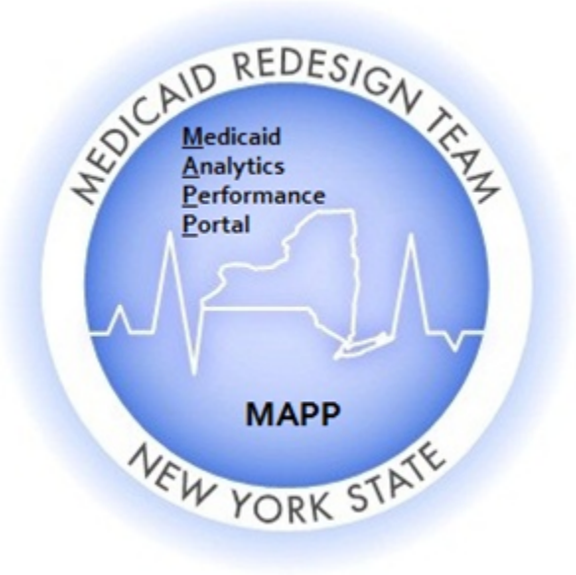
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Nassau University Medical Center

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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: **14_SEC000_Nassau Queens PPS Lead Financial Viability Document.pdf**

Description of File

Nassau Queens PPS Lead Financial Viability Documents

File Uploaded By: am1013
File Uploaded On: 12/22/2014 11:24 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: am1013
Last Updated On: 12/30/2014 01:34 PM

Certified By: vp300076
Certified On: 01/06/2015 10:57 AM
Lead Representative: Victor F Politi

Unlocked By:
Unlocked On:

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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	To create an integrated delivery system. Start DY1 through DY5	The existing fragmented system has led to poor value as measured by cost/outcomes. The Nassau Queens PPS (NQP) expects to: - Have an integrated network of providers across the care continuum committed to risk sharing, care coordination and evidenced based medicine - Establish a Program Management Office to align the PPS and partners -Monitor financial stability of partners - Reduce avoidable hospitalizations (readmissions, admissions, and emergency department visits) by 25% - Incentivize providers to meet DSRIP goals/metrics - Develop a coordinated system of providers linked by Health Information Technology; current review indicates many partners may not be connected to the RHIO - Establish care management protocols and process for patients with chronic conditions - Partner with Community Based Organizations (CBO) to address the basic needs of the population - Educate providers in cultural competent care (race and ethnicity, faith, gender, sexual orientation) and health literacy
2	To create PCMH Level 3 safety-net providers and link patients to them: Start DY1 through DY3	PCMHs organize primary care emphasizing care coordination, communication and minimize use of unnecessary specialty and ancillary services. The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be". Medical homes can lead to higher quality and lower costs and can improve patients' and providers' experience of care. - Expand PCMH designation to safety-net primary care practices - Enhance availability and access to care through systems such as open scheduling, expanded hours and use of technology - Decrease no-show rate by 15% - Ensure all primary care practices are connected to the Regional Health Information Organization (RHIO) - Use Electronic Health Record (EHR) registries to identify at-risk patients and make appropriate care coordination referrals
3	Co-locate primary care in hospital EDs with high	Use of the Emergency Department (ED) for preventable and avoidable

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#	Goal	Reason For Goal
	volume of preventable and avoidable visits	visits is the most expensive type of care and reinforces the fragmentation of the delivery system - Regularly track ED visits (i.e., quarterly or more frequently, if necessary) for preventable and avoidable visits, report same to hospitals and PPS - Refer patients with multiple preventable and/or avoidable ED visits to PCMH and assign care coordinator - Develop hospital billing and ED policies and procedures for triage and referral of ED patients to co-located PCMH level 3 primary care practice - Link hospital EMR system with real time notification system, preferably through the RHIO - Establish community awareness program for PPS partners and ED signage to raise awareness of primary care alternatives to the ED
4	Coordinate the expansion of community-based behavioral health services in an organized way	Address how access barriers in the community for substance abuse and psychiatric services contribute to avoidable hospital use. Start DY1 through DY5 - Expanding primary care in behavioral health centers and behavioral health care in primary care practices - Expand crisis stabilization services that are available 24 hours, 7 days a week, 365 day per year - Annually evaluate the need for crisis stabilization services in the PPS community needs assessment - Educate providers in culturally appropriate patient interaction - Educate and ensure that hospital and behavioral health centers develop policies and procedures for referral to crisis stabilization services - Develop a centralized triage service among providers
5	Integrate the provision of physical and behavioral health services	Physical and behavioral health problems are frequently co-occurring, yet the delivery system is not organized to provide care for the multi-faceted needs of patients in one setting. Long Island FQHC ran a one-month study by conducting PHQ4s on all patients and determined that 27% had a score that would warrant behavioral health referral. - Expanding primary care in behavioral health centers and behavioral health care in primary care practices - Hold regularly scheduled meetings to develop collaborative practices and share evidence based care protocols - Ensure screenings (such as PHQ-9, SBIRT) are conducted for all patients and that they are documented in the patient electronic health record
6	Improve care transitions to reduce 30 day re-admissions for chronic health conditions	Inadequate communication between providers in patient transfers and unclear patient care plans can lead to errors in care resulting in hospital re-admissions - Provide the Medicaid and uninsured the ability to sign up for the RHIO - Develop and implement policies and procedures of hospital transition care plans with transition care plans to SNF or Home Care or PCP - Identify patients with chronic health conditions and link care coordinators, as necessary - Link providers electronically to share patient records and transition care plans - Train providers on using transition care plans - Incentivize providers to actively participate in transition care plan reporting and performance
7	Implement the INTERACT project with SNF partners	The use of the INTERACT program principles and program have been shown to reduce patient transfers from SNFs to hospitals - Use INTERACT training program for the staff of SNF participating partners encompassing care pathways and INTERACT principles - Ensure that all participating SNFs establish an INTERACT coaching

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#	Goal	Reason For Goal
		program - Ensure that the INTERACT project committee uses quality improvement and rapid cycle improvement methodologies
8	Implement patient activation activities to engage the uninsured and Medicaid's low/non-utilizers.	NQP wants to engage fully the Medicaid and uninsured populations of Nassau and Queens, even hard-to-reach populations like low- and non-utilizers of health care and the uninsured. To achieve this, it plans to: -Partner with CBOs to assist in patient "hot spotting" -Undertake Patient Activation Measure (PAM) training for PPS partners -Set goals per each PAM activation level for improvement - Utilize beneficiaries as a resource to promote preventive care -Establish performance measurement reports on the number of patients screened; number of clinicians trained, number of patient:PCP bridges established, number of patients identified, linked by MCOs -Share member engagement lists with insurance companies on a monthly basis - Measure and improve volume of non-emergent visits for uninsured, non-utilizers, and low-utilizers -Community navigators prominently placed in "hot spot" areas -Timely access for navigator when connecting individuals to services
9	Implement evidence-based strategies for disease management for high-risk adult populations	Monitoring and early intervention of cardiovascular disease and diabetes can attenuate chronicity - Registries are used to identify patient with chronic conditions like cardiovascular disease (CVD) and/or diabetes - Participating primary care practices meet connectivity to the RHIO HIE - Identify and track actively engaged cardiovascular and/or diabetes patients for metrics and milestone reporting - Educate and implement tobacco control protocols for participating primary care practices - Assist patients presenting with early CVD and/or diabetes in self-management - Track participating primary care provider clinical record documentation of self-management goals. - Track implementation of policies and procedures which reflect initiatives of Million Lives Campaign
10	Partner with CBOs for outreach, patient engagement and meeting the non-health needs of patients	NQP is committed to a true partnership with CBOs to reach the Nassau and eastern Queens communities and to address non-health needs. -Utilize Community Based Organizations to reach into the community, increase the number of referrals both to and from CBOs. -Have CBOs provide outreach and engagement with the diverse populations, utilize them to help disseminate PAM. Number of PAM trainings among CBOs. -Measure the number of referrals to CBOs for non-health needs and identify gaps in services, working to address those gaps
11	Become a culturally competent network and address the health literacy needs of our patients	- Engage CBOs in development of culturally competent training and performance and addressing the health literacy of the population -have cultural competence training and health literacy as part of its workforce strategy -undertake training for all staff in both cultural competence and health literacy for providers, train patients in health literacy on a regular basis -Commit to Improving diversity in hiring
12	To build on care redesign experience of partners to move to payment reform by the end of DY 5	By the end of the DSRIP period, we expect many providers to be participating in pay-for-performance, risk based models for Medicaid patients. The hubs have experience with running insurance companies, participating in the Medicare shared savings program, and partnering with MCOs, such as Healthfirst on a risk and other value payment basis. This experience will give us a starting point for the transition from fee-for-service

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#	Goal	Reason For Goal
		reimbursement to value-based payment. -Increase the number of risk-based contracts with MCOs during the DSRIP period -Increase the number of capitation contracts by the end of the DSRIP period -Measure for baseline and increase number of contracts with CBOs that are on a risk basis, assuming that payers will cooperate

***Formulation:**

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

Catholic Health Services of Long Island (CHS), Long Island Jewish Medical Center (LIJ) and Nassau University Medical Center/NuHealth created the NQP, serving the communities of Nassau and eastern Queens. The Project Advisory Committee or PAC was created to involve community stakeholders in the PPS. Our PAC contains over 180 members representing hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health treatment programs, health homes, hospices, developmental disability providers, community agencies, unions, Medicaid managed care plans, food banks, housing organizations, OMH, OASAS and other governmental agencies. Many of these groups also participate as active partners in DSRIP projects. PAC members were involved in the CNA and selection of projects. Their on-going involvement assures that NQP will be able to identify and address health disparities. In addition, NQP will continue to hold stakeholder meetings and to publish our findings on the website. We will encourage community members to provide ongoing feedback on our DSRIP projects throughout the term of the DSRIP program.

***Steps:**

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

The vision for the PPS is to ensure the health and well-being of community members via a delivery system that focuses on community-based ambulatory care rather than inpatient care. The vision is to be achieved by connecting individuals to comprehensive, culturally sensitive primary care and assuring that care is provided in the most appropriate settings, avoiding unnecessary care, and sharing information among providers in real time. The PPS will accomplish this vision and be able to manage (and be paid for) the population on a risk basis by the end of the DSRIP period. The system will be sustainable because payment will be based on per capita amounts reflecting current care patterns. Value based payments will provide an incentive to treat patients in the most appropriate, community-based settings, instead of relying on inpatient settings.

***Regulatory Relief:**

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

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

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

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

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#	Regulatory Relief(RR)	RR Response
1	Grant of Certificate of Public Advantage (COPA) and/or Accountable Care Organization (ACO) Status	The Nassau Queens PPS (NQP) and potentially sub-groups within the PPS intend to apply for COPA and/or ACO status for NQP, pursuant to the pending COPA Regulations, when finalized, using the application forms released by the NYS DOH on December 5, 2014. Additional time will be needed to complete the COPA and/or ACO application because extensive market studies that are required are different than those for the DSRIP Community Needs Assessment. The protection from regulatory challenges based on antitrust and other laws may be crucial to implementation of the DSRIP Program by NQP, which by definition requires extensive collaboration to coordinate care and health efforts with respect to the Medicaid population, as well as funds flow among entities that might otherwise be viewed as competitors or referral sources. These waivers will impact on Project 2.a.i (IDS), and on all other PPS Projects. There is no expected impact on patient safety.
2	Waiver of 10 NYCRR 600.9 –Sharing of Medical Facility Revenue	The DSRIP program provides for each PPS to receive DSRIP incentive payments and distribute those funds to participating partners and others, in accordance with a funds flow approach outlined in NQP's DSRIP Application. It is conceivable that an Article 28 entity serving as a hub leader or a participating provider might receive DSRIP Funds for re-distribution to others providers and entities within the PPS. To facilitate smooth operation of the PPS and the processing of DSRIP funding, NQP requests a waiver of Reg. 600.9(c), which limits the sharing of "total gross income or net revenue of a medical facility." In case DSRIP funds would come within this definition, and to permit sharing of DSRIP funds received by hospitals or other Article 28 facilities in accordance with NQP's funds flow methodology, a waiver should be granted. This impacts project 2.a.i (IDS) and general PPS operation, and would have no impact on patient safety.
3	Waiver of 10 NYCRR 405.3(f) Regarding Management Contracts	NQP and its Project Management Office (PMO) will be providing a range of services to the partners, including coordination of care management, support in project implementation, collection and analysis of data, and other PPS administrative functions. While NQP does not view these centralized functions as constituting traditional "management contracts," and while each facility will retain its existing governance and management structure, services provided by NQP and the PMO might be viewed as "management" services that might require DOH approval under DOH Reg. 405.3 initially and every 3 years. Waiver is sought so that it will be clear that DOH approval of PPS administrative activities do not require such approval. This waiver impacts project 2.a.i (IDS) and general PPS operation. This waiver would not have any impact on patient safety because all patient services will be provided by licensed facilities and practitioners who remain subject to applicable regulations concerning their patient care activities.
4	Waiver of Regulations and Guidelines to Facilitate Information Sharing	Although the agencies have indicated that a simple waiver is not available for this issue, we understand that DOH, OMH and OASAS plan to coordinate on the development of a model information release consent form for use by PPS providers that would cover all forms of patient information exchanged by providers. In that process, to facilitate information sharing among providers in connection with care management and other PPS collaborations, we suggest that the agencies seek clarification of SHIN-NY guidance be issued to facilitate information sharing, including "opt-out" approaches for clinical information exchange, and clarification that sharing of information among PPS Participating Providers in connection with DSRIP constitutes permitted sharing of information for treatment purposes that does not require consent. Impacts Project 2.a.i (IDS) and all other projects that incorporate patient engagement, care management and outreach. There is no impact on patient safety.
5	Waiver of Limitations on Home Visits	DOH Reg. 401.2(b) provides that an operator may provide services listed on its operating certificate only for the designed site of operation. Care management is a key element of many of the DSRIP projects, and with the

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#	Regulatory Relief(RR)	RR Response
		DSRIP target population, it is likely that some of the elements of care management and project implementation may be best accomplished through home visits by physicians, nurses, care managers and other staff from PPS participating partners. Specifically, projects 2.b.iv (Care Transitions), 3.a.ii (Behavioral Health Community Crisis Stabilization Services), 3.b.i (Disease Management – Cardiovascular, and 3.c.i (Disease Management – Diabetes). This waiver does not implicate patient safety, since licensed facilities or professionals in those fields would provide all services requiring professional licensure.
6	Waiver and Expedition of Construction Regulations	To facilitate construction and placing renovated facilities in service as quickly as possible, NQP requests that the agencies expedite approvals or waive CON, PAR and other approvals and permit architectural self-certification, and similarly waive the need methodology for construction and equipment purchases related to DSRIP projects, Regulations potentially to be waived are DOH Reg. 401.3, 712-2.4, 713-4.3, 713-4.4, 713-4.9, 713-4.10 714.4, 715-2.4, 717.2; OMH Regs 599.5 and 599.12; and OASAS Regs. 814.2, 814.3, 814.6 and 814.7. Patient safety will not be impacted, if self-certification is permitted because the facilities where these projects will be implemented are already approved. These waivers impact on Projects 2.b.ii (Co-located Primary Care); 3.a.i (Integration of Primary and Behavioral Health Services); and 3.a.ii (Behavioral Health Crisis Stabilization Services), and possibly others in which construction may be required at one or more PPS provider locations.
7	Waiver of Regulations Limiting Changes in Capacity on Operating Certificates	While the agencies have reduced the number of service changes that require CON or other reviews, we request that the agencies waive or expedite approvals of changes in services to the extent necessary to implement a DSRIP Project. Examples include adding behavioral health services at an FQHC site under Project 3.a.i, and co-location of primary care and ED services (Project 2.b.ii). Waivers would include: DOH Reg. 710.1 OMH Reg. 551 pertaining to prior approval review for quality and appropriateness; and OASAS Reg. 810 pertaining to establishment, incorporation and certification of providers of chemical dependence services.
8	Waiver or Expedited Scheduling of Pre-Opening Surveys	In order to make facilities available as soon as construction or renovations are completed, we request that the agencies waive pre-opening inspections or expedite scheduling of pre-opening inspections for renovations or construction in existing facilities that otherwise would be required under DOH Reg 710.9. This impacts Project 2.b.ii (ED Care Triage); 3.a.i (Integration of Primary and Behavioral Health Services); and 3.a.ii (Behavioral Health Crisis Stabilization Services). Patient care issues can be addressed by architectural self-certifications and the fact that the waiver would be for projects in already licensed and inspected facilities.
9	Waiver of Limitations on Billing for Multiple Services on the Same Day	Scheduling primary care and psychiatry visits on the same day is more convenient for patients, and captures the essence of Project 2.b.11 (Co-Location of Primary Care). While this is permissible under Medicaid, not all Managed Care Organizations concur. Payment for same day, multi-specialty billing is needed, and the agencies are requested to waive any guidance or regulations that support the MCO position.
10	Payment for Telemedicine	Telemedicine allows for clinic access for clients where travel to a clinic is difficult or impossible, especially in rural areas, for patients who have difficulty travelling, or in areas where transportation is difficult; allows immediate clinic access when a rapid evaluation is needed; and allows a patient in a primary care office to access psychiatry through telemedicine. Currently proposed changes to OMH regulations 599.17 involving telemedicine do not provide sufficient regulatory relief as it requires that both the client and the prescriber must physically be in an OMH clinic. Similarly, DOH regulations should be waived or amended to permit telemedicine between non-Article 28 sites. Telemedicine will assist with Project 3.a.ii (Behavioral Health Crisis Stabilization Services). These

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#	Regulatory Relief(RR)	RR Response
		waivers will enhance patient safety, as they will permit more timely evaluation of patients' conditions, and reduce avoidable ED visits.
11	Issue Waivers/Simplify the Process of Approvals Required For Co-Location of BH & Primary Care Servic	DSRIP Project 3.a.i involves the integration of Primary and BH Services. In addition to physical plant issues (i.e. Interchangeable offices), flexible staffing, and billing, waiver or expedited reviews will be required in order to permit primary care facilities to add behavioral health services, and vice versa. Specifically, wavier is requested of DOH Reg. 401.3(d), and similar OMH and OASAS regulations. In addition, Proposed OMH Reg. 14-599-1 should add provisions for an expedited process and for recognition of the combined services for reimbursement purposes.
12	Waiver of Admission, Discharge and Transfer Regulations	NQP requests waivers to facilitate placing patients into facilities with the highest quality and most well-coordinated care. While decision-making tools designed to help patients and families refocus the decision discourse from geography to quality exist, current regulations constrain discussions in a way that inhibits this approach. To achieve greater flexibility, NQP is requesting waivers of the following regulations: DOH 400.9 (transfer and affiliation agreements), 400.11 and 700.3 (assessment of LTC patients), 405.9 (admission and discharge) and 415.38 (long term ventilator dependent residents; Social Services Reg. 505.20 (alternate care); OMH. 36.4 (community placement of patients discharged or conditional release) and 504.5 (community placement after behavioral health discharge); and OASAS 815.7 (discharge). All decisions about facility placement are ultimately subject to patient choice. Patient safety will be enhanced by the focus on quality in transfers and discharges.
13	Waiver of General Hospital Discharge Regulation	DOH Reg. 405.9(f)(7) requires hospitals to "ensure that no person presented for medical care shall be removed, transferred or discharged from a hospital based upon source of payment." In view of the potential that the incentive payments for DSRIP Projects could come within the Reg. 405.9(f)(7)'s definition of source of payment, NQP requests a waiver of that regulation, so that there can be no question that NQP and its providers can pursue the DSRIP Projects that seek to improve care management and could impact discharge and transfer decisions without violating this regulation. This waiver relates to DSRIP Projects 2.a.i (IDS), 2.b.ii (ED Triage), 2.b.iv (Care Transitions and 2.b.vii (INTERACT), and does not present any risk to patient safety.
14	Waiver of Hospice Need Methodology	NQP requests a waiver of the hospice need methodology set forth in DOH Reg. 790, in order to expand the geographic areas in which hospices participating in NQP's DSRIP Projects are authorized to operate. This waiver will ensure that existing hospices have the ability to expand their geographical scope to the extent necessary to address the needs of individuals for whom the PPS is responsible. This waiver relates to DSRIP Projects 2.a.i (IDS), 2.b.ii (ED Triage), 2.b.iv (Care Transitions), and 2.b.vii (INTERACT), and does not present any risk to patient safety, since the hospices are already fully licensed and approved.

