings to our PPS a track record of evaluating and selecting the most appropriate training vendor to meet employer and worker needs; writing curricula; working collaboratively with employers, unions, and training providers to design and deliver high quality programs. The Fund has been an integral part of our PPS, and played a key role in our planning process, both in regional PACs as well as the central Transformation Teams. The PPS will build on this relationship and contract with TEF in order to leverage the fund's expertise in continuing to refine the workforce and training strategy, and as a vendor for its many nationally recognized training programs.

2) Care Management Learning and Innovation Center, Montefiore: The Center was developed out of rapidly growing need for staff with expertise in care management and population health. Using evidence-based strategies grounded in the structure of the Association for Nursing Professional Development (ANPD) model, the center has developed 18 new curriculum pathways over the past 3 years, and

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currently guides over 600 employees through major role changes, including population health management. The Center's work has been recognized by awards from the ANPD and the Case Management Society of America (CMSA). The Center will support our PPS by providing curricula, developing new curricula as required, potentially serving as a training site, and training local workforce leaders.

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.

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

☑ ***I hereby attest as the Lead Representative of this PPS Montefiore Hudson Valley Collaborative that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

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

Lead Representative:	Lynn Richmond
Submission Date:	12/22/2014 04:32 PM

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