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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

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

This section is broken into the following subsections:

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

Scoring Process:

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

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

Section 2.1 - Organizational Structure:

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

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

The Nassau Queens PPS (NQP) combines Long Island Jewish Medical Center (LIJ), Nassau University Medical Center (NUMC/NuHealth) and Catholic Health Services of Long Island (CHS), all designated as safety-net entities, each of which received Planning Design Grants and designation as emerging PPSs. Because of shared regional responsibilities to serve Medicaid enrollees in Nassau and Queens, they combined to pursue a single PPS, with NUMC/NuHealth as the PPS lead. There is a PPS Executive Committee, a Project Advisory Committee (PAC), Project and Clinical Oversight Committees and other committees as shown on the attached Organizational Chart. The Executive Committee will appoint Clinical Oversight, IT, Workforce and Finance Committees.
As they have combined into one PPS for Nassau County and part of Queens, these three safety-net providers have adopted the Delegated Model through the creation of Nassau Queens PPS LLC (NQP), which sought a VAP Safety Net Exception. The three entities will be the members of the LLC, have executed a Term Sheet, and will be involved in the management and operation of the combined PPS. The Organizational Chart shows a "hub" model, in which each hub leader will manage its facilities and the participating partners. The LLC will be governed by an Executive Committee composed of 21 voting members drawn from the safety net entities and their partners,

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appointed by NUMC/NuHealth (with 11 members), LIJ (with 5 members) and CHS (with 5 members). The Executive Committee will oversee the Project Management Office (PMO), which shall have defined staff including an Executive Director. Specific duties of the PMO, include: management of DSRIP funds; coordination of hub activities; participating partner evaluation and support; data aggregation and distribution to hub leaders, actuarial and accounting staff; data analysis for performance measurement; Rapid Cycle Evaluation and PPS network gap analysis; preparation of reports for submission to NYS DOH and CMS, Compliance Officer, and other PPS administrative support staff.
Project committees will develop project-specific protocols. This may be done at the individual project level, or for a number of inter-related projects. Similarly, project committees may be hub-specific or across hubs. Hubs will adopt the same projects. Protocols recommended by the Project Committees will be reviewed by the Clinical Oversight Committee, consisting of the Chairs of each Project Committee and other staff. Draft protocols will be reviewed with the PAC, and then presented to the Executive Committee for review and approval. The projects will be governed by NQP-wide policies and protocols. Hub leaders will obtain commitments from each partner to adhere to project implementation protocols, milestones and metrics to be met (e.g., PCMH Level 3 status), participation in care management and information sharing programs, data collection and reporting requirements. Capital funding will be sought separately from the Capital Restructuring Financing Program.
The adopted structure is critical to the success of NQP in that it provides a basis for combination of three potential PPSs into one PPS, ensuring that the more than 223,518 Medicaid beneficiaries in Nassau County, the uninsured in Nassau County, and a significant portion of Medicaid beneficiaries in Queens are included in the DSRIP Program. The structure and the Executive Committee model will ensure that oversight is provided by individuals appointed by the hub leaders, drawing on the considerable administrative, clinical and financial management resources of each of the members, with emphasis placed on successful implementation of the projects, transparency and reporting, and management of NQP. Additional input and advice will be obtained from the Project Committees, the PAC and other stakeholders.

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:	**14_SEC021_\\swab\G-M_Global_MyDocs\amehta1\My Documents\Downloads\NQP Organizational Chart revised.pdf**

Description of File

NQP Organizational Chart revised

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***Structure 2:**

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

The governance plan for the Nassau Queens PPS (NQP) is shown on the attached Organizational Chart. NUMC/NuHealth will be the PPS Lead, and the LLC will be governed by an Executive Committee composed of leadership drawn from the safety net entities and their partners appointed by the three provider systems. The Executive Committee will oversee the Project Management Office (PMO), which shall have defined staff and duties.
The Executive Committee model will ensure that oversight is provided by individuals appointed by each of the hub leaders, thereby drawing on the considerable administrative, clinical and financial management resources of each of the members, with emphasis placed on successful implementation of the projects, transparency and reporting, and management of NQP. The Executive Committee's appointment of Finance, Information Technology, Clinical Oversight, and Workforce Committees, and a Compliance Officer will provide an additional level of input from experts within each hub leader's organization, as well as from the ranks of participating providers and stakeholders.
The development of protocols for implementation of the projects by project committees in each hub or on a combined basis, and review by the Clinical Oversight Committee, review and advice by the PAC, and, finally, review and adoption by the Executive Committee will provide multiple levels of input and review by all clinicians and others participating in the projects, as well as by stakeholders and community based organizations who will be involved at various levels of the process. The PAC has over 100 members and organizations

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representing every aspect of the health care system including but not limited to: hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health and substance abuse programs, health homes, hospices, developmental disability providers, community agencies, Medicaid managed care plans, food banks, housing organizations, OMH, OASAS, and other governmental agencies, and health care advocacy coalitions.
In sum, the selected structure provides a centralized Project Management Office and multiple layers of clinical, partner, stakeholder and other input into the development of project implementation plans and protocols, all subject to the final decision-making role of the Executive Committee. This structure has been constructed with a series of checks and balances, to ensure adequate management and oversight of the implementation of NQP's participation in the DSRIP program.

***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.

Clinical governance will be provided through the Clinical Oversight Committee and the project committees that have been organized. Project committees may be organized at the individual project level, or for a number of inter-related projects. Similarly, project committees may be within each hub for each DSRIP Project, or on a combined basis. The hubs will adopt the same 11 projects. The project committees will be drawn from the providers who will participate in each project, and will develop evidence-based, multi-disciplinary proposed protocols covering the required project elements, including recommending quality standards and measurements, clinical care management processes, data collection and reporting requirements, and accountability for achieving clinical metrics. The role of the Clinical Oversight Committee is to monitor clinical quality and related issues. Proposed protocols will be reviewed by the Clinical Oversight Committee, and then submitted to the PAC for review and recommendations, prior to being submitted to the NQP Executive Committee for review and action.
Each hub leader will additionally apply its existing clinical oversight and performance improvement processes to the implementation of projects in its hub. Existing resources, such as LIJ-affiliated Krasnoff Quality Management Institute, may be drawn upon for its expertise in the development and measurement of quality standards. Clinical governance, with input from clinicians from all three hubs, will be provided through these committees and processes. All clinical decisions and protocols will be reviewed by the Clinical Oversight Committee, whose role would be to monitor clinical quality and related issues, and provide additional input to the Executive Committee on clinical issues.

***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.

NQP members are committed to working with each other, and with the participating partners in each hub, to achieve the goals of DSRIP. This collaborative process has already been evidenced in their ability to join under a single PPS. While each hub leader will continue to pursue its managed care strategy, and will take advantage of its existing relationships with key Medicaid MCOs, DSRIP investments will permit each hub leader and participating providers to proceed incrementally in risk contracting. Each of the PPS members has already had some experience with and success in value-based contracting. NQP leads and the participating providers will work together to develop and refine strategies for managing population health and ultimately enter into risk contracts for attributed Medicaid enrollees. We expect that successful performance under DSRIP will result in development of new value-based contracting opportunities with Medicaid MCOs.

In the process, the structures and approaches developed by NQP and the hub leaders will put them in an improved position to meet the challenges of the future payment system, in that they will be better positioned to be held accountable for patient outcomes and overall healthcare cost; more effectively manage the health of populations; accept and distribute payments; share and analyze data; provide performance data to MCOs and the State; explore ways to improve public health; and be capable of accepting bundled payments and other risk-based payments.

Section 2.2 - Governing Processes:

Description:

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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.

Executive Committee Victor Politi, M.D. Chair –NUMC/NuHealth Appointee
Executive Committee John Ciotti NUMC/NuHealth Appointee
Executive Committee Craig Rizzo NUMC/NuHealth Appointee
Executive Committee Harold McDonald NUMC/NuHealth Appointee
Executive Committee Vincent DiSanti NUMC /NuHealthAppointee
Executive Committee Michael Gatto NUMC/NuHealth Appointee
Executive Committee Michael Ferrandino NUMC/NuHealth Appointee
Executive Committee Joseph Libertelli NUMC/NuHealth Appointee
Executive Committee Thomas Alfano NUMC/NuHealth Appointee
Executive Committee John Maher NUMC/NuHealth Appointee
Executive Committee Timothy Sullivan NUMC/NuHealth Appointee
Executive Committee Jeffrey Kraut LIJ Appointee
Executive Committee Kris Smith, MD LIJ Appointee
Executive Committee Laurence Kraemer, Esq. LIJ Appointee
Executive Committee Sunny Chiu LIJ Appointee
Executive Committee Robert Hettenbach LIJ Appointee
Executive Committee Terence M. O'Brien CHS Appointee
Executive Committee David DeCerbo CHS Appointee
Executive Committee Richard L. Brown CHS Appointee
Executive Committee Natalie Schwartz, M.D CHS Appointee
Executive Committee Patrick M. O'Shaughnessy, D.O. CHS Appointee

***Process 2:**

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

NUMC/NuHealth, LIJ and CHS, three separate health systems, have shared regional responsibilities to serve Medicaid enrollees in Nassau and Queens. With encouragement from NYS DOH, the three organizations combined to create NQP as a single PPS to work collectively to achieve the objectives of the DSRIP program. The three member organizations have the right to appoint the members of the Executive Committee. The members of the Executive Committee have broad and varied experience in the health care field. As they were appointed by each hub leader, they represent a cross-section of the PPS, and bring a range of experience to the Executive Committee. For example, one appointee is the president of a large network of community behavioral health providers in NYC and Long Island, and another appointee is the president of a large IPA in the metro NYC area. As described above, the Executive Committee will receive recommendations, advice and consultation from participating partners, stakeholders, and community-based organizations through the PAC and its more than 100 members, through the project committees, and through on-going town hall meetings and informal contacts as the DSRIP projects are developed and as the projects are implemented.

As described in more detail in the Project Advisory Committee section, the number of participating partners was so large that an alternative structure was selected, in which a smaller group of individuals will represent categories of entities and their related workforce. The initial members of the PAC were selected after reviewing the list of participating partners to identify individuals who could represent each of the types of providers (for example hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health and substance abuse treatment programs, health homes, hospices, developmental disability providers, community agencies, Medicaid managed care plans, food banks, OMH, OASAS and other governmental agencies). Individuals were contacted and asked whether they would be willing to serve on the PAC. Additional requests to join the PAC were honored, in order to provide a broad range of representation. NQP plans to have consumer representatives in the PAC. In establishing the project committees, the hub leaders have assembled the most knowledgeable individuals from their organizations and from their participating partners to develop the protocols for each project.

In combination, these levels of committees provide a structure through which broadly representative individuals will have input into the development and implementation of the DSRIP projects undertaken by NQP, and the Executive Committee will have the benefit of that input as it serves as the governing body of NQP.

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***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 Project Advisory Committee is composed of representatives of each category of provider, unions and stakeholders, and provide a forum for input from a broad range of participating providers, community based organizations, workforce representatives, and stakeholders. The PAC includes hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health and substance abuse treatment programs, health homes, hospices, developmental disability providers, community agencies, labor unions, pharmacies, Medicaid managed care plans, food banks, community agencies, OMH, OASAS and other governmental agencies. Major unions related to each hub leader are included. Additional opportunities to provide input include the project committees, which draw upon clinical leadership across the PPS. Large town hall meetings were held during the design phase to elicit community input, and will be continued into the future.

***Process 4:**

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

Coalition partners have been included at several levels of the organizational structure. More than 100 coalition partners and stakeholders are members of the PAC and project committees. These groups were briefed as the NQP organizational structure evolved. They also had significant input into the CNA and were polled on the selection of projects to be pursued by NQP. NQP has been working closely with the Health and Welfare Council of Long Island, an organization serving as the umbrella for agencies serving Long Island's poor and vulnerable. In the CNA process, HWCLI was hired to convene focus groups and to distribute surveys to community agencies and individuals. NQP expects that as CBOs participate in the projects, contracts with CBOs may include allocations for project costs that are not otherwise reimbursed. As we make decisions about NQP's needs for support in achieving and maintaining cultural competence, we also expect to contract with CBOs based on particular expertise.

***Process 5:**

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

The decision-making and voting process is set forth in the Term Sheet executed by the three hub leaders in connection with the creation of the LLC, and will be incorporated into the LLC Operating Agreement and other PPS-related documents. Specifically, NUMC/NuHealth will be the PPS Lead, and the LLC will be governed by an Executive Committee appointed by NUMC (11 voting members), LIJ (5 voting members) and CHS (5 voting members). At the Executive Committee level, three levels of vote have been defined for distinct groups of decisions, depending on the significance to NQP as a whole: simple majority, super majority and unanimous decisions. This approach requires a broader approval requirement for the more fundamental and important decisions. Each of the hub leaders has committed to follow the prescribed representation on the Executive Committee, and the required level of vote for the designated decisions.
In addition to the Project Committees, additional committees are being established to assist the Board in several key areas, including Finance, Information Technology, Workforce, and Clinical Oversight. A Compliance Officer will be appointed.

At all advisory committee levels, recommendations will be the subject of discussion and vote by simple majority. Before making final decisions, the Executive Committee will receive input and recommendations from the Project Committees, the PAC, the PMO, and other relevant committees.

***Process 6:**

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

The hub leaders have committed themselves to the level of representation that each entity will have on the Executive Committee, and to simple majority, super majority and unanimous votes required for specified decisions. For items coming before the Executive Committee for decision, the hub leaders and the members of the Executive Committee have made a commitment to discuss and work out any disagreements, while relying first on votes at the required levels for particular decisions (simple majority, super majority and unanimous). If disagreements persist, the hub leaders will seek the involvement of the Presidents/CEOs of their respective organizations to try to craft a resolution. The three hub leaders have successfully collaborated in developing and launching a RHIO using a similar governance model. Not once during the past six years that this entity and its successor entity have operated were the parties unable to resolve key operating issues.

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***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.

Minutes will be maintained of all Executive Committee meetings. The PAC and all other committees will be required to keep records of their meetings. The Executive Committee will adopt a communication plan through which relevant information about NQP and the development and implementation of the DSRIP projects will be communicated to the PAC, participating partners, CBOs, stakeholders, patients and the public. This may include newsletters providing a summary of decisions made at the NQP governing level, subject to protections for patient-related and employee-related information, as well as confidential business information, consistent with standard industry practice for deliberations and business decisions. NQP has developed a website (http://www.nuhealth.net/dsrip/), which will be expanded and continually updated to contain all relevant information about its projects and NQP activities. An annual report will be prepared of NQP activities, PPS budget, and funds distribution.

***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.

NQP has developed an inclusive approach as it develops its PPS strategy, engaging stakeholders in meaningful ways including meetings, forums and surveys. Additional engagement will continue through the PAC meetings, and project committees will seek formal and informal stakeholder input as appropriate. NQP plans to engage stakeholders and Medicaid members through the NQP website, which will provide updates of the DSRIP projects and the activities of NQP, and through newsletters, website postings and periodic Town Hall meetings. The patient engagement strategies for each project also will provide the means for broad outreach efforts and strategies for engaging Medicaid members in the NQP projects and other activities. Finally, if additional input or involvement from stakeholders and members is needed, the survey and focus group approach used in the CNA process will be repeated annually.

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.

Initially, the NUMC/NuHealth emerging PPS identified a group of entities that were invited to send representatives to its PAC. Similarly, LIJ and CHS identified PAC representatives for their emerging PPSs in Nassau and Queens. These efforts have led to a PAC that now includes more than 100 people, drawn from management and staff at a broad range of organizations, many of which serve as umbrella organizations and thereby represent the perspective of a large group of providers and stakeholders. The PAC members include the following range of health care providers: hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health and substance abuse treatment programs, health homes, hospices, developmental disability providers, community agencies, labor unions, pharmacies, housing organizations, Medicaid managed care plans, OMH, OASAS and other governmental agencies, and health care advocacy coalitions. Representatives for a given partner category may rotate over the life of the DSRIP Program.

Preliminary Town Hall meetings, which evolved into PAC meetings, began in January 2014, and continued in May, June, August, September, November and December 2014.

With more than 100 participating partners, NQP developed an alternative structure PAC, as initially described in the NUMC/NuHealth DSRIP Design Grant Application. NQP has worked with its partnering organizations to identify staff and workforce representatives, preferably local employees who have direct knowledge of the partnering organizations and the communities they serve. Local staff members bring a practical perspective to the PAC's discussions, and may be involved in implementation of projects. Representatives from the major labor unions associated with the hubs are represented on the PAC.
The PAC's broadly representative membership will continue throughout the 5-year DSRIP Program. The PAC has provided input and recommendations to the Executive Committee on project selection and implementation, as well as other DSRIP and PPS-related matters. Additional input from key stakeholders and participating partners will be provided through the project committees.

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

During the design process and throughout the DSRIP program period, NQP has consulted and will continue to consult with the PAC, stakeholders and other consumer and community representatives. The PAC and stakeholders provided input during sessions that addressed the community needs assessment, the structure of the PPS, polling on the selection of projects, development and implementation of project plans for the DSRIP projects, identification of milestones and metrics, and assessment of electronic systems for information sharing for care management purposes, and for tracking and reporting on milestones and metrics. PAC meetings will be used for on-going information-sharing and input. The PAC will also have responsibility for communicating information about NQP to stakeholders throughout the duration of DSRIP, extending the NQP communications plan to a broader group. The valuable input and advice provided by the PAC and its members will continue throughout the 5-year DSRIP program.

***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).

At Town Halls, PAC meetings, CNA meetings and in surveys with patients and community groups, and in other contexts, NQP discussed DSRIP and obtained feedback from a broad range of stakeholders, participating partners and other entities on the Community Needs Assessment, the PPS's structure, and elements of participating providers' roles in projects. Input was sought concerning best administrative approaches and definition of partners' roles, with an emphasis on programmatic activities needed to achieve the milestones and metrics of each Project, and on improving the connection of health care and social services entities. As part of the CNA process, PAC members were asked to identify key informants as participants in stakeholder forums, as well as to participate directly. CNA findings were shared with PAC members for review and feedback. NQP's final selection of projects reflected a poll of PAC members.

***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.

The PAC is composed of more than 100 representatives of each category of provider and stakeholder to provide a forum for input from the broad range of participating providers, community based organizations, unions, and stakeholders participating and otherwise involved with the effort to address the population health aspects of the DSRIP Projects. The PAC members were chosen to incorporate representatives of all categories of providers and stakeholders. The PAC includes hospitals, physician groups, nursing homes, FQHCs, home care agencies, behavioral health programs, health homes, hospices, developmental disability providers, community agencies, housing organizations, labor unions, pharmacies, Medicaid managed care plans, food banks, OMH, OASAS and other governmental agencies and healthcare coalitions. These PAC members provided invaluable input in the evolution of NQP, including the development of projects, and ultimately, a selection process that confirmed final project selection.

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.

A Compliance Officer (CO) will be appointed by the Executive Committee of NQP. The CO will be an individual with no other role or relationship with NQP, and will be employed or retained by contract. The CO will be responsible for developing and implementing the compliance practices and serving as an NQP-wide resource. The CO shall have direct responsibility to report to NQP and the NQP Executive Committee. The CO will have direct access to the NQP Executive Director and the Executive Committee. The CO will attend meetings of the Executive Committee at least quarterly.

***Compliance 2:**
Describe the mechanisms for identifying and addressing compliance problems related to the PPS' operations and performance.

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The CO will be responsible for the on-going review of NQP arrangements, policies and procedures. The CO will report the results of its activities to the PMO Executive Director and the NQP Executive Committee on a regular basis.

The following compliance plan mechanisms will be established:

- Internal Risk Assessments: periodic established formal baseline assessments of each hub, with compliance risks prioritized.
- Identified Performance Indicators (benchmarks): periodic assessment of compliance with applicable laws, regulations and policies.
- Ongoing Monitoring: continuous measurement of the effectiveness of management attainment of performance indicators at intervals with feedback to the Executive Director and the Executive Committee.
- Corrective Action: follow-up and address identified risk issues.
- Focused and routine audits: scheduling of periodic audits and checks for incident reporting and regulatory concerns.

***Compliance 3:**

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

The CO will evaluate existing compliance programs of its members and then develop a modified program appropriate to DSRIP. The CO will develop general and specific compliance education and training programs. Existing and new employees will attend in-person and web-based training programs covering:

- NQP's compliance philosophy and commitment to compliance.
- Compliance standards applicable to all employees.
- Employee obligation to adhere to laws, regulations and ACP Codes of Conduct, and consequence for non-compliance.
- Reporting standards.
- Identification of CO and overseers of compliance.

Agents and subcontractors also will receive compliance training, and medical staff leadership will provide compliance training for practitioners. The Compliance Program will be developed and implemented by the end of the second quarter of 2015.

***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.

NQP will broadly disseminate to individuals attributed to NQP (or their representatives) written and web-based information concerning their rights to file complaints or register concerns about their health care providers. No provider or entity may retaliate against an individual for filing a complaint. The complaint may be registered:

- On-line at the NQP website or a member's website.
- By email at an address that will be listed on the NQP Website and included in newsletters and other materials.
- At the NQP complaint hotline, through which they may speak to an NQP representative.

Members and beneficiaries will be informed of the complaint process in the provider's notice of privacy practices and in materials available on-line, which shall be available by the time the Compliance Plan is instituted.

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.

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The Executive Committee will appoint a finance committee to provide recommendations on NQP financial matters. Drawn from the financial management leaders from the three hub leaders, it is responsible for the development of funds flow plans (elements include administrative costs, attributed lives, costs of implementing projects, contribution to achievement of metrics and milestones, incentive payments, lost revenues, 5% limitation on payments to non-safety net facilities, and reserves). Reserves are important in case NQP has unanticipated costs and to assure the smooth flow of funds. The funds flow plan, reviewed and updated at least annually, requires Executive Committee review and approval. Once adopted, the funds flow plan will be transparent to all PPS partners through their partner participation agreements.
The finance committee will also make recommendations regarding banking and special account arrangements, and development of cash management, monitoring, and auditing functions. It will recommend data collection/reporting mechanisms necessary to monitor finance activities in real time, and to file the required data and reports in accordance with DSRIP program requirements.

***Organization 2:**

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

The finance committee will make recommendations regarding funds management, banking and special account arrangements, and development of internal or external cash management, monitoring, and auditing functions with respect to the DSRIP program funds and, with input from the IT Committee, on data collection and reporting mechanisms necessary to monitor activities in real time and to file the required data and reports, in accordance with DSRIP program requirements.

It is expected that DSRIP funding received by NQP will be deposited into a segregated account of the Nassau Queens PPS LLC, except for funds distributed by the State directly to NUMC/NuHealth, in connection with the DSRIP funding for public hospitals. The NQP accounts will be separate and segregated from the accounts of the three members of the LLC, and from the accounts of any participating provider. Processing of funds within the LLC will be through a system of internal controls that include segregation of duties, multiple signature requirements, and a structured system of checks and balances between functional areas of finance.

***Organization 3:**

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

Each of the hub leaders has internal audit programs, and engages an independent firm of Certified Public Accountants to perform an external audit each year. All grants received are the subject of audits, in accordance with applicable rules, such as A-133. It is expected that these functions will be established and followed by NQP. Given the importance of documenting and accounting for the use of DSRIP funds in accordance with the goals and requirements of the DSRIP program, and in support of transparency and accountability, independent audits are essential, and the necessary funds will be allocated for this administrative purpose. In addition, the CO will perform internal reviews of financial concerns that arise in the operation of the NQP or through hot lines and other complaint mechanisms.

***Organization 4:**

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

All Medicaid providers maintain a compliance program, as required by NY Social Services Law §363-d. Each of the hub leaders, and all PPS partners who are Medicaid providers, already meet this requirement. In addition, consistent with the requirement that NQP have its own Compliance Program, NQP will retain or recruit an independent CO either through employment or contract. The role of the CO will be to develop and oversee the implementation of a Compliance Program applicable to NQP and implementation of the DSRIP projects. The program will be developed to fully comply with SSL§363-d, as well as to meet all required elements in accordance with DSRIP program guidance. The program will establish mechanisms for submission of questions and concerns to the CO via telephone hotlines, websites, and other avenues. The CO will have access to the Executive Director and the Executive Committee on compliance Issues, will review contracts and other PPS documents and approaches, and will provide relevant compliance training to the Executive Committee, hub leaders, committees, and, to the extent necessary to supplement existing compliance training.

Section 2.6 – Oversight:

Description:

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

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***Oversight 1:**

Describe the process in which the PPS will monitor performance.

Coalition partner Participation Agreements will spell out quality standards, clinical care management processes, data collection/reporting requirements, accountability for DSRIP funds received and clinical outcomes proscribed by the State. The project committees, the PMO, and/or the hub leaders may identify participating partners who are not performing at the required levels. The relevant information will be provided to the hub leader responsible for that participating partner, who will be responsible for reviewing the data/working with the participating partner to develop a corrective action approach within a reasonable timeframe, not to exceed 30 days, with the goal of bringing each participating partner into full compliance. If those attempts are unsuccessful, the project lead will be authorized to bring the matter to the Executive Committee for review and appropriate action, including potential removal of the participating partner from the project. This process and the timeframes for acting on potential removal of a participating partner will be incorporated into the Participation Agreements, consistent with the need for clarity and transparency regarding obligations/remedies.

***Oversight 2:**

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

Data to evaluate provider performance at the hub level will be generated on a monthly basis, and results shared with individual partners. The PMO and clinical staff and project committees will develop and present to the Clinical Oversight Committee (COC) recommendations and determine implementation of a corrective action plan. After consultation with the Executive Director and the Executive Committee, the Clinical Oversight Committee will work in conjunction with the Executive Director (ED) to consider corrective action and to provide constructive feedback to lower-performing providers including sharing information regarding their performance on relevant metrics. The lower performing provider will be given the opportunity to improve performance for the next review cycle. If the provider does not improve and meet the minimum expectations discussed during the initial performance meeting, then the issue will be brought to the COC for discussion and recommendation. Recommendations will be transmitted to the ED for review, and ultimately, presentation to the Executive Committee for approval.

***Oversight 3:**

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

If a need for corrective action is identified at the hub level, the relevant information will be presented in writing to the partner, informing them of reasons for poor performance, and dates and deadlines for the correction. NQP will implement at the hub level a systematic corrective action approach for low and borderline performing providers. The corrective action plan will consist of identifying specific areas of deficiency and providing needed education, training and detail-oriented support to the provider. Ongoing training and support may be provided to a low performer to help achieve higher performance for up to 90 days.

The Executive Committee will have the ultimate decision to remove the provider from NQP membership, once the hub has decided that a member needs to be removed, if the Executive Committee determines the evidence suggests that the provider under consideration will not be able to or is not willing or able to improve their performance. The Executive Committee also may provide a lower-performing provider with a plan to improve performance over time and inform the lower-performing provider that if such provider fails to show progress, they will be removed from the program.

***Oversight 4:**

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

In addition to NQP's monitoring performance of providers through the collection and analysis of data, mechanisms will be developed for obtaining feedback from Medicaid beneficiaries and advocates concerning the performance of the broad range of entities participating in the NQP DSRIP projects. These may include hotlines, reports from care managers and the "contact us" sections of the NQP website. The PMO will be responsible for responding to consumer feedback. The Clinical Oversight Committee, and ultimately, the Executive Committee, will be made aware of low performers and will evaluate the situation and potential corrective action plans. Low performers will be monitored more frequently and receive timely assessments.

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***Oversight 5:**

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

NQP expects that removing a provider will be a rare occurrence. If a provider is removed from NQP, the PMO will review the DSRIP program guidelines to determine the nature of communication that is permitted to be provided to individual Medicaid beneficiaries. As permitted, the PMO will communicate with the affected Medicaid beneficiaries regarding the provider's removal from NQP through available and permitted channels, potentially including e-mails, letters, the NQP website, newsletters, or other approved mechanisms. In cases where beneficiaries may need help making arrangements necessary to maintain continuity of care management and other services coordinated by NQP, help lines, outreach by care managers, and other resources will be made available. Removing a provider from NQP will have no impact on Medicaid beneficiaries' eligibility, or their ability to continue obtaining care from that provider, as long as the provider remains a participant in the Medicaid program and in the managed care plan, as applicable.

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.

A CNA Steering Committee was formed among the partner organizations as well as the Health and Welfare Council of Long Island, Visiting Nurse Service of New York (VNSNY) and the Queens Wellness Partnership, representing the broader social service provider network. A series of community stakeholder meetings were held to discuss the CNA process including the CNA methodology; recruitment of community, academic and government partners; secondary data analysis; primary data collection from external stakeholders; evaluation of primary data; identification of health system and community resources; identification of NYSDOH Priority Agenda items and prioritization of DSRIP projects.

A consumer survey of Medicaid beneficiaries was conducted to ascertain their health perceptions and key concerns. The consumer survey explored key concerns of community residents, as well as identifying service needs and barriers to care. The surveys were administered in Creole, English, and Spanish. The survey was distributed through an electronic link, hospital outreach programs, ambulatory health providers with high volumes of Medicaid recipients including hospital-based, free standing and FQHC sites, community–based organizations, county agencies, and other outlets such as faith-based organizations and community centers. A total of 3,600 surveys were completed.

A series of Medicaid-focused stakeholder forums were held. The forums were held to gain a better understanding of the health care delivery system, areas of strength, and what changes might help NQP achieve the goals of the DSRIP program. The forum discussions focused on significant health problems in the CBO's communities; barriers to care; quality of care; current health services; gaps in services/access and recommendations for improving services. A total of 17 stakeholder forums were conducted with over 270 participants.

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

Secondary data analysis informed the Community Needs Assessment. The CNA Guidance provided a blueprint for the work. Using a variety of data sources, indicated below, we developed a detailed catalog of health resources available in the community. A detailed demographic assessment of the community was conducted. A comprehensive review of the health status of the community was completed which included morbidity and mortality data for most diseases. Special attention was given to identify communities with poor health status. The CNA also highlighted the health care utilization, including avoidable hospital use, again identifying "hot spot" communities of Medicaid beneficiaries and individuals without insurance.
Specific data sources included:
- Center for Workforce Studies, NY Workforce Planning Data Guide

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- Department of Agriculture and Markets, NYS Farmers' Markets
- DOH Health Care Provider Profiles
- DSRIP Dashboards
- Greater New York Hospital Association Health Information Tool for Empowerment (HITE)
- Health Data NY website
- Nassau County DOH Community Needs Assessment, 2013
- NYS Prevention Agenda Dashboard
- Salient NYS Medicaid Claims Data
- SPARCS – hospital and department use
- United Way 211 Long Island
- US Census Bureau, American Community Survey, 2012

When available, data specific to the NQP area in eastern Queens were used as the basis for analysis. In some instances, however, data were only available at the county level. Those instances are noted in the narrative. Primary data from the consumer surveys and stakeholder forums were used to incorporate the experiences of consumers and to highlight experiences of particular population subgroups (uninsured, individuals with chronic illness, individuals using behavioral health services, individuals using the Long Term Care system). These efforts provided a better understanding of how well the health care delivery system is meeting the needs of consumers, and where there are opportunities for improvement.

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	15	15
2	Ambulatory surgical centers	18	7
3	Urgent care centers	60	3
4	Health Homes	5	2
5	Federally qualified health centers	25	8
6	Primary care providers including private, clinics, hospital based including residency programs	3422	1773
7	Specialty medical providers including private, clinics, hospital based including residency programs	5021	3638
8	Dental providers including public and private	1461	31
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	363	234
10	Behavioral health resources (including future 1915i providers)	209	135
11	Specialty medical programs such as eating disorders program, autism spectrum early	116	51
12	diagnosis/early intervention	109	15
13	Skilled nursing homes, assisted living facilities	79	48
14	Home care services	27	11
15	Laboratory and radiology services including home care and community access	323	76
16	Specialty developmental disability services	74	17

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
17	Specialty services providers such as vision care and DME	589	28
18	Pharmacies	302	10
19	Local Health Departments	2	2
20	Managed care organizations	20	3
21	Foster Children Agencies	5	1
22	Area Health Education Centers (AHECs)	1	1

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

***Infrastructure 2:**

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

Creating an integrated delivery system will require a significant increase in the number of care managers throughout the system. These individuals will need to be linguistically and culturally matched with the populations they serve.

SNFs lack clinical staff and infrastructure, particularly in evenings and on the weekend, which directly contributes to avoidable emergency department visits and hospitalizations. If a nursing home resident has a change in status and no clinician is available to provide a clinical assessment, the cautious approach is to seek clinical judgment in an emergency department.

Nassau and Queens lack psychiatrists to meet community need; NQP partners will need to hire and deploy non-MD professionals, particularly bilingual staff, to meet the goals of an integrated delivery system. Crisis care is particularly lacking, as no resources exist outside the emergency department.

As we plan to co-locate primary care at behavioral health sites, a multi-level workforce in BH settings will be needed.

Access to primary care in the Rockaway peninsula is very difficult, particularly for low-income residents. Many physicians who were affected by Superstorm Sandy left the area and did not return; one of the two hospitals on the Rockaway peninsula closed and the remaining hospital moved its primary care clinics to the Joseph P Addabbo Family Health Center. There is only one FQHC on the peninsula. More access to primary care is a continuing need in the Rockaways.

There are insufficient providers to handle the pandemic of diabetes. We will need to develop a larger outpatient workforce, both physician and non-physician to meet the needs, particularly in PCMHs. Diabetes educators will be needed to staff community-based programs that are less medically focused.

To expand the reach of PCMHs will require added numbers of physician assistants and nurse practitioners. A shortage of advanced practitioners will limit NQP's ability to implement advanced primary care across the PPS. The number of NPs and PAs in NQP's region is at the 10th percentile; the workforce gap is estimated at 650 NPs and PAs to get to the 50th percentile.

A serious lack of detox services was reported in both Nassau County and Queens (no detox beds exist in the Rockaways), and agencies report long waiting lists for services as well as a high rate of recidivism. Denials for inpatient detox are common, but no alternative outpatient services are available in Nassau County. Outpatient services are the preferred treatment modality, but the outpatient detox capacity has not been established to replace inpatient services.

For individuals who are HIV-positive, preventive care is reported as inadequate, especially for the uninsured. Access to care in the clinics is limited, and private physicians are frequently unaware of current, appropriate treatment. Stigma remains an issue among clinicians, leading people to avoid care. Lack of services for the LGBT community is an on-going problem. Mental health providers with competence in HIV/AIDS are lacking.

Section 3.3 - Community Resources Supporting PPS Approach:

NYS Confidentiality – High

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

DSRIP PPS Organizational Application

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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	98	38
2	Food banks, community gardens, farmer's markets	82	14
3	Clothing, furniture banks	15	11
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	93	9
5	Community outreach agencies	362	82
6	Transportation services	26	7
7	Religious service organizations	1247	27
8	Not for profit health and welfare agencies	1966	25
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	116	66
10	Peer and Family Mental Health Advocacy Organizations	203	64
11	Self-advocacy and family support organizations and programs for individuals with disabilities	404	12
12	Youth development programs	212	57
13	Libraries with open access computers	115	2
14	Community service organizations	1896	804
15	Education	888	176
16	Local public health programs	5634	36
17	Local governmental social service programs	695	16
18	Community based health education programs including for health professions/students	366	204
19	Family Support and training	430	47
20	NAMI	1	1
21	Individual Employment Support Services	99	10
22	Peer Supports (Recovery Coaches)	53	35
23	Alternatives to Incarceration	19	7
24	Ryan White Programs	27	0
25	HIV Prevention/Outreach and Social Service Programs	48	10

***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.

Lack of safe, secure, affordable housing is a major challenge. This was mentioned in every stakeholder session we held. Housing vouchers are inadequate to meet the cost of housing, and all emergency housing programs have wait lists. Homeless individuals face an additional challenge of maintaining connections to providers as a result of transience.

Housing instability is problematic for those with behavioral health conditions. The number of people seeking shelter through the

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emergency shelter system with substance use and mental health complications is up sharply in recent years.

Community-based providers and CBOs identified a lack of centralized information about resources and services available, making it hard to connect clients to services. County departments of social services can play that role, but their performance is inconsistent.

Transportation is a major challenge, especially after hours. For individuals living off public transportation routes, access is a major problem. Transportation in eastern Queens and the Rockaways is inefficient, and has a direct impact on participation in mental health services, as both the cost of transportation and the time required provide significant deterrents. Free Metrocards or other subsidies are needed. Inadequate public transportation encourages people to call an ambulance to get to a doctor, increasing ED use. Co-locating services, including health care, behavioral health and social services, would make it easier for families to navigate the system and obtain needed care.

While the developmentally disabled system has significant resources on the residential side, advocates indicate that community-based supports are inadequate. The system is heavily provider-dominated, and family support organizations are under-funded.

Peer services are in a fledgling state, particularly in chemical dependency programs in Nassau. NYS OASAS is establishing recovery centers across the state, but none currently exists on Long Island. There is an informal recovery network on Long Island, LIRA (Long Island Recovery Association), but it is small and under-funded. MHA operates a Peer Consumer Link as well as Hands Across Long Island. There is a veteran peer program called Vet-to-Vet. MHANC is opening a peer respite program in January in Nassau as part of a hospital diversion program.

The communications between mental health providers and the criminal justice system is limited. Mental health agencies frequently don't know if one of their clients is incarcerated, or when they will be released. Treatment and housing agencies are supposed to be informed pre-release, but care coordinators can be looking for clients who they can't locate, and will check public web sites to learn whether they have been incarcerated. Nassau County has recently entered into an agreement with the sheriff that provides a daily list of who has been incarcerated and who is due for release. They plan to share those lists with the health homes, and depending on the health homes to share that information with other providers.

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:

Nassau County, with a population of 1,339,532 residents, comprises 16 percent of the statewide population; Queens, with 2,230,725 residents, comprises just over twenty-seven percent. eastern Queens, east of the Van Wyck Expressway and including the Rockaways, has a total population of 1,055,746. When looking at age, Nassau residents are slightly older than the statewide average while Queens residents are slightly younger. Persons under 5 comprise 5.4% of the population in Nassau and 6.2% in Queens; the NYS rate is 6.0%. Persons over 65 make up 16.1% of the Nassau population and 13.4% of the Queens population; the NYS rate is 14.4%.

Almost 20% of Medicaid beneficiaries in Nassau, and 17% in Queens, are below the age of 5; one-third of Nassau beneficiaries and 30% of Queens beneficiaries are below the age of 20. 12% of beneficiaries in Nassau and 9% in Queens are over the age of 70. Over 18% of Nassau beneficiaries are duals; in Queens it is 14%.

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

Nassau is 76.7% white, 12.4% Black/African Amer., 8.7% Asian and 15.7% Latino. Queens is 49.7% White, 20.9% Black/African Amer., 25.2% Asian, 28.0% Latino.

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Queens is extremely diverse, with large minority and immigrant populations. Almost 50% the Queens population is foreign-born, and more than half speak a language other than English. Nassau is more homogenous, although the immigrant population has been growing rapidly in recent years. The National Center for Education Statistics estimates that 10% of Nassau population and 46% of the Queens population lack basic prose literacy in English. Nassau is home to 223,494 Medicaid beneficiaries; Queens is home to 445,274 Medicaid beneficiaries. Medicaid beneficiaries are disproportionately minority with only 26% in Nassau and 11% in Queens identifying as white.

A sizeable share of the uninsured are non-citizens, many undocumented. Foreign-born non-citizens lack insurance at the highest rate, with 39% in Nassau and 35% in Queens uninsured.

***Demographics 3:**

Income levels:

Nassau County has a median household income of $97,690 per year, with 6% of total population living below the poverty level, compared to Queens with a median household income of $57,001 and 15.0% of persons living below the poverty level. Within Nassau, the two areas with the most Medicaid enrollees had a significantly lower median household income, and much greater percent of persons living below the poverty level. The towns are Hempstead and Freeport with 20.5% and 13.7% of the population living below the poverty level.

The median household income for Hempstead was $52,214 while Freeport was higher at $67,874. Eastern Queens, Jamaica, Flushing, Fresh Meadows, and Far Rockaway had the highest concentrations of Medicaid enrollees. Within eastern Queens, poverty data reveal that the Rockaways have the highest poverty rate at 42.9% followed by Jamaica at 33.7%. Flushing–Clearview is slightly below Jamaica at a 30.1% poverty rate followed by Fresh Meadows which has a 24.3% poverty rate.

***Demographics 4:**

Poverty levels:

Just over 14% of the Queens population is below poverty, compared with the NYS average of 15%; 6% of the Nassau population is below the poverty line. These figures mask pockets of significant poverty. In NUMC/NuHealth's primary service area the poverty rate is 9.4%, and three zip codes in the primary service area report a poverty rate of over 10 percent. Nine communities in Nassau County have been identified as "at risk" for poor health status due to their economic status. In these communities (Freeport, Hempstead, Inwood, Long Beach, Westbury, Roosevelt, Uniondale, Elmont and Glen Cove) poverty rates ranged from 15 – 21%.

***Demographics 5:**

Disability levels:

Census data report that 164,354 individuals in Nassau, or 12% of the population, and 134,170 individuals in eastern Queens, representing 5%, are disabled. Within that cohort, 38.7% of disabled persons between the ages of 0-64 are on some form of public insurance, and 6.7% of individuals in the same cohort are uninsured. Of the disabled persons between the ages of 0-64 on public insurance, only 4.4% are under the age of 18, while those uninsured less than 18 years old drops to well below 1%. Similarly, in eastern Queens, 134,170 individuals are reported as disabled, of whom 50.3% of those between the ages of 0-64 are on some form of public insurance, and 10.7% of individuals in the same cohort are uninsured. Of the disabled persons between the ages of 0-64 on public insurance, only 5.5% are under the age of 18, while those uninsured less than 18 years old drops to well below 1%.

***Demographics 6:**

Education levels:

Forty-one percent of the Nassau population 25 years and older has attained a Bachelor's Degree or higher, while 11% has less than a high school diploma. Twenty-nine percent of the Queens population 25 years and older has attained a Bachelor's Degree or higher, while 19.9% has less than a high school diploma. While the high school graduation rate is 89% in Nassau, it is 41% in Hempstead, 74% in Roosevelt, and %75% in New Cassel, minority and low-income communities. The NYC high school graduation rate is 65%, while Jamaica rates are as low as 45%. Far Rockaway's graduation rate is 40%.

***Demographics 7:**

Employment levels:

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The unemployment rate in Nassau County was 4.9% as of August 2014, while in Queens it was 6.1%. In Jamaica, 9% of residents are unemployed, and Far Rockaway reports a 14% unemployment rate.
Approximately 120,000 people in Nassau County (8.0%) and 150,000 people in eastern Queens (14.2%) are without health insurance. When looking at coverage by employment status, 29% of the unemployed in Nassau and 36% of the unemployed in Queens are uninsured; 9% of the employed in Nassau and 17% of the employed in Queens are uninsured.

***Demographics 8:**

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

NQP is home to both the Nassau County Correctional Facility and Rikers Island. The Nassau facility has a census of 1300 inmates; Rikers has an average daily population of 14,000 inmates. Both facilities are jails, confining pre-trial detainees and inmates sentenced to less than 1 year. As such, they pose particular challenges with health care because of rapid turnover, lack of continuity, lack of access to medical records, poor discharge planning and interruptions in insurance. Detainees are disproportionately affected by substance abuse, chronic infectious diseases including HIV, and mental illness. The Division of Criminal Justice of NY offender reentry task force shows that the needs most commonly identified for high risk inmates upon re-entry to the community are employment, social service needs, chemical dependency treatment, housing and mental health treatment.

The Queens Detention Facility is a facility for people awaiting deportation, which can house up to 222 prisoners.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
14_SEC034_C:\Users\amehta1\Downloads\14_SEC034_Project 2.b.vii, Question 1E, Nassau Queens PPS.docx	12/30/2014 10:52:34 AM	Nassau Queens PPS 2.b.vii Question 1E
14_SEC034_C:\Users\amehta1\Downloads\14_SEC034_Project 2.b.iv, Question 1E, Nassau Queens PPS.docx	12/30/2014 10:51:03 AM	Nassau Queens PPS 2.b.iv Question 1E
14_SEC034_Project 3.b.i, Question 4C, Nassau Queens PPS.docx	12/22/2014 12:08:26 PM	Nassau Queens PPS 3.b.i Question 4C
14_SEC034_Nassau Queens DSRIP PPS Community Member Survey Report.pdf	12/22/2014 09:57:38 AM	

Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

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

***Challenges 1:**

Leading causes of death and premature death by demographic groups:

The leading causes of death in Nassau and Queens are very similar to the reported causes of death in the US and in NYS. In Nassau heart disease ranks first, followed by cancer, chronic lower respiratory disease, stroke, and influenza. In Queens, heart disease is the leading cause of death for white, black and Latino populations, and cancer is second, while for the Asian population the order is reversed. Age-adjusted mortality rates reflect racial disparities in both counties. Whites and Blacks have the highest age-adjusted mortality rates; Asians have the lowest. The top five causes of premature death in Queens are cancer, heart disease, unintentional injury, diabetes and stroke. The leading causes of premature death in Nassau County are cancer, heart disease, chronic lower respiratory disease and stroke. When looking at premature death, in both counties, Blacks, Hispanics and Asians have almost double the premature death rates than Whites.

***Challenges 2:**

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Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The leading causes of Pediatric preventable hospitalizations in the NQP service area are asthma, gastroenteritis and urinary tract infections. Leading causes of PPS adult preventable hospitalizations in the NQP service area are asthma, chronic obstructive pulmonary disease, and heart failure. The difference in adult preventable hospitalizations by county is that bacterial pneumonia is one of the leading causes of preventable hospitalizations in Queens and urinary tract infections is in Nassau. In Queens, Blacks have double the rate of preventable hospitalizations compared to the other race groups. In Nassau, Whites have the highest rates followed by Blacks and Hispanics.

***Challenges 3:**

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

In Nassau and Queens the rate of avoidable ED visits is 75% and 71% respectively. In Nassau we see 28 ED visits for ambulatory care sensitive conditions per 100 Medicaid beneficiaries, and 31 per 100 in Queens. Almost one third of children do not receive the recommended number of well child visits. Initiation of alcohol and drug dependence treatment is below the state average for the NQP region. Antidepressant medication management for the effective treatment of the acute phase and 30-day follow-up after a mental health admission was below the state average for Queens. Throughout NQP, diabetes monitoring for people living with schizophrenia is lower than the state average. Nassau Medicaid beneficiary comprehensive diabetes care HbA1c testing and diabetes monitoring for people living with diabetes and schizophrenia are lower than the state average. In Nassau, breast, colorectal and cervical cancer screenings are below the state average.

***Challenges 4:**

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

In Queens, there are 32 % beneficiaries with cardiovascular disease while in Nassau 27%. It is the number one associated condition associated with hospital admissions and second highest condition associated with ED visits. Diabetes is present in of 12% Queens and 9% of Nassau beneficiaries. Adult uncontrolled diabetes avoidable hospitalization rates in Nassau county are above the state average. In Queens, there are 16 % beneficiaries with mental health conditions while in Nassau 19 %. It is the group that is most associated with ED visits and the second most related to inpatient admissions. Substance abuse is present in 3.8% of Queens and 4.9 % of Nassau beneficiaries. It is the third most associated with ED and inpatient admissions in either county. Respiratory conditions are present in 8% of Nassau and Queens Medicaid Beneficiaries. In Queens and Nassau there are 0.2% % and 0.9% beneficiaries with HIV/AIDS.

***Challenges 5:**

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

Infant mortality rate per 1000 live births in Nassau (3.9) and Queens (4.6) are both below the state average of 5.6. The percent low birth weight births are also below the state average (8.0 in Nassau, 8.1 in Queens compared with 8.5 statewide). The maternal mortality rate in Nassau, at 28.4 per 100,000 live births, is higher than the rate in Queens (20.8) and higher than the statewide average of 21.7. Premature births, less than 37 weeks gestation, represented 11% of all births in both counties, consistent with the state average. The percent of births with early (1st trimester) prenatal care in Nassau is 81.4, compared with Queens which at 70.2%, is slightly below the state average of 72.5. Conversely, the percent of pregnancies receiving late/no prenatal care was 3.1% in Nassau, but 7.5% in Queens, compared to a state average of 5.6%. While these counties have better than average maternal health statistics, selected communities within the NQP region have significantly poorer indicators. The 9-community region in Nassau County identified as high risk has an infant mortality rate of almost 8%, a low birth weight rate of 9%, and over 5% of pregnancies received late/no prenatal care.

***Challenges 6:**

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

The pediatric and adult obesity rates in Nassau and Queens are 16%/19% and 21%/22% respectively. In Nassau County, 28% of the population eats the recommended amount of fruits and vegetables, compared to 10% in Queens. One in four Nassau and Queens residents get no exercise. Adult cigarette smoking occurs in 12% of Nassau and 14.9% of Queens residents. Low income adults have a 23% smoking rate. The prevalence of tobacco use by NYS high school students is 21.8%. Nassau and Queens county residents have an adult binge drinking rate of 13.4% and 18% compared to the state average of 18%. Drug related hospitalizations in Nassau and Queens are 19.6 and 14.5 compare to the state rate of 25.7/10,000.

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***Challenges 7:**
Any other challenges:

N/A

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**.

When looking at hospital beds, the bed to population ratio is above the state average in Nassau County, at 321.7 per 100,000 compared with 289 statewide; Queens County, at 168.3 beds per 100,000 is significantly lower than the statewide average. The inpatient occupancy rate among NQP hospitals was 71% in 2013, and ranged from 48% to 85%.

While a large number of nursing homes exist in Nassau and Queens, the counties both have lower bed-to-population ratios than the state-wide average. The statewide ratio is 597 per 100,000; the ratio in Nassau is 553.3 and 551.9 in Queens.

1,963 primary care physicians are practicing in Nassau County; 2,241 practice in Queens. This translates into a rate of 145.5 primary care physicians per 100,000 population in Nassau, 98.4 primary care physicians per 100,000 population in Queens. Compared to a statewide rate of 120.0 primary care physicians to 100,000 population, Nassau has an over-supply while Queens has an under-supply. Nassau County also has a very high number of medical specialists and of residency training programs. Looking at overall numbers can be deceptive as it does not reflect areas that are medically underserved.

Nassau County has a large supply of medical providers. The Center for Health Workforce Studies indicates 4,446 medical specialists practice in Nassau County, generating a rate of 329.5 specialist physicians per 100,000, compared with a state-wide rate of 228 per 100,000. In contrast, Queens has 2,572 non-primary care physicians for a rate of 112.9 per 100,000. When looking at surgeons, the statewide rate per 100,000 is 8 for general surgeons and 38 for surgical subspecialists. In Nassau the rates are 10.6 per 100,000 for general surgeons and 59.7 for surgical subspecialists. Queens is less well-resourced with 5.8 general surgeons per 100,000 and 16.1 surgical subspecialists per 100,000.

The availability of psychiatrists is low in both counties: compared to a statewide average of 36 per 100,000 population, in Nassau the rate is 29.9 and in Queens it is 20.2.

While 2 psychiatric emergency departments and 13 hospital-based psychiatric units are operating, mobile crisis programs have limited availability, and can require as much as 48 hours' wait to obtain care. The outpatient care continuum includes 30 mental health clinics and 48 outpatient substance abuse clinics, but lacks the transitional supports and peer navigators needed to fully leverage those assets. Post-hospitalization community-based services are hard to find for those without insurance. While Emergency Medicaid covers inpatient care, it rarely follows an individual back into the community. Locating home and community-based services for those without insurance is very difficult.

Health services for uninsured are limited across the board. Waits for appointments in sites with sliding fee scales range from 4-6 weeks.

***Gaps 2:**
Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services, such as hours of operation and transportation, which are contributing to the identified needs of the community.

The FQHCs are an important source of accessible care, particularly for Medicaid and uninsured patients. Capacity is limited by financial constraints. In particular, FQHCs currently lack resources to further expand hours. The availability of evening hour and walk-in urgent care

services would have a direct impact on emergency department use, especially for those without insurance.
In order to expand primary care capacity the region will have to address non-physician providers. When looking at non-physician primary care providers, Queens falls significantly below state-wide averages. Queens has 36.2 nurse practitioners per 100,000 population and 43.6 physician assistants per 100,000 population. These data compare to the statewide numbers of 76 nurse practitioners per 100,000 population and 61 physician assistants per 100,000 population. Queens is lacking in a primary care workforce that will be necessary to enact system transformation, particularly on the non-physician side.
While there are large numbers of dental providers, consumers reported trouble obtaining care. The availability of dentists does not necessarily translate into access to care for the Medicaid and uninsured populations. Medicaid rates for dental care remain low, and while dentists may accept Medicaid, they limit the numbers they will see.
Public transportation in Nassau County is limited both geographically and in terms of hours of operation. The community survey identified transportation as one of the leading reasons that prevented people from getting care, and is a contributing factor in reliance on ambulance transportation that results in unnecessary ED use.

***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.

NQP established a Clinical Oversight Committee (COC). The COC will develop a set of reports that will provide project teams with information necessary to monitor progress in real-time across a wide range of indicators, including both physical and behavioral health metrics. These reports will generate PPS-wide assessments of performance, allowing NQP to track the performance of the projects. Data will be reported to the COC and shared with the Executive Committee. Results also will be shared with the participants and their providers.

The project teams will be responsible for identifying service gaps that need to be addressed for them to effectively implement projects and for determining the flow of funds within its projects. Organizations will participate in incentive payments based on their level of participation in projects. As community-based providers and organizations take on additional functions within the PPS, their resources will be augmented according to DSRIP guidelines. Final decisions about developing, expanding or repurposing resources will be approved by the Executive Committee.
Consistent monitoring of the impact of DSRIP on inpatient utilization will be needed. The region currently has excess inpatient capacity, which will increase further as inappropriate utilization is reduced. Excess capacity will be scattered across a number of hospitals, each of which will develop a strategy that allows them to shift to value-based reimbursement to maintain financial viability. RCE will be an important tool in allowing NQP to transform from a disparate group of providers operating in the same geography into an integrated system that provides consistent, coordinated, metric-driven quality to a large population while reducing unnecessary hospitalizations and expense.
For gaps that were identified in the CNA, the hub leaders will work with relevant providers to determine how to expand services to fill those gaps--if a gap is identified or develops during the DSRIP implementation period, the hub leaders will work with relevant providers to develop a plan for filling that gap as quickly as possible. Regarding re-purposing, each hub leader is committed to adapting its facilities to the shifting needs of the community, and will continuously assess whether there are opportunities to re-purpose facilities for other uses that would better address evolving needs.

Section 3.7 - Stakeholder & Community Engagement:

Description:

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

***Community 1:**

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

The CNA would not be complete without broad stakeholder input and representation so a coordinated engagement process was developed. With this in mind, the community engagement process began in May 2014, when community providers and organizations were convened to hear about and discuss the goals and planned activities of the DSRIP program. Over the next three months, representatives

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from 72 organizations attended DSRIP stakeholder sessions that were held in May, June and August. In September, two separate meetings of community-based organizations were held, one in Nassau and one in Queens, seeking their input on a draft community health survey and stakeholder forums. Organizations were asked to distribute surveys to their clients (primarily Medicaid and uninsured), to participate in stakeholder forums, and to identify additional participants that would bring a broad perspective on the Nassau County health care delivery system.

At that time, the three hubs began collaborating on the Community Needs Assessment. A CNA Steering Committee was formed with representation from the three organizations and included the Health and Welfare Council of Long Island (HCWCLI),a CBO which represents the broader social service provider network. Agreeing to participate in obtaining the voice of the consumer, 23 agencies and providers distributed consumer surveys in English, Spanish and Creole. A total of 3,600 surveys was completed. Stakeholder forums were also held to explore the health issues of special populations. This included organizations that cared for or advocated for dual eligibles; persons with severe mental illness and substance abuse problems; persons having difficulty with obtaining housing; and persons with multiple chronic diseases. The Steering Committee reached out to coalitions as well as agencies identified by United Way, other associations (Advanced Health Network, and Alliance of Long Island Agencies, and Medicaid Matters New York), NYC DOHMH and Nassau County Health and Human Services Departments. HWCLI reached out to CBOs within its membership.

A NUMC/NuHealth, then NQP website was established in November 2014, which provided the background of DSRIP and included all presentations; findings from the community needs assessment; information about the PAC, as well as a place for website visitors to provide comments and feedback.

***Community 2:**

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

17 stakeholder focus group (aka forums) were held in each county. Approximately 400 organizations were invited. Each forum had significant attendance. In all, 176 organizations attended the 17 forums. The forums focused on:

- Basic Needs (Homeless, housing, food, hunger)
- Addiction (Providers, community agencies, peer supports, recovery supports, consumer advocates)
- Mental health (Providers, community agencies, peer supports, recovery supports, consumer advocates)
- Chronic Conditions (Primary care providers, care manager, health homes, advocacy organizations)
- Dual-Eligibles: Community-based long-term care (Home care providers, consumer advocates, independent living)
- Dual-Eligibles: Skilled Nursing Facility (Nursing home providers, hospital care transition coordinators, consumer advocates/family representatives)
- Immigrants/uninsured (FQHCs, religious/other service organizations)
- People with HIV/AIDS (Providers, community agencies, consumer advocates)
- Persons with Intellectual/Developmental Disabilities. (Advanced Care Alliance DISCO; community residential facilities, parents/caregivers)

***Community 3:**

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

The stakeholder forums' key findings and conclusions included:

- Lack of Communication – between physical health and behavioral health providers, even within a single institution; between inpatient service and community-based providers; between inpatient service and community service agencies; between County agencies and the health care provider system; between behavioral health providers and the criminal justice system; between mental health and chemical dependence providers; and between providers and health homes.

- Lack of 24/7 high quality clinical assessment and crisis intervention
- Lack of care coordination
- Lack of patient education and self-management support
- Lack of medication adherence

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- Lack of housing – the lack of stable, secure, affordable housing was mentioned in every session.
- Lack of public transportation - The limits of the public transportation system and the available transportation programs restrict access to care.
- Lack of services in languages other than English contributes to disparities in outcomes, as well as to lack of compliance with treatment; language barriers are a particular problem in behavioral health services.

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.

[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Able HealthCare Service	Certified Home Health Agency and Special Needs Certified Home Health Agency	Provided stakeholder input on Community-Based Long Term Care issues related to care transitions, communication gaps, and preventable readmissions
2	ACLD	Not-for-profit agency providing Primary Care, Neurology, Psychiatry, Counseling, Podiatry, Dentistry, Dermatology, occupational, physical, speech therapy, psychological testing and Women's Health Services	Provided stakeholder input on health care issues for persons with intellectual/developmental disabilities regarding preventable emergency department admissions from residential facilities and health care and related service gaps
3	Aids Center of Queens County	Non-profit organization providing no-cost HIV/AIDS services including case management, health education and prevention, housing, and legal services; programs including harm reduction, syringe exchange, and food pantry programs; and a licensed mental health clinic	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
4	Asthma Coalitions of LI, ALA & NE	Aims to improve quality of life for those with asthma through information-sharing, networking and advocacy	Provided stakeholder input on issues for persons with chronic conditions related to preventable readmissions, medication costs, and patient knowledge and empowerment
5	Attentive Care, Inc.	Provides nursing services including homemakers, personal care aides, home health aides, nurse's aides. Registered Nurses or live-ins to persons who need assistance with their daily living tasks. Provides services in the patient's home, in the hospital or nursing home	Provided stakeholder input on Community-Based Long Term Care issues related to care transitions, communication gaps, and preventable readmissions
6	Belair Care Center	Skilled nursing facility of 102 beds providing long term care, occupational, physical and speech therapy, sub-acute care, wound care and short-term rehabilitation	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
7	Bridge Back to Life	Provides education, treatment and support to recovering individuals and their families in a certified, medically supervised outpatient substance abuse treatment center. Incorporates a 12-step self help program into the treatment philosophy	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
8	Care Center South Shore Child Guidance	Provides chemical dependency treatment to individuals identified as substance abusers, significant others, and loved ones with special emphasis on children of substance abusers	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
9	Catholic Charities	Non-profit religious organization delivering, coordinating, and advocating for quality human services and programs for those in need through a network of administered, sponsored and affiliated agencies	Provided stakeholder input on mental health service issues related to avoidable hospital use, availability of hospital alternatives, and care coordination
10	CCSWN NAFAS	Alliance providing a full range of services to those affected by drugs, alcohol, gambling and more; also educates and advocates for addiction treatment	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
11	CDCLI	Housing agency aiming to provide solutions that foster and maintain "vibrant, equitable, and sustainable communities "	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
12	Central Island Healthcare	202 bed, sub acute rehabilitation and skilled nursing center	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
13	Central Nassau Guidance	Nonprofit organization providing clinical treatment, rehabilitation, housing opportunities, social and support services, counseling and guidance to individuals, families and the community affected by mental illness, developmental disabilities, psychological difficulties, addiction and/or addiction problems	Provided stakeholder input on chemical dependency and mental health services issues related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
14	CHN	A network of not-for-profit community health centers providing medical, dental and social services to neighborhoods	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
15	Choices Women's Medical Center	Abortion clinic providing abortion, gynecological, and prenatal care services	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
16	Cornerstorne Treatment	Chemical dependency treatment facility providing a full range of inpatient and outpatient treatment services	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
17	Counseling Service EDNY	Not-for-profit organization providing treatment alternatives to incarceration Accepts referrels from federal and state probation and parole, as well as the court systems; also provides addiction treatment for individuals	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
18	Dominican Sisters FHS	Home health agency providing home care, family care, and a managed long term care program	Provided stakeholder input on Community-Based Long Term Care issues and on persons with chronic conditions related to preventable readmissions
19	Empire Justice Center	Non-profit multi-issue, multi-strategy public interest law firm providing services for poor and low income families and litigation backup to local legal services	Provided stakeholder input on barriers to health care access for immigrants and the uninsured,

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		programs and community based organizations.	including language and trust barriers; and suggested ways to improve health care delivery and communication between health care providers and the population
20	EPIC/South Shore Child Guidance	Organization providing comprehensive outpatient behavioral health services to children and families	Provided stakeholder input on chemical dependency and mental health service issues as well as issues for persons with intellectual/developmental disabilities, and for persons with chronic conditions related to preventable emergency room visits
21	Federation of Organizations	Not -for-profit corporation which provides multi-service, community-based social welfare agency operating programs that utilize peer support within a self-help model. Develops programs designed to meet the needs of those recovering from mental illness, the homeless, low-income seniors, at-risk children and other groups	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
22	FEGS Health and Human Services	Human services agency with over 350 locations providing programs in health, disabilities, home care, housing, employment, workforce, education, youth, and families	Provided stakeholder input on Community-Based Long Term Care issues and on issues for persons with chronic conditions related preventable admissions/readmissions
23	Five Towns Community Center HIV/STI prevention	Provides HIV/AIDS/STI prevention education to high risk youth, women and men in Nassau and Queens counties.	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
24	Guildnet	Healthcare program which manages and coordinates home services, medical/therapeutic, equipment, and multi-location services	Provided stakeholder input on Community-Based Long Term Care issues related to care transitions, communication gaps, and preventable readmissions
25	Hagedorn Foundation	Foundation providing support to organizations which support and promote social equity	Provided stakeholder input on barriers to health care access for immigrants and the uninsured, including language and trust barriers; and suggested ways to improve health care delivery and communication between health care providers and the population
26	Hispanic Counseling Center	Multi-service agency that provides bilingual treatment and prevention services for chemical dependency, mental illness, and youth and family programs for those of all races, religions, ethnicities, and economic status with the primary focus on needs of Latino families	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
27	HWCLI	Not-for-profit health and human services planning and advocacy organization serving as an umbrella for agencies serving Long Island's poor and vulnerable individuals and families	Provided stakeholder input on barriers to health care access for immigrants and the uninsured, including language and trust barriers; and suggested ways to improve health care delivery and communication between health care providers and the population

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
28	Island Harvest	Hunger relief organization and food bank	Provided stakeholder input on basic needs issues related to primary health care and community mental health care accessibility and connectedness, housing, and healthcare for the homeless
29	L.I. Association for AIDS Care	Provides a stable and comprehensive safety net for many diverse communities	Provided stakeholder input on issues for persons with chronic conditions and chemical dependency and mental health service issues related to preventable emergency room visits
30	L.I. Council on Alcoholism & Drug Dependence	Not-for-profit agency promoting addiction prevention through education and early intervention strategies to solve addiction and family related problems	Provided stakeholder input on issues with services for people with HIV and chemical dependency services related to preventable emergency room visits
31	L.I.B.A.	Networking organization of premier business professionals; meets regularly as a group, in one-on-one sessions and at networking events and charitable projects	Provided stakeholder input on mental health service issues related to avoidable hospital use, availability of hospital alternatives, and care coordination
32	ALLIANCE OF LONG ISLAND AGENCIES INC	Non-profit corporation aiming to provide services for persons with mental retardation and developmental disabilities	Provided stakeholder input on health care issues for persons with intellectual/developmental disabilities regarding preventable emergency department admissions from residential facilities and health care and related service gaps
33	Long Beach Reach, Inc.	Performs community-based services with the goal to engage individuals and families and help develop self-awareness and self-esteem	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
34	Long Island Gay and Lesbian Youth	Performs community-based services with the goal to engage individuals and families and help develop self-awareness and self-esteem	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
35	Maryhaven Center of Hope	Group of non-profit organizations working to serve Long Island's GLBT community throughout the lifespan; provides education, advocacy, youth leadership, development and support	Provided stakeholder input on chemical dependency and mental health service issues related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
36	Mercy First/ The Childrens Collaboration	Not-for-profit human service agency serving children and their families of regardless of race, religion, sexual orientation and physical condition	Provided stakeholder input on issues for persons with chronic conditions related to preventable readmissions, medication costs, and patient knowledge and empowerment
37	Melillo Center	Tax exempt charitable organization providing an outpatient mental health clinic, outpatient chemical dependence clinic, assertive community treatment (ACT), supervised community residences, supported housing, and an independent living program	Provided stakeholder input on chemical dependency and mental health service issues related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			detox services
38	MHA of Nassau County	Not-for-profit membership organization aiming to improve mental health in the community through advocacy, education, program development and the delivery of direct services	Provided stakeholder input on health care issues for persons with intellectual/developmental disabilities regarding preventable emergency department admissions from residential facilities and health care and related service gaps
39	Nassau Extended Care Facility	Skilled nursing facility of 280 beds providing long term care, adult day care, alzheimer's disease and dementia care, occupational, physical, speech and respiratory therapies, respite care, pain management, short-term rehabilitation, sub-acute care, parenteral nutrition, tracheostomy care and wound care Affiliated with Sentosa Care, LLC Call for further information	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
40	National Healthcare Associates	Group of centers providing a scope of physical, occupational and speech therapy specialists, no matter what healthcare support the patient needs	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
41	NCOMHCDDDS	Provides mental health, chemical dependency, and developmental disabilities services, and abehavioral health awareness campaign	Provided stakeholder input on mental health service issues and on issues for persons with intellectual/developmental disabilities related to avoidable hospital use
42	New Horizon Counseling Center	Non-profit counseling center providing individuals ages 6+ with individual therapy and medication management	Provided stakeholder input on mental health service issues related to avoidable hospital use, availability of hospital alternatives, and care coordination
43	North Shore Child and Family Guidance Center	Not-for-profit children's mental health agency	Provided stakeholder input on mental health service issues related to avoidable hospital use, availability of hospital alternatives, and care coordination
44	Nurses On Hand Registry	Home Care Services Agency providing home health aides, nursing, and personal care	Provided stakeholder input on Community-Based Long Term Care issues related to care transitions, communication gaps, and preventable readmissions
45	NYS Oasas Long Island Field Office	Aims to improve the lives of the community through comprehensive premier system of addiction services for prevention, treatment, and recovery	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
46	Peninsula Counseling	Offers a variety of mental health counseling services including family counseling, marital counseling, children and adolescent counseling, treatment for addictions/chemical dependencies, depression, trauma recovery, bereavement and grief counseling, services for older adults/those with Alzheimer's disease	Provided stakeholder input on chemical dependency service and mental health service issues related to preventable emergency room visits
47	Pilgrim Psychiatric Center	State-run psychiatric hospital providing inpatient and outpatient psychiatric, residential, and related services with approximately 380 inpatient beds and 4 outpatient treatment centers plus one ACT Team	Provided stakeholder input on issues regarding immigrants and the uninsured, mental health services, and chemical dependency services

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			related to preventable emergency department and hospital admissions
48	Pride for Youth/Long Island Crisis Center	Service and advocate for lesbian, gay, bisexual and transgender (LGBTQ) youth, ages 13-26 who aims to enhance the health, wellness and cultural competency of LGBTQ youth through education, supportive services and youth development	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
49	Rockaway Center	Organization promoting community development, education reform, and health by providing low income housing, employment and adult training programs, advocating for school choice, promoting charter schools, and creating resources that will improve the educational programs of public schools, and assisting underserved residents with medical treatment options and access to proper medical care	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
50	Safe Space NYC, Inc.	Group of family resource centers providing health and wellness, maternal/child health, and school-based and youth services to the community	Provided stakeholder input on issues with services for people with HIV related to preventative care, services for the LGBT community, and social stigma
51	Sunharbor Manor-Roslyn Heights	Comprehensive Rehabilitation & Skilled Nursing of 266 beds providing rehab services, hemodialysis, care after heart attack, stroke, or heart surgery; post-orthopedic surgical care, pain management, respiratory therapy, diabetes management, hospice care, and an extensive wound care program	Provided stakeholder input on Long term care issues related to care transitions, preventable emergency department and hospital admissions
52	The Inn	Private social service agency and interfaith network of soup kitchens, emergency shelters, and housing facilities aiming to reduce hunger and homelessness	Provided stakeholder input on issues with services for people with HIV and basic needs issues related to preventable emergency deperatment admissions
53	The Safe Center	Not-for-profit agency serving child or adult victims of sexual abuse, physical abuse, and domestic and family violence	Provided stakeholder input on barriers to health care access for immigrants and the uninsured, including language and trust barriers; and suggested ways to improve health care delivery and communication between health care providers and the population
54	United Celebral Palsy Nassau	Independent, not-for-profit health agency serving children and adults with cerebral palsy, developmental and other disabilities	Provided stakeholder input on health care issues for persons with intellectual/developmental disabilities regarding preventable emergency department admissions from residential facilities and health care and related service gaps
55	YES Community Counseling Center	Non-profit, community-based organization which helps individuals struggling with domestic violence, chemical dependence, family conflict, sexual abuse, marital/peer difficulties, bereavement, health concerns, and other issues by providing school-based social work, counseling, drug/alcohol treatment, and other services	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and effectiveness and accessibility of detox services
56	Youth and Family counseling	Non-profit, multi-service agency that provides a wide range of mental health and social welfare services to individuals and families	Provided stakeholder input on issues with chemical dependency services related to preventable emergency room visits, monitoring of clients, and

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			effectiveness and accessibility of detox services
57	American Lung Assoc.	Organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
58	CAPS/Samuel Field YM & YWHA - Community Advisory Program for the Elderly (CAPE)	Non-profit outpatient mental health clinic offering seniors (ages 50+) and their families individual, group, and family therapy; psychiatric evaluations; medication monitoring in both outpatient and in-home settings; caregiver support groups; and coordina	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
59	EAC--Empowerment, Assistance, & Caring	Not-for-profit human service agency providing a total of 70 services to people of all ages; provides meals-on-wheels, senior computer instruction, health promotion and community service programs for seniors	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
60	Federation of Organizations	Not -for-profit corporation which provides multi-service, community-based social welfare agency operating programs that utilize peer support within a self-help model	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
61	Health Solutions	Independent, non-profit organization providing health research and health service programs for low-income, high risk New Yorkers	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
62	Hempstead Park Nursing Home	For-profit 251-bed nursing home providing skilled nursing for seniors	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
63	Jamaica Service Prog. for Older Adults	Non-profit psychosocial senior center offering the frail elderly with memory impairment and psychiatric issues ages 60+ with lunch, field trips, individual counseling with social workers, physical and cognitive programs, art therapy, and weekly visits fro	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
64	JASA--Jewish Assoc. Serving the Aging	Non-profit center providing seniors ages 60+ with legal assistance in relation to elder abuse/domestic violence, housing, finances, entitlements, and adult protective services	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
65	JBFCS, Pride of Judea	Non-profit outpatient mental health center offering youth, adolescents, and adults individual, group, family, and couples counseling/therapy; psychological testing; medication management; crisis intervention; psychiatric evaluations; and information and r	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
66	Long Island Consultation Center	Non-profit mental health center providing individuals (ages 6+) with mental health services including individual counseling, family counseling, parenting counseling, couples counseling, group therapy, substance abuse counseling, MICA counseling, and psych	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
67	NYC DOHMH	Department of the New York City Government	Provided stakeholder input on mental

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		responsible for public health and mental hygiene	health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
68	NYC Housing Authority	Government agency providing public housing for low-to moderate-income residents throughout the five boroughs	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
69	Phoenix House	Non-profit substance abuse treatment center providing adult men and women with residential treatment, including treatment of co-occurring mental health issues; and a medically monitored outpatient detoxification and rehabilitation program offering safe wi	Provided stakeholder input on mental health, substance abuse, Long-term Care and Homecare issues related to avoidable hospital use
70	PSCH—Promoting Specialized Care & Health	Not-for-profit organization offering individuals with developmental and psychiatric disabilities clinical, mental health, housing, vocational, supportive, and rehabilitative services	Provided stakeholder input on mental health, substance abuse, Long-term Care and Homecare issues related to avoidable hospital use
71	Road to Recovery	A program providing residents of The Bridge who are chronically homeless or have had long stays in State psychiatric/correctional facilities with an introductory readiness experience prior to participating in more formal recovery programs such as PROS or Supported Employment	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
72	Services Now for Adult Persons	Not-for-profit agency providing seniors aged 60+ with senior centers and transportation to senior centers, doctor's appointments and shopping	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
73	Visiting Nurse Service of NY	Not-for-profit organization providing in-home nursing care, therapy and hospice and palliative services to people of all ages and backgrounds	Provided stakeholder input on mental health, substance abuse, Long-term Care and Homecare issues related to avoidable hospital use
74	Bishop MacClean Episcopal Nursing Home	Not-for-profit 163-bed long term care facility also providing resident and family counseling services	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
75	CFW Healthcare Centers	Group of three health care facilities: Cliffside, ForestView, and Woodcrest, which provide a variety of medical and rehabilitation services	Provided stakeholder input on Long term care and Home Care issues related to care transitions, preventable emergency department and hospital admissions
76	HELP/PSI	Non-profit health-and-wellness organization providing primary and mental healthcare for at-risk and underserved populations	Provided stakeholder input on mental health, substance abuse, Long-term Care and Homecare issues related to avoidable hospital use; acted as a case manager
77	New Horizons	Non-profit counseling center providing individuals ages 6+ with individual therapy and medication management	Provided stakeholder input on mental health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
78	Rockaway Wellness Partnership	Community service project of the Visiting Nurse	Provided stakeholder input on mental

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[Nassau University Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Service of New York providing customized health interventions such as health education, individual counseling, support groups and educational seminars to individuals and families	health and substance abuse issues related to avoidable hospital use, availability of hospital alternatives, monitoring of clients, and care coordination
79	Family Residences & Essential Ent.	Organization providing advocacy, behavioral health, community and family, crisis, day and employment, and OPWDD residential services and a family wellness center for the disabled.	Provided stakeholder input on chemical dependency and mental health service issues related to preventable emergency room visits.
80	NY Immigration Coalition	Aims to achieve a more just society that values the contributions of immigrants and extends opportunity to al; promotes immigrants' full civic participation, fosters their leadership, and provides a unified voice and a vehicle for collective action of the community.	Provided stakeholder input on barriers to health care access for immigrants and the uninsured, including language and trust barriers; and suggested ways to improve health care delivery and communication between health care providers and the population.

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.

[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for an Integrated Healthcare Delivery System	In Nassau , cardiovascular disease is the #1 chronic condition, affecting 52,994 Medicaid members, followed by mental diseases with 37,763, and diabetes with 17,381. In Eastern Queens, cardiovascular disease is also the number one chronic condition, effecting 133,168 Medicaid members, followed by mental diseases with 66,580, and diabetes mellitus with 50,014. Compared to the other chronic conditions, cardiovascular disease and mental disorders are associated with greater total inpatient admissions and ED visits . Eastern Queens PQI hospitalizations, acute composite is the greatest contributor at 30%, circulatory composite 28%, 22% respiratory composite and diabetes	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations, PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety, 2014 N014 ; NYS CHI Reports

Nassau University Medical Center (PPS ID:14)

[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		composite at 20% For Nassau PQI hospitalizations, acute composite is the greatest contributor at 30%,circulatory composite 28% , respiratory 22% and diabetes 20%. The difficulty in accessing healthcare was cited by both the community member survey and stakeholder forums from the uninsured community. Barriers included cost, lack of information on how to obtain healthcare and trust in health care providers especially among undocumented immigrants. Health care in NQP is very fragmented with primary care, specialty care, behavioral health and long term care silos resulting in unnecessary hospital utilization, in the form of potentially preventable admissions, readmissions and emergency department visits. This results in increased utilization of emergency department care and underutilization of primary care.	& Prevention Agenda Dashboard
2	Need for ED care triage for at-risk populations in the Emergency Department	Nassau County is home to 223,494 Medicaid beneficiaries and Queens has 445,274 Medicaid beneficiaries. Nassau County has 121,639 unique uninsured persons while Eastern Queens has triple with 404,127. Areas with increased concentrations of uninsured align with areas of Medicaid recipient's density. There are 324,510 ED visits combined in both counties. The EDs that will have co-located primary care practices established in our project account for 53,644 members with 84,329 visits, or 26% of the total ED visits in these counties. Half of community member respondents indicated that they or a family member went to the ED in the past year. Many patients, approximately 45% EQ and 40% N, are using the ED unnecessarily, indicating that the ED is closest provider, they have no other place to go, could not get an appointment with health care provider, or doctor's office not open. 10% noted that all of their care was received in the ED. There is a lack of provider continuity and poor handoffs from the ED resulting in poor implementation of treatment plans and preventable hospitalizations and readmissions. In Nassau, 71% of all the Medicaid ED visits were classified as potentially avoidable similar to Eastern Queens at 75%. Adult acute illnesses comprised 42%N/39%EQ of all avoidable ED treat and release visits and 41%N/29%EQ of all ED visits in the region. Chronic disease made up 24%/28% of all avoidable ED Treat and Release and 25%/21% of all ED visits in Nassau and Eastern Queens.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations, PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety, 2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard
3	Need to Reduce 30-day Hospital Readmissions for Chronic Health	Circulatory disorders and psychiatric disorders represent the two largest diagnosis classes for 30 day readmissions in Eastern Queens. They are responsible for 31% of all 30 day readmissions among the top 10 diagnosis classes. Circulatory disorders represent the largest diagnosis class for	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA)

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[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		30 day readmissions in Nassau County. This is followed by digestive disorders, psychiatric disorders and substance abuse. These are 4 out of 5 top diagnosis classes, and represent 39% of all 30 day readmissions among the top 10 diagnosis classes. Communication barriers—between patients and medical and social services providers, as well as between the various health care system "silos"—were brought up at virtually every stakeholder forum. Queens is a very diverse community , with nearly 140 different languages spoken by the people who reside there. Several stakeholders pointed out that literacy level of non-English speaking patients is low even in their own languages, making it difficult for patients follow discharge instructions. Lack of timely communication within healthcare organizations and with other providers in the community is one of the top issues leading to preventable re-admissions. A common theme among forum participants was the need to foster communication between medical and social services; clinical and social services must be able to coordinate patient needs for a safe and effective transition back to the community.	ER Visits, PA Hospitalizations, PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety, 2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard
4	Need to reduce avoidable hospital readmissions from SNFs.	Potentially avoidable hospitalization rates for patients in Skilled Nursing Facilities (SNFs) in Eastern Queens are 5.18 hospitalizations/ 10,000 long-stay episode days which is the highest rate in NYS. In Eastern Queens, COPD and asthma in older adults are the top PQI hospitalizations (742). This is followed by heart failure and bacterial pneumonia (728 and 524). In Nassau County, COPD and asthma in older adults are the top Mediciad PQI hospitalization (526). This is followed by heart failure and urinary tract infection (311 and 283 respectively). Urinary tract infection, dehydration, hypertension and uncontrolled diabetes all have PQI rates higher than the state average. These conditions are commonly seen in residents of SNFs and related to hospital admissions. Readmissions are most often caused by inadequate clinical coverage in SNFs. LPN staff cannot perform assessments and rely on ED care in the absence of consultation resources. There is a lack of provider continuity to support patients during care transitions . SNF providers participating in focus groups noted that readmissions could be avoided with improved responsiveness, more thorough and timely discharge reports from the region's ED/hospitals, shared medical records, improved patient and family education, and standardized evidence-based protocols. These needs are addressed by the INTERACT model, which will provide a foundation for ensuring will be able to rapidly reduce the area hospitals' readmission rates.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations, PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety, 2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard

Nassau University Medical Center (PPS ID:14)

[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
5	Need to engage uninsured and low/non-utilizing patient populations into community based care	Stakeholders reported that many immigrants prefer to seek care at storefront medical practices and are reluctant to become connected to the health care system due to fear of deportation. The Nassau immigrant population has been growing rapidly in recent years, primarily from Latin America and the Caribbean. Eastern Queens has a very large Asian community, with sizeable populations from Latin America and the Caribbean. Nassau and Eastern Queens have high-poverty communities that are largely minority with increased rates of chronic disease and avoidable ED and hospitalizations. Community member survey results indicated lack of health insurance was the most cited reason for not accessing care. Major barriers cited by the uninsured, low or non-utilizers is a sense of disempowerment or a lack of knowledge of the health care system. Several factors are related to uninsured status in the NQP. Insurance coverage status in Nassau County greatly differs between residents based on citizenship. Those who are native born, foreign born-naturalized, and foreign born-non-citizen have uninsured rates of 4%, 8% and 39% respectively. Insurance coverage based on citizenship in Eastern Queens has a similar pattern. The rate of residents who have less than a high school degree that are uninsured is 35% in Nassau and 30% in Eastern Queens. In Eastern Queens, 36% of unemployed individuals are uninsured. PAM requires that NQP find ways to locate individuals who may be reluctant to engage care.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS
6	Need for the integration of primary care and behavioral health services	16 % of beneficiaries in Queens and 19% in Nassau have mental health condition. It is the group that is most associated with ED visits and the second most related to inpatient admissions. In Nassau County, cardiovascular disease is the number one chronic condition, affecting 52,994 Medicaid members, followed by mental diseases with 37,763, and diabetes mellitus with 17,381. Geocoding of the NQP IP admissions & ED Visits (Observed – Expected) for Medicaid beneficiaries with chronic conditions such as diabetes and cardiovascular disease and mental disease shows significant overlap of these conditions. Findings from the Queens and Nassau County consumer surveys show that mental health issues were the most prevalent of 14 different health conditions asked about in the survey. In virtually every stakeholder forum behavioral issues were discussed, mostly to reflect how complicated care becomes when patients have behavioral problems. The main causes were the lack of or insufficient reimbursements for the care of people with behavioral health issues; few resources in the	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS

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[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		community that can accommodate them; and poor communication between mental health providers and hospitals, primary care physicians, nursing homes, and home care agencies. Co-location of behavioral health and primary care services would address the barriers and needs of beneficiaries and providers alike.	
7	Need for behavioral health community crisis stabilization services	The Nassau immigrant population has been growing rapidly in recent years, primarily from Latin America and the Caribbean. Eastern Queens has a very large Asian community, with sizeable populations from Latin America and the Caribbean. Nassau and Eastern Queens have high-poverty communities that are largely minority with increased rates of chronic disease and avoidable ED and hospitalizations. Community member survey results indicated lack of health insurance was the most cited reason for not accessing care from a health provider. Major barriers cited by the uninsured, low health care utilizers, or non-utilizers is a sense of disempowerment or a lack of knowledge of the health care system. Several factors are related to uninsured status in the NQP. Insurance coverage status in Nassau County greatly differs between residents based on citizenship. Those who are native born, foreign born-naturalized, and foreign born-non-citizen have uninsured rates of 4%, 8% and 39% respectively. Insurance coverage based on citizenship in Eastern Queens has a similar pattern. A relationship exists between level of educational attainment and the uninsured. The rate of residents who have less than a high school degree that are uninsured is 35% in Nassau and 30% in Eastern Queens. In Eastern Queens, 36% of unemployed individuals are uninsured.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS
8	Need for evidence-based strategies for CVD disease management in high risk/affected population	Cardiovascular disease is the number one chronic condition in the NQP. Cardiovascular disease affects 52,994 Nassau Medicaid members, followed by mental diseases with 37,763. In Eastern Queens, cardiovascular disease affects 133,168 Medicaid members. Nassau's Medicaid avoidable hospitalization rate for adult hypertension is 121/100,000 recipients compared to the NYS rate of 104. The Rockaways has one of the highest hypertension rates in Queens. Medicaid beneficiaries show significant community hotspots of cardiovascular disease prevalence in minority communities such as Jamaica, Far Rockaway, Long Beach, Freeport, Roosevelt, and Hempstead. In Nassau, 28% of the population consumes the recommended amount of fruits and vegetables, compared to 10% in Queens; one in 4 NQP residents are inactive; and smoking rates are significantly higher for people with low SES (28%),	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS

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[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		behavioral health conditions (33%) and substance abuse conditions (63%) compared to the general population. The stakeholder's forums identified a lack of culturally competent care coordination, evidence-based chronic disease treatment protocols and self-management programs. These findings demonstrate opportunities to redesign the care for cardiac patients.	
9	Need for evidence based strategies for diabetes management in high risk/affected populations.	Of the 3,818 total PQI hospitalizations in Eastern Queens, the all diabetes composite PQI comprises 20%. In Nassau County, diabetes is the third most prevalent chronic condition, affecting 17,381 Medicaid members. Diabetes shows a similar presence in Eastern Queens affecting 50,014 Medicaid members. Medicaid avoidable hospitalization for adult uncontrolled diabetes in Nassau, at 63 admissions per 100,000, is above the state average of 46. The Queens rate of 36/100,000 belies rates of illness in specific areas. The communities of Bellerose, Freeport, Glen Cove, Jamaica, Rockaway and Westbury are "hot spots" for adult diabetes. The rates of avoidable hospitalizations for adult diabetes short term complications follows a similar pattern with areas in Eastern Queens exhibiting high rates compared to the rest of the county. Nine low-income communities identified by Nassau County as high-risk for health disparities evidence twice the hospitalization rate for type 2 diabetes when compared with the rest of the county. Over half of NQP adults are either overweight or obese. Lifestyle factors, nutrition and physical activity, impact diabetes management. In Nassau County, 28% of the population gets the recommended amount of fruits and vegetables, compared to 10% in Queens and 1 in 4 NQP residents are inactive. Stakeholders identified a lack of culturally sensitive effective care coordination, evidence-based chronic disease treatment protocols and self-management programs.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS
10	Need to strengthen mental health and substance abuse Infrastructure across systems	NYS OMH estimates of the number of individuals with serious mental illness and serious/persistent mental illness for Nassau and Queens include 154,200 individuals with SMI and an additional 74,245 with SPMI. OMH reports that 16,848 individuals are served by public mental health services in the county, representing about 10% of the population with SMI. In the NQP, mental diseases are the number two chronic condition, affecting 104,343 Medicaid members. Stakeholders report many gaps in behavioral health services. Current crisis services are not accessible after hours and on weekends, and need to be linguistically and culturally appropriate, including race/ethnicity, faith, LGBTQ, and age. Existing community-based respite	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda

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[Nassau University Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		programs exclude the homeless, making it difficult to find services for high-utilizing patients. Transportation services in the NQP are lacking and the public transportation system requires users to schedule extended time for travel to and from appointments. A number of behavioral health agencies have closed, and others have reduced services. No uniform standards exist to evaluate need for an admission, or the kinds of extended services needed post-discharge. Peer supports and health coaches have demonstrated success in helping facilitate connection to the delivery system, yet peer services are not widely available.	Dashboard, BRFSS
11	Need to promote tobacco use cessation, especially among low SES populations and those with poor men	Smoking and other tobacco use are significant risk factors for many chronic conditions identified as priorities, such as heart disease, diabetes, cancer, COPD and pediatric asthma. The age-adjusted percent of adults who smoke was 10.1% in Nassau and 15.5% in Queens, while the state rate was 17.0% (2009). While smoking rates in NY have declined, they remain high among certain subgroups. The prevalence of tobacco use by NYS high school students is 21.8%. The smoking rate among the general population has declined to 16% but individuals with low SES continue to smoke at a rate of 28%. Nassau County Community Needs Assessment indicates that smoking continues to be highly prevalent among the mentally ill population. People with mental health disorders have a 33% smoking rate. Additionally, 63% of people with substance use disorders smoke even though data demonstrate that people who stop using tobacco and other substances simultaneously are more likely to abstain from both in the long term. Finally, rates of asthma in children are substantially higher in homes with an adult smoker. Medicaid covers counseling sessions and medication for smoking cessation, but knowledge about this benefit does not seem to be widespread.	NQP Community & Partner Surveys, Stakeholder Forums CAHPS & HEDIS Measures Potentially Avoidable (PA) ER Visits, PA Hospitalizations,PA Readmissions PQI Suite, PDI Suite NYSDOH Health Data NYSDOH Office of Quality and Patient Safety,2014 N014 ; NYS CHI Reports & Prevention Agenda Dashboard, BRFSS

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
14_SEC038_NQP DSRIP CNA FINAL.pdf	12/22/2014 09:20:06 AM	

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

DSRIP PPS Organizational Application

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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: **Nassau_Section4_Text_C:\Users\amehta1\Downloads\Nassau Queens PPS Project Plan Application Section 4.docx**

Description of File

Projects 2.a.i, 2.b.ii, 2.b.iv, 2.b.vii, 2.d.i, 3.a.i, 3.a.ii, 3.b.i, 3.c.i, 4.a.iii, 4.b.i

File Uploaded By: am1013

File Uploaded On: 12/30/2014 01:33 PM

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

Currently Uploaded File: **Nassau_Section4_ScopeAndScale_Nassau Queens PPS SPEEDSCALE Draft 12-22-14.xlsx**

Description of File

This is a DRAFT of Speed and Scale to be updated prior to Jan 12th.

File Uploaded By: jwyman01

File Uploaded On: 12/22/2014 11:58 AM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

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

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

NQP's goal of reducing avoidable hospital utilization 25% over the DSRIP period will lead to workforce realignment and accelerate demand for staff in ambulatory settings through retraining, redeployment and new hires. To support this change, existing clinical staff need to develop competencies in phone triage, health coaching, cultural competency, health literacy, navigation and other skills.

There are 33,000 employees in NQP participating hospitals who may be affected by the transformation. To estimate impact, NQP used workforce models for community-based care management, such as Geisinger ProvenCare and the NYS Health Home. We stratified the population by health status (e.g., mental health/substance abuse, multiple chronic illnesses) to estimate workforce need and found a gap

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of over 1000 care managers. In most specialties, including primary care, NQP has a physician per 1000 rate that is in the 70th-90th percentile, statewide. For NPs and PA, NQP is at the 10th percentile; the workforce gap is estimated at 650 NPs and PAs to get to the 50th percentile.

NQP's goal is for displaced staff to be retrained and redeployed. Demand for new staff will exceed any excess staff created by reducing hospital use. Normal staff turnover will mitigate any staff displacements resulting from the shift from acute to outpatient care.

Initially new hires will be needed for the projects. NQP will encourage partners to use current workforce for new positions. NQP will work with colleges to increase NP and PA programs, and with medical assistant and other medical technical training programs to fill workforce opportunities. LIJ can recruit additional social workers needed as it serves as a clinical training site for SW interns enrolled in several NYS master's level programs. Furthermore, LIJ has a dedicated military veteran's recruiter who can tap into a traditionally underutilized labor pool.

NUMC is a teaching hospital with over 250 medical residents, and nursing, social work and psychology students. The link to LIFQHC allows students to train in outpatient settings. LIFQHC has already experienced the need for social workers, and psychology interns and externs. It has expanded evening and weekend hours to prevent ED utilization, facing demand for staff. In addition, LIFQHC will be training 18 family medicine residents.

Labor unions have been involved in developing the workforce strategy. Several NQP partners have union staff in their workforce, and existing collective bargaining agreements require the union to have input into the organization's strategic plan. NUMC/NuHealth is bound by Civil Service Law to work with the Nassau County Civil Service Commission to justify, classify, recruit and approve much of its staff positions.

NQP expects the following impact by provider type:

RD=Redeploy, RT=Retrain, NH=New Hire, NSC =Negligible Staffing Change

Allied Health Professionals–RT, NH
Ancillary Staff–RD, RT
Behavioral Health Staff/All Levels–RD, RT, NH
Care Managers–RD, RT, NH
CNA/PCA/Medical Asst.–RD, RT, NH
Community Health staff–RD, RT, NH
Data Analysts–NH
Dentists and support staff–RD, NH
Dietitians/Nutritionists–RD, RT, NH
EMTs and paramedics-RD, RT, NH
Billers, Registration, Financial Counselors–RD, NSC
Health Literacy Specialists/interpreters–RD, RT, NH
Home Health workers–RD, RT
Human Resources Staff–RT, NH
Information Technology Staff–RT, NH
LPN-RD, RT, NH
MD and DO staff–Primary Care, Pediatric and Women's Health – RD, NH
Medical Coders–ambulatory coding RD, RT, NH
Medical Interpreters–RD, NH
NPs and PAs–RD, RT, NH
Pharmacists/pharmacy techs–RD, RT, NH
Population Management Professionals–NH
Practice Management Professionals–RD, RT

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Project Managers–RD, NH
PT/OT–RD, RT
Registration Clerks–RD, RT, NSC
RN-RD, RT, NSC (reduction through attrition)
Social Workers/Case Workers–RD, RT, NH

***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.

A decrease in avoidable hospital utilization will result in a staff shift to ambulatory settings through retraining, redeployment and new hires.

To mitigate disruption, the workforce strategy is to keep staff in their positions as much as possible. If that is not possible, voluntary retraining and reassignment of appropriately licensed and skilled staff will be undertaken, mindful of their scope of practice. We estimate an additional 2000 positions will be needed, mostly in care management. We will encourage partners to redeploy staff in an open and transparent manner. Communication will be consistent and frequent to ensure that employees are aware of new opportunities. NQP will include unions throughout this process via the PAC and the workforce committee.

NQP will rely on partners' training programs and also contract with existing vendors on NYS Department of Labor's (DOL) Eligible Training Provider List. LIJ's affiliates operate the Center for Learning and Innovation which includes nurse and administrative fellowships, a medical record coding development program, a physician leadership and management program and training for surgical technologists, paramedics and EEG technicians, among other programs. In addition, NQP will work with 1199 SEIU's Training and Employment Fund (TEF) for certain areas of workforce development and retraining. TEF is the largest joint labor-management training organization in the U.S., with 45 years of experience in health care workforce planning, training, consulting, development and placement.

To assist NQP, LIJ can utilize 4 sourcing specialists and over 30 experienced recruiters who recruit utilizing: social media, internet job boards, DOL advertisements, interview days, cold calling. LIJ's team is comprised of core recruiting specialists as well as Advanced Practice Recruiters that focuses only on the recruitment of NPs and PAs. LIJ and its affiliates plan to open a new nursing school in 2015 focused on training for the health care needs of the future.

NUMC/NuHealth has a commitment to employee advancement and skill development that can easily be deployed to meet training/retraining needs of the NQP. Tuition reimbursement occurs for college courses for employee professional development. NUMC/NuHealth has a Leadership Academy open to staff looking to expand skills.

CHS has a focus on lifelong learning through continuing education and formal tuition reimbursement. Collaborative programs with local colleges on clinical and leadership topics are regularly scheduled and will continue to be available to support staff in their own professional development.

NQP members have experience with LEAN and Six Sigma approaches to management training and process redesign. The philosophy of these programs is to create the most efficient working environment while increasing staff satisfaction. These tools may be adapted to the redeployment process.
Current workforce shortages exist for some staff positions, which will require extra attention in the workforce strategy. Shortages exist in nurse practitioners and physician assistants, psychiatrists and psychiatric medical practitioners, and bilingual or multi-lingual caregivers.

***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.

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Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application

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Workforce Implication	Percent of Employees Impacted
Redeployment	.5%
Retrain	30%
New Hire	6%

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.

NQP will have a comprehensive workforce strategy that articulates the various steps for employees, from retraining and/or redeployment to release. The strategy will be managed by existing structures within each hub. Our goal is to fill new jobs related to DSRIP projects with redeployed and retrained staff from within NQP and minimize layoffs. We expect a reduction in inpatient admissions and ED visits to occur over time, resulting in opportunities to retrain staff including nurses, social workers and pharmacists and redeploy them to new positions that support care transitions and care management. We expect a decrease in the use of sub-acute facilities through greater use of evidence-based guidelines for post-acute referrals, resulting in reduced staffing needs at SNFs. Under the INTERACT program we will see an increase in demand for staff with the training and skills to provide more intensive observation and stabilization of patients at the SNF, and to support transitions in the community. Home care volume and intensity of services may increase, creating additional opportunities to retrain professionals (e.g., physical and speech therapists, home health aides, RN's and social workers) from inpatient or SNF settings.
The workforce committee can assist partners with developing job descriptions and competency requirements, as well as scheduling training sessions for new or enhanced roles and retraining sessions for staff being transitioned to different settings that are consistent across hubs' organizations. For new or redeployed staff starting a new or enhanced position, we will expect partners to use tools such as a Position Analysis Questionnaire and Job Analysis Checklists to create a knowledge, skills, and abilities (KSA) template that identifies levels of proficiency needed. The KSA for a particular job can be used to identify types of staff to target for retraining and education. A learning needs assessment can be conducted to identify specific areas and topics where training efforts should be focused. Once identified, interviews and focus groups with subject matter experts will be conducted to develop the content needed o retrain interested individuals. The options for redeployment/retraining range from: redeployment with little or no training other than department orientation; process redesign with training in a new process, but not in the position function; upgraded position training handled with a vendor; simulation and on-the-job training; acquisition of new skills and capabilities will require more intensive training over a longer period of time (e.g., academic courses, degree programs).
The 3 hubs not only have internal training functions, but also vendor training agreements and access to labor union training facilities. As part of developing the detailed implementation plan, NQP hub partners will determine which options are appropriate.
To the extent possible, the retraining will be voluntary. For those currently in roles whose scope increases, training will be required so that they are equipped with the knowledge, skills and abilities to perform individually and as part of a team. In the event a change is being made within an existing department where the employee's skill set and licensing are still appropriate, retraining may be required and may be considered involuntary. In the event an inpatient unit is being downsized, staff will first be given an opportunity to move voluntarily to a new unit and then trained in the competencies of that unit. If no volunteers answer a job posting, a candidate will be chosen for transfer/training per the requirements of the applicable collective bargaining agreement.
Any involuntary retraining will adhere to current collective bargaining procedures which may govern procedures to be followed.

***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.

DSRIP will accelerate a shift from inpatient settings to outpatient settings. Historically pay in outpatient settings has been lower. Wages and benefits are likely to rise with the new demand for outpatient workers. NQP will help partners to match jobs to competitive markets

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regarding wages and benefits, consistent with collective bargaining agreements. Community-based jobs will be priced at prevailing market wage and benefit levels.
While every attempt will be made to keep the employee whole, the redeployed position may result in lower compensation. NQP may assist the partner, through DSRIP project funds and/or partner incentive payments to initially keep the employee whole. NQP health system leaders participate in many salary and benefits surveys in order to remain comparable to the market, Positions are reviewed both internally and externally to ensure that the rewards package offered is comparable recognizing accomplishments through experience and degree differentials and career ladders. In this way new job roles and salaries will reflect the market rate and provide maximum opportunity to recruit, hire and retain personnel, both for union and non-union positions.

***Retraining 3:**

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

NQP intends to mitigate any negative impact on employees. NQP will encourage partners to redeploy and retrain before hiring new staff, and, for unionized employees, will operate within existing collective bargaining agreements. Routine turnover will create vacancies that can help displaced workers. NQP will encourage redeployment or retraining. In the event employees refuse redeployment assignments, NQP hubs will work with such employees to identify other job positions; if another position cannot be found, NQP hub policies/practices and collective bargaining agreements will be followed. Termination would be a last resort and collective bargaining agreements protocols would be followed.

***Retraining 4:**

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

Labor representatives within the three hubs will be involved in the development of the DSRIP workforce plan. Labor representatives sit on the PAC and have regular input on overall strategy and direction of NQP with respect to DSRIP. The workforce committee consists of human resources staff from the hospitals and other appointees by the Executive Committee as well as representatives from 1199, CSEA, and NYSNA. The workforce committee will meet on a regular basis and be responsible for recommendations for changes in the workforce strategy. The activities of the workforce committee will regularly be reported to the PAC for review of plans and to the Executive Committee for decisions.

***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	85%
Partial Placement	15%

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.

NQP will design a detailed system to keep track across the partners of the need for new employees and surpluses of current employees. If a unit or area is closed due to decreased inpatient utilization, impacted employees will be the first considered for reassignment in outpatient areas. They will be offered retraining as necessary for the new positions, with guaranteed employment when their training is satisfied. New employees will be considered for hire only when current employees are not available for placement.
The DSRIP process will result in newly created roles in community-based care, health promotion and care management. Health care educators who focus on high risk populations are needed, specifically for cardiovascular disease and diabetes. To support transformation to outpatient and home-based settings, existing clinical staff, including nurses will need training to develop competencies in telephone triage, coaching and activation, motivational interviewing, cultural competency, health literacy and other skills. Care management will be

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required across many projects. Patient activation activities will likely require community health workers for outreach and engagement.
In addition, there will be training on the 5 A's of intervention (ask, advise, assess, assist and arrange); teaching primary care providers how to treat depression; teaching behavioral health staff to manage diabetes and other chronic conditions.
We will assess the resources of the Center for Learning Innovation at LIJ, 1199 and any other training that is being undertaken by PPS partners. We will utilize the NYS Department of Labor Eligible Training Provider List to identify potential training entities in Nassau and Queens, including local community colleges. To the extent that external training is needed for the workforce, NQP will consider the robust training resources of the unions.

***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.

A shift from inpatient to and expansion of outpatient care is anticipated over the five-year DSRIP program. A goal of the workforce strategy will be to keep employees "whole". As mentioned, the PPS will develop a detailed system for tracking job opportunities across the PPS (which consists of most of the providers in the region). Typically outpatient salaries are lower than inpatient, which could potentially impact employees shifted, although demand for outpatient jobs will rise, raising salaries. It is expected that jobs will be priced at prevailing market wage and benefit levels. NQP workforce committee will encourage partners to adopt the following principles: All potentially redeployed employees will be given first option for new positions; if they cannot be placed or are unwilling to accept a new position within a reasonable period of time, they will be released; employees will be given all salary and benefit information comparing their current job to the new deployment to make a fully informed decisional redeployment will happen according to collective bargaining agreements. NQP expects that displaced employees to be redeployed whenever possible.

***Redeployment 3:**

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

Employees who refuse their assignment will go into a redeployment pool for a period of time. They will be offered other placements as they arise. Training opportunities will also be available, and additional placements offered as they undertake training for other positions. After a reasonable period of time in the redeployment pool, the employee will be released. If/when the redeployment process affects union-represented employees, the PPS will ensure that the redeployment process is consistent with applicable collective bargaining agreements.

***Redeployment 4:**

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

NQP views its relationship with labor as collaborative. Representatives from 1199, NYNSA and CSEA are on the PAC and on the workforce committee. NQP will consult with labor as it builds its detailed implementation plan for workforce in January and February via the workforce committee. The workforce committee will meet on a regular basis and be responsible for developing the workforce strategy. The committee will report to the PAC for review of plans and to the Executive Committee for decisions, continuing beyond the implementation phase to oversee the workforce issues that arise during the DSRIP period. Some of these issues may be addressed in the collective bargaining process. Aspects of DSRIP that will have an impact on one or more sites may be discussed at local labor-management meetings or town hall meetings. Labor union issues with a PPS-wide impact may be reviewed by the workforce committee, with labor representatives and management. The workforce committee and labor representatives will also collaborate throughout this process with the NQP hubs on collective bargaining agreement provisions.

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.

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The model we used to calculate new staff requirements was based on best practice models for community-based care management, such as Geisinger ProvenCare and the NYS Health Home.
An estimated 2,000 new jobs will be created, which would be broken out approximately as follows: 1000 care managers,
650 nurse practitioners and physician assistants,
180 administrative staff, and
170 other positions that would fall into various areas including those outlined below.
Administrative – to support the work of others in the PPS
Behavioral health – to address unmet behavioral health needs for high risk patients
Care managers – to develop care plans and assist PCPs in order to better manage patients across the continuum of care
Community outreach workers– to engage individuals in the community that need assistance with engagement, compliance and follow up
Data analysts/statisticians—to help the PPS manage, analyze, and disseminate data on metrics and milestones to decision-makers and front-line teams
Dietitians – to help individuals with chronic conditions manage their health through improved diet choices
Enrollment specialists – to help enroll or refer members to available assistance programs
Financial counseling staff – to help patients access means-tested programs
Health educators and Health Coaches – to teach patients and staff how to manage chronic conditions, including diabetes and hypertension, and to support health promotion and prevention of diseases such as coronary artery disease
Home health workers – to provide care in the home setting
IT staff – to assist with the need for connectivity among PPS partners
Marketing/communications—to communicate internally and externally about the work of the PPS and what it is accomplishing and changes that are occurring
Medical Coders-to support the revenue cycle in outpatient settings
Nurse aides – to assist nurses in the care of patients
Nurse practitioners and physician assistants – to address the need for outpatient care in community based settings
Paramedics and EMTs – to provide ambulance staffing and alternate locus of care navigation
Pharmacists—to address high-risk pharmacy needs
Physicians – most likely community-based primary care physicians and psychiatrists will be needed
Population management experts – to help the PPS transition to population-based care and reimbursement
RNs – to provide nursing services in outpatient settings
Social workers – to assist patients before and after discharge and to address referrals to other non-health providers.

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	180
IT Staff	14
Mental Health Providers Case Managers	33
Nurse Practitioners	365
Other	1,086
Physician	22
Social Workers	300

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	6,127,406	12,254,811	14,284,730	7,340,337	6,931,843	46,939,127

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Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Redeployment	680,823	1,361,646	1,361,646	590,046	544,658	4,538,819
Recruiting	944,000	944,000	944,000	354,000	354,000	3,540,000
Other	385,700	385,700	385,700	385,700	385,700	1,928,500

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.

NQP will take advantage of new grants that become available during the DSRIP period.
1. LIJ will utilize available grant funds from the "Health Workforce Retraining Initiative" for retraining to the extent such programs align with workforce development needs arising from the redesigned care model.
2. NYS grant funded programs called "Care Coordination", Patient Centered Care and the Language of Care are examples of programs that align well with for employee training in community based care under DSRIP projects (the 1199 training and employment fund received a grant for this).
3. In the past 18 months, over $470,000 in Health Care Reform Act grant funding was spent to retrain 950 LIJ and its affiliates' employees with skills that support health care delivery transformation through programs in patient centered care, care coordination, basic computer skills and technical training.
4. The 1199 Training and Employment Fund (TEF) offers Train the Trainer programs that create internal capability for sustainable organizational learning for training, redeployment and recruiting.
5. LIJ and its affiliates serve as a co-lead in the Long Island STEM Hub, which represents a collaborative effort among education, industry and government to foster career growth for students and displaced workers in the areas of science, technology, engineering and math. STEM, a workforce readiness program supported by Empire State Development Corporation and Long Island Regional Economic Development Council, will create a talent pipeline for roles emerging across these 5 year health care transformation projects.

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.

Efforts have been made from the very beginning of the DSRIP application process to have an inclusive and collaborative approach to workforce development. A workforce committee was established with HR representatives from NUMC/NuHealth, LIJ, CHS, St. John's Episcopal Hospital (SJEH),and labor representatives from 1199, NYSNA and CSEA. This group met in person and via conference call several times to understand the DSRIP process and understand the potential impact of projects, and to develop the workforce strategy. The process was iterative – concepts around recruitment, redeployment and retraining were discussed, various team members shared written material, all sources of information were combined into one document which was then shared with the team for reaction and comment, and then the workforce strategy was finalized.

***Engagement 2:**

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

The following organizations were included in the development process of our workforce strategy, including:
NUMC/NuHealth HR representatives
LIJ HR representatives
CHS HR representatives
SJEH HR representatives
1199 labor union

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1199 SEIU Training and Employment Fund
CSEA labor union
NYSNA labor union
The labor unions have been actively involved in the PAC and will continue to do so NQP hubs met with their labor groups throughout the application process to obtain their input and buy-in on the planning and development of the PPS' approach. The Executive Committee and workforce committee each had multiple meetings with executive representatives from 1199 SEIU and NYSNA, where the details of the PPS plan were discussed and modified to ensure labor representatives were comfortable with the approach. Our early collaboration has provided union representatives the time to share the workforce strategy through their organizations, to the front-line union representatives and delegates. Our collaboration, beginning at the initial stages of the PPS, will strengthen the relationship and ownership of the DSRIP workforce strategy over the next five years.

***Engagement 3:**

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

NQP is committed to open communication with employees regarding the DSRIP process, recognizing that we must work together to design the many system changes that need to occur to effectively transform the health care delivery system in concert with the DSRIP goals. Implementation planning for NQP will include the development of a workforce engagement and communication strategy. This plan will include the use of social media, development of a website, regular newsletters, both hard copy and electronic, meetings, teleconferences, and other venues and materials to ensure that all employees understand DSRIP. The workforce engagement and communication strategy will be designed to establish mechanisms for employee feedback, both to the PPS, the partner and the labor union(s) on what is happening as NQP makes the changes needed to meet DSRIP goals.

***Engagement 4:**

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

The workforce strategy was developed with a group of human resources professionals from the 3 hubs health systems and members of 1199, CSEA, and NYSNA.
A more detailed workforce implementation plan will be developed and will include the same individuals, who will continue to participate in the workforce committee. The workforce committee will meet on a regular basis to further develop the workforce strategy.
A detailed engagement and communication plan will be developed starting in January. Elements of the plan will be rolled out to employees via a system-wide intranet link and social media to keep them informed. The plan is expected to include a process for ongoing input from the Collaborative Care Councils and Labor Management Project Consultants (TEF), and other ad hoc committees as needed, as part of efforts to assess the workforce impacts of DSRIP implementation over time, and to develop best practices in retraining and redeployment strategies over the course of the DSRIP program

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.

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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.

Nassau Queens PPS (NQP) is committed to sharing data among its partners. NQP has formed an IT Committee (ITC) that will develop policies and procedures to promote the responsible use of data and ensure strict confidentiality. ITC will ensure that clinicians have real time access to core data elements required for successful patient management, and that access to data is role-based. The ITC will ensure that consent protocols are followed and that HIPAA-compliant participation agreements and business associate agreements (BAAs) are signed when required. Membership on ITC will include members of the Executive Committee as a means of ensuring close coordination of ITC with the governing board. In addition to the members of the Executive Committee, other members of ITC will include: CIOs from the three hubs; one or more representatives of Counsel's offices; CMOs and/or quality staff; patient advocates; and representatives from the project leadership of each of the 11 projects.

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

PPS partners will ensure privacy and data security, including upholding all relevant state and federal data privacy protections and HIPAA. We understand that any transmission of protected health information requires protecting the confidentiality and integrity of the data.

All three hubs and many other providers in the PPS have experience sharing data with Healthix/other RHIOs. Health homes have developed data sharing with down-stream providers in order to coordinate care. Finally, the health systems within NQP have been receiving claims data for their Medicare and commercial contracts. As a result, robust data protection and encryption measures have been developed/can be leveraged. ITC will require all members of NQP to sign HIPAA-compliant data sharing confidentiality agreements/will establish auditing compliance with those agreements before any data are shared between or beyond the three hubs. The ITC and the Executive Committee will monitor progress and compliance on data sharing

***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.

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The ITC will conduct a comprehensive analysis of the IT capabilities of all PPS partners and will develop a plan (based on the available funding) to transition any partners with paper-based systems to interoperable EMRs or thin, cloud-based, secure, encrypted applications that will enable them to access data in real time and update patient records with appropriate treatment information. This plan will leverage the relationships PPS members have with RHIOs and SHIN-NY and investments that PPS members have made in EMRs and other health IT, including internal health information exchange platforms, and will facilitate appropriate sharing of patient data. Over time, this will enable clinicians at all sites to access data necessary for integrated, coordinated care and will enable NQP to collect data necessary for outcome monitoring, rapid cycle evaluation and continuous performance improvement. Within that context, ITC will promulgate policies, procedures and consent protocols, and implement technology safeguards to ensure that data, especially personally identifiable health information, is accessed only under appropriate circumstances and by appropriate personnel. NQP will develop tracking systems and rules regarding access that will allow for NQP to detect when inappropriate use of PHI has occurred, and will monitor progress through the system and through partner surveys.

ITC will develop a change management plan for implementing the IT strategy that will span the entire five-year DSRIP life cycle. Key elements of the plan will be:

-Communication with stakeholders throughout NQP
-Identifying staff to carry out the strategy
-Resourcing workforce changes that may be needed
-Managing patient consent processes per prevailing state guidelines
--Developing and implementing the needed training to ensure appropriate use and protection of data, including required HIPAA-compliant BAA and other agreements
-Maintenance and revision to adjust to changing realities

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.

NQP will establish a Clinical Oversight Committee (COC) that will include some members of the Executive Committee (EC) and other clinical staff including representatives from the project committees. The COC will be responsible for monitoring the progress for all clinical and programmatic milestones for the 11 projects. The COC will report to the EC on the progress of the 11 projects and will make recommendations if a project is floundering. The EC in consultation with the COC will make decisions regarding project changes including project location, funding and personnel.

NQP will establish project committees for the 11 projects. Each project committee will develop key performance indicators based on the DOH milestones and metrics as well as risk indicators that will populate dashboards developed by the PMO, the ITC, the COC and the project committees. The PMO will provide support to the project teams on data capture and aggregation. The PMO will be responsible for assuring that the COC has timely and accurate data necessary to monitor the progress of the project teams. The reports and dashboards will also regularly be reviewed by the PAC.

***RCE 2:**
Outline how the PPS intends to use collected patient data to:

- Evaluate performance of PPS partners and providers

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- Conduct quality assessment and improvement activities, and
- Conduct population-based activities to improve the health of the targeted population.

Project committees, with the COC, will select indicators that reflect the projects' goals as well as indicators defined by the State. The COC will benchmark providers in the PPS and monitor them on a monthly basis using dashboards. For problems, the PMO office will assist the project teams using long-established performance improvement (P.I.) techniques such as Plan-Do-Check-Act or Six Sigma to identify root causes of the issue, test hypotheses with data and devise a strategy to improve the projects. Dashboards and P.I. activities will be reported to the PAC and to the Executive Committee monthly.

At a population level, NQP will aggregate de-identified claims and clinical data for attributed lives to funnel into population health analytics tools. NQP will identify communities with high rates of preventable medical events and identify patients with poor outcomes. NQP will be able to direct its efforts and funding towards communities and patients most likely to benefit.

***RCE 3:**

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

The COC will develop with the project teams a set of performance dashboard reports. Project teams will have detailed reports to monitor their progress in real time across a wide range of indicators. They will share an executive dashboard with the clinical oversight committee, which will review the executive dashboard and provide it to the Executive Committee to focus attention on the areas with the most opportunities for improvement. Both the Executive Committee and the COC will be able to request additional detail as needed.

The project committees will share appropriate data and benchmarks with the providers participating in each project and other members of NQP. The COC will also be expected to share the dashboards with the PAC on a regular basis. Requests by members of the PAC for more data will be handled on a case by case basis. All dashboards will present aggregate data and will not compromise the confidentiality of patients.

***RCE 4:**

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

When there are gaps in performance, NQP will utilize well-established performance improvement strategies like focused Plan-Do-Check-Act cycles or clinical microsystems. These strategies will be supported by statistical analysis that allow for the creation of highly reliable, data-driven, scalable organizations. These tools have been proven on clinician, organization and systems levels and have been shown to be applicable in different settings. They guide organizations away from politics, history and supposition and toward data-driven evidence-based clinical and administrative quality and systems of care that are responsive to patients and their needs.

Each hub will support RCE. Data will determine at what level change happens. RCE will enable NQP to transform from a disparate group of providers operating in the same geography into a system that provides consistent, coordinated, metric-driven quality to a large population while reducing unnecessary hospitalizations and expense.

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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.

The immigrant population in Nassau has been growing rapidly in recent years. Immigrant populations in Nassau are principally from Latin America and the Caribbean. Nassau also has several high-poverty communities that are largely minority. Queens County is extremely diverse, with large minority and immigrant populations. Almost half the Queens population is foreign-born, and more than half speak a language other than English. eastern Queens is home to a very large Asian community, as well as sizable populations from Latin America and the Caribbean. Several communities in Queens and Nassau are also home to a large Orthodox Jewish population.

This diverse population has created challenges for the health care delivery system. The availability of bilingual staff, particularly clinical staff, is inadequate. Providers are reliant on primarily telephonic translation services. It is particularly problematic in behavioral health services, where direct communication can be essential to successful treatment. Working to build a culturally diverse workforce is a priority. Access to culturally competent translation services, and a workforce that has formalized training in cultural competence including mechanisms and protocols for requesting assistance in dealing with patients whose health beliefs maybe at variance with western medicine, is critical. In addition to language barriers, immigrants coming from very different health care delivery systems in their native countries have unique navigational challenges when confronting the US delivery system.

Cultural competency extends beyond traditional cultures and ethnic backgrounds to include special populations such as the LGBT community, individuals with HIV/AIDS, individuals with behavioral issues, homeless individuals and families. Developing these

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competencies is critical in order for NQP to create trusted relationships essential to improved health outcomes.

***Competency 2:**

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

The organizations forming NQP have all developed programs to address cultural competency. CHS has ongoing staff training in competence and ethnic beliefs related to patient care of the multiethnic community it serves. LIJ and its affilates' Office of Diversity, Inclusion and Health Literacy (ODIHL) provides education and resources for employees, patients, communities, and peer institutions to further advance cultural competence and promote effective communication. At NuHealth in addition to formal diversity policies, a large proportion of the staff resides in the communities where the NuHealth facilities are located, assuring a familiarity with the cultural background of the patient population.

NQP will adopt the HHS Office of Minority Health Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) to advance health equity, improve quality, and help eliminate health care disparities. These standards provide a framework for providing services responsive to individual cultural health beliefs and practices, preferred languages, health-literacy levels, and communication needs. NQP will incorporate CLAS into a comprehensive workforce training program.

Written materials on how to care for diverse populations will be shared across all PPS partners. Materials will be specific to given populations and will address issues such as Health Beliefs and Practices, Communication Style/Non-verbal Communication, Religious/Spiritual Beliefs, Family structure, and Food/Diet Practices.

All the FQHC boards, as well as each of the LIFQHC's advisory boards, provide an additional strategy for achieving cultural competence. Community members serve on those bodies; they are engaged in the health care system as users themselves, and are also trusted members of the community. They raise issues that data cannot, including barriers to care, information that can be used to shape NQP's ability to meet needs in ways that are culturally appropriate.

***Competency 3:**

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

A number of organizations bring unique resources that NQP can utilize to achieve and maintain cultural competence. Many of these were identified through the community and stakeholder input in developing our DSRIP plan, including Long Island Families Together, ERASE Racism, Mental Health America (both Nassau and NYC chapters), New York Association of Psychiatric Rehabilitation Services (NYAPRS), LI GLBT Network, immigrant advocacy organizations (Make the Road, Asian Americans for Equality, Kalusugan Coalition), and the independent living centers. The Hempstead Hispanic Civic Association and the Roosevelt Community Revitalization Group have strong ties with two of the most economically depressed communities we serve. NQP has been working closely with the Health and Welfare Council of Long Island in the development of the PPS. HWCLI is a not-for-profit health and human services planning and advocacy organization serving as the umbrella for agencies serving Long Island's poor and vulnerable individuals and families. Its member agencies work with the diverse low-income population of Long Island on a daily basis, providing direct services at the grassroots level. These organizations (and others) may provide trainings to clinical providers and other staff, development of appropriate health education materials, or technical assistance. As we make decisions about NQP's needs for support in achieving and maintaining cultural competence, these organizations will be assessed on a number of criteria: quality of their work (based on performance data); alignment between their expertise and NQP's identified needs; and the ability to monitor their performance against our expectations and requirements.

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

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appropriate decisions about their healthcare needs and priorities. Health literacy incorporates the ability of the patient population to read, comprehend, and analyze information, weigh risks and benefits, and make decisions and take action in regards to their health care. The concept of health literacy extends to the materials, environments, and challenges specifically associated with disease prevention and health promotion.

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

***Literacy:**

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

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

When addressing health literacy the first challenge is language. Many patients served by NQP are not native English speakers. ODIHL provides Language and Communication Access Services (LCAS), with providing medical interpretation and document translation services are available 24/7. Similarly, CHS has developed a Language Assistance Program (LAP) where foreign language interpretive services are provided, primarily through the use of video interpretive methodology.

The National Center for Education Statistics estimates that 10% of the Nassau population and 46% of the Queens population lack basic prose literacy in the English language. In addition, for non-native English speakers, written comprehension typically lags behind oral comprehension, and low-literacy versions of patient education material are not always available. It is not only the patient who may have comprehension issues; many caregivers, both family members and paid caregivers, are not native English speakers. This creates a challenge when communicating health information and treatment plans, as caregivers may have trouble understanding and complying with complex treatment plans.

In addition to language, health literacy requires helping individuals understand their health care choices, and make effective decisions that reflect their personal values and goals. AHRQ has developed a health literacy toolkit that provides straightforward approaches to improving communication with patients in three domains: improving supportive systems such as transportation, insurance and appointment scheduling; improving spoken and written communication, and improving self-management and empowerment. This toolkit will guide NQP's efforts around improving health literacy. It includes modules on improving verbal communication, improving written communication, how to create and use health education materials effectively, and strategies for enhancing patient engagement.

NQP will be implementing DSRIP project 2.d.i – "Implementation of Patient Activation Activities." This project will be the platform for improving the health literacy of our patient population. NQP will conduct outreach to uninsured individuals, and to Medicaid beneficiaries currently unconnected to care, and encourage them to connect with a primary care provider. These individuals will be assessed for patient engagement and health literacy using the PAM, and an array of interventions will be available based on identified needs (such as Motivational Interviewing, Wellness Self-Management, Health Literacy Training for Medical Professionals, the Health Literate Care Model, and The Chronic Disease Self-Management Program (CDSMP)).

NuHealth operates NuCare, a program that connects uninsured patients to a primary care medical home, providing enrollees with a personal physician, an EMR, and a membership card to facilitate coordinated care. Many of our partners conduct health fairs at which free health screenings and services attract uninsured. This provides an additional opportunity to conduct patient engagement assessments and link people to a primary care setting. By connecting people to a medical home, we will have made an essential step toward improving health literacy.

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

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Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

NQP's Executive Committee has developed a plan for the distribution of funds for the PPS and each hub based on the following 8 elements: Inter Governmental Transfer, recognizing that NUMC provides the local share for DSRIP funding; Administrative costs for the Project Management Office; Lives attributed to each hub and its partners; Net project costs; Performance on milestones and metrics; Lost revenues from DSRIP Implementation; DSRIP limits (5% for non-safety net providers); and Reserves.

NQP's Finance Committee, consisting of financial management leaders from the three hubs, is responsible for the development of formulas for funds flow based on the 8 elements, for review and approval of the Executive Committee, subject to annual review and update as necessary according to the 8 elements or other new factors that may be identified. The funds flow plan will be transparent to all PPS partners through their partner participation agreements.

On a high-level, approximately 95% of NQP funds will be distributed to the hubs based on the funds flow formula. The 5% of funds not distributed will be used as follows: 2.5% for PPS Project Management Office and 2.5% for reserves. Each hub will distribute funds to its partners based on funds flow principles, including but not limited to, performance on milestones and metrics, net costs for project implementation, lost revenues, additional revenues to cover non-reimbursed costs of providing care to attributed population, administrative costs and other factors necessary to meet the PPS goals. We do not expect the funds flow plan to be based on specialty but it will likely be based, in part, on provider type along the care continuum and contribution to the project. The hubs will determine those allocations. On a quarterly basis, the hub will report on the distribution and expected use of funds to the Finance Committee which will then report on the combined distribution and use of funds by the hubs to the Executive Committee. The PAC will review the detailed funds flow distribution plan before it goes to the Executive Committee. The percentages in the table in this section 8 may change once the amount of the DSRIP award and the exact flow of Inter-Governmental Transfers are known. IGT-related payments are shown in the table on a gross basis.

As each hub will implement each of the 10 projects (NUMC/NuHealth will be responsible for implementation of project 11) funds are going

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to be allocated to the physicians and organizations implementing the projects. The providers receiving funding will be among the approximately 1,525 primary care physicians, 405 behavioral health resources, 23 hospitals, 9 FQHCs, 1,760 Community Based Organizations (CBO), 3,649 non-primary care practitioners, 77 SNFsand 23 health homes/care management entities across the continuum of care and 10 projects. NQP through its three hubs expects to reach over 665,000 Medicaid enrollees and 526,000 uninsured in Nassau and eastern Queens.

The funds flow plan will address the DSRIP goals and objectives in the following ways: Funds will be distributed, initially, based on each hub's attributed population, with each hub being responsible for a defined population and participating partners. This population-based approach could be utilized later in the DSRIP program to distribute funds to all partners, reflecting population- and value-based payments. Hubs will reward providers that achieve the metrics and milestones according to the PPS funds flow plan, incentivizing providers to achieve metric and milestone goals that will further positive outcomes for patients and meet the DSRIP objectives. Partners will develop experience with population-based and incentive-based reimbursement during the course of the DSRIP period, and will enhance participating provider's readiness to engage in risk sharing payment models.

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	15%
2	Revenue Loss	10%
3	Internal PPS Provider Bonus Payments	70%
4	Administrative	2.5%
5	Reserves	2.5%
	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.

NQP is a new not-for-profit limited liability corporation (Nassau Queens Performing Provider System, LLC dba Nassau Queens PPS, or NQP). A Vital Access Provider (VAP) application has been submitted to NYS and CMS to recognize NQP as a safety-net provider and therefore eligible to be approved as a PPS. CHS, LIJ and NUMC/NuHealth individually passed the financial feasibility test, NUMC/NuHealth with support of Nassau County and if needed LIJ. Should NUMC/NuHealth prove unable to carry out the operational or financial requirements of DSRIP, LIJ will step in as the PPS Lead. This process ensures the sustainability of NQP and has been agreed to by the NYSDOH, CHS, LIJ and NUMC/NuHealth.

Based upon a review of their financial reports to NYS, the other hospital partners are financially stable. The other partner's financial strength cannot be discerned definitively at this time. The NQP process will be to assist potentially unstable partners in several ways. NQP will annually survey key financial indicators of participating partners' financial condition to review overall financial stability and look for signs of financial stress. In the case of financially stressed partners, the hubs will discuss with the partner the reasons for their current financial position. Hubs can decide to allocate funds from project costs or reserves to supplement provider services, seek to find another partner for the failing partner to merge with or find another partner to fill the potential gap left by the partner should they not be able to carry out their obligations to the PPS. The provider issues will be brought to the attention of the Executive Committee and referred to the workforce committee to help ensure the employment status of the failing partner workforce.

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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.

NQP recognizes that there may be negative impacts on all levels of providers through the transformation of the health care delivery system. Weaning a system of care from sick care to well care may be detrimental for some providers in NYS. The Nassau Queens PPS CNA and the reduction targets do not bode ill for the region's providers whether hospitals or SNFs. When taken at the level of the individual inpatient provider, the reduction targets do not represent closures of hospitals or even nursing units. The reductions in readmissions and transfers from nursing homes over the 5 years will serve to increase the occupancy of SNFs. Planned changes in reimbursement to behavioral health and substance abuse providers, while not directly related to DSRIP, are likely to challenge those providers' financial states. This has already been evidenced in the region as FEGS, one of the largest regional providers of mental health and substance abuse services announced a $19 million deficit. Important regional partners may have to be sustained in the near term in order to ensure the goals of DSRIP are met. Those financially fragile partners may need to reexamine their mission, however, and find like-minded organizations with which to merge in order to sustain services to the Medicaid and uninsured populations.

NQP's finance committee will maintain a regular schedule of reviewing the status of the inpatient providers, particularly in the later years of the DSRIP period, to ensure that redesign does not negatively impact the goals of the PPS and the DSRIP program. NQP will attempt to advise the providers about restructuring if assistance is needed. As a general principle, NQP will attempt to support organizations that are essential to achieving DSRIP outcomes, and to ensure that needed services are maintained in the community, consistent with meeting DSRIP goals. NQP is making specific provisions in its budget for smoothing out challenging short-term financial difficulties. It will identify at-risk providers that are essential for meeting DSRIP metrics and milestones, to determine whether support is needed.

Section 9.2 – Path to PPS Financial Sustainability:

Description:

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

***Path 1:**

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

During the first quarter of 2015 the Executive Committee will task the Finance Committee with creating a plan for financial sustainability for NQP Areas that the plan will have to address include:

Contracting - It is expected that participating providers will be required to contract with NQP. This contract will lay out the responsibilities of the PPS to the partner and the partner to the PPS including providing financial information (e.g., 990, certified financial statements)

Reporting – it is expected that participating partners will report on their use of DSRIP funds as well as reporting on their meeting performance metrics and milestones.

Financial Monitoring and Remediation - Financially fragile partners will be guided by the Finance Committee in developing a restructuring plan that may include expense reductions, debt restructuring, changes in service configuration, a remediation time period and a monitoring plan. The restructuring plan will be reviewed with the Executive Committee and progress periodically reported to the Executive Committee. NQP guidance and help in developing a remediation plan will allow the provider to continue to contribute to the success of the PPS.

***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.

NQP will create a system of reporting financial, utilization and quality metrics on a regular basis to evaluate whether inpatient partners are meeting metrics and milestones and are financially viable to continue participating in DSRIP. Those data will be reported to the Finance Committee and to the Executive Committee. Other partners will also be monitored regularly for financial, utilization, and quality metrics. Those results will also be reported to the Finance Committee and the Executive Committee. If a large provider that is key to the DSRIP plan's success is in jeopardy, the Finance Committee will work with the provider to develop a financial viability plan. If those efforts, when

implemented, are not successful and will jeopardize the DSRIP plan, NQP will develop alternatives to that provider – either by finding another provider or contracting for services. For smaller providers in jeopardy, NQP will attempt to ensure that adequate services are maintained in the community with respect to the goals of the DSRIP program. The quality metrics of the partners will be reported to the Clinical Oversight Committee.

NQP does not include any financially fragile hospitals.

***Path 3:**

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

NQP expects that the DSRIP outcomes can be sustained after the conclusion of the program because the foundational work of redesigning the regional health care system will be emphasized in the next five years. NQP partners will develop capacity and experience in coordinating care and social resources for low-income patients. We expect that the DSRIP period will result in inpatient capacity right-sizing and outpatient capacity expansion. Moreover, DSRIP will set the foundation and infrastructure for population health management. Additionally, all NQP partners will learn and undergo performance improvement techniques that can be replicated in future years. Ability to track and manage data, and use it to drive improved health outcomes will be developed in all NQP partners during the DSRIP period. It is also expected that providers will be reimbursed through value-based reimbursement with performance-based DSRIP incentive payments. Thus, PPS participating providers will be better positioned to participate in risk-based arrangements, either with NQP or separately, and will have developed capacity to implement the population health approach that aligns with risk-based contracting.

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

Description:

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

***Strategy 1:**

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

NQP's vision is aligned with the goals of DSRIP and expects that by the end of the DSRIP period, many providers will be on a capitated or other value based approach for payment for the Medicaid population. Those with less experience in payment reform will be undertaking shared savings arrangements. Payment will be contingent on performance to ensure quality standards are maintained, even for those less experienced with payment reform.

NQP has experience with payment reform. LIJ and its affiliates operate an insurance company, CareConnect. The experience LIJ and Beacon IPA (a PPS partner) and South Nassau Community Hospital have developed by participating in Medicare Shared Savings programs will facilitate NQP's ability to participate in additional shared savings and other payment models. LIJ and Winthrop University Hospital have experience with the Medicare bundled payment initiative. All of this experience will be useful in helping PPS partners transition to payment methodologies that include risk, value and quality measures.

The three hubs have relationships with many of the six Medicaid managed care plans operating in Nassau and the 10 operating in Queens. Healthfirst is on the NQP PAC, and is thus able to participate in developing strategies for approaching payment reform with the Medicaid MCOs. NQP will initially seek to develop sub-capitated payments that are based on performance and that contain an element of shared risk. Ultimately, NQP seeks for all MCO payments to the PPS to be value-based.

***Strategy 2:**

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

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NQP expects to move rapidly away from fee-for-service toward a range of risk-sharing and value-based payment methodologies. Care redesign will be happening hand-in-hand with payment reforms. Reimbursement will be less dependent on utilization of services and more on maintaining the health of the population. As inpatient capacity decreases, outpatient capacity will increase, and payments may be made so as to incentivize and reinforce these changes.

Financially fragile safety net providers will need to restructure to meet the DSRIP goals, with some compensation for revenue loss. Safety net providers in the community that are key to achieving the DSRIP goals, such as food and housing organizations, may have a new source of funding from participating in DSRIP. Other safety net providers will need to restructure to adjust and potentially re-purpose inpatient capacity and increase outpatient capacity – along with all PPS partners – but will have value-based payments in future years to make the transition occur more smoothly.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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

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

Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

All 3 hubs are experienced in population health management, featuring risk stratification, care management, care transitions, community, and in-home programs.

LIJ participates in full/shared risk and shared savings contracts with Medicaid and commercial payers, taking responsibility for over 250,000 lives. Programs include Independence at Home (1 of 18 national MSSP demonstration sites targeting high risk seniors); Bundled Payment for Care Improvement (multisystem episode of care arrangement targeting high risk/utilization conditions including COPD, Stroke, Joint Replacement, Valve Replacement and CABG); NYS Health Home (care coordination for the chronically ill with behavioral health disorders); Healthy Transitions (CMS Innovations program for advanced renal disorders); and Care Solutions (facilitating system collaboration with post-acute entities). LIJ and its affiliates invested heavily to build CareConnect and obtain a Managed Long Term Care License, growing its population health infrastructure to perform claims processing, risk stratification, provider engagement and utilization management. CareConnect will receive a Fully Integrated Duals Advantage license in 2015, a joint CMS/NYS demonstration project.

NuHealth's FQHC has 5 PCMH practices that are actively engaged in managing patients with chronic conditions and increasing access. NuHealth was an early partner in the Chronic Illness Demonstration Project, working in close collaboration with FEGS.

Population health is directly tied to the CHS mission and is now its own division. CHS has entered into multiple risk-sharing contracts and has relationships with major payers to improve access, quality, and the experience of care while lowering unnecessary costs. CHS has also assumed joint ownership of an Accountable Care Organization, its constituent care coordination team, and care managers. CHS fully intends to expand the care coordination team to streamline and improve access to care through all populations.

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.

Via LIJ and its affiliates' Center for Learning and Innovation (CLI), NQP will partner with the 1199 Training and Employment Funds (TEF) to develop and organize the training of the new PPS expanding the long standing contractual relationship which already exists. The partnership with CLI and TEF will include contracting with vendors and using the Job Security Fund/employment center as a referral source to transition workers to newly established work settings. Working with the TEF will leverage previous Healthcare Worker Retraining Initiative state grants that provide opportunities to enhance job skills for an incumbent work force to align with and reflect new industry delivery of care models.

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

Primary Lead Provider Name: NASSAU UNIVERSITY MEDICAL CEN
Secondary Lead Provider Name:

Lead Representative:	Victor F Politi
Submission Date:	01/06/2015 10:57 AM

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

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SECTION 4A – Speed and Scale Final version:

Please upload the final version of the Speed and Scale File for the selected projects.

DSRIP Project Plan Application_Section 4A (Speed and Scale): (Microsoft Excel only)

Currently Uploaded File: **(none)**

Description of File

File Uploaded By:

File Uploaded On:

☐ ***I hereby acknowledge as the Lead Representative of this PPS that this is the final version of the Speed & Scale File for the selected projects.***