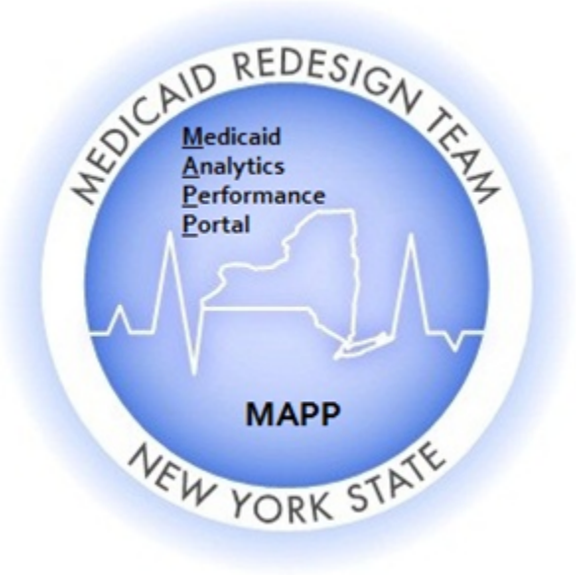
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



The New York Hospital Medical Center of Queens

New York State Department Of Health
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DSRIP PPS Organizational Application

The New York Hospital Medical Center of Queens
(PPS ID:40)

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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: **40_SEC000_NYHQFinancial Stabilitylow.pdf**

Description of File

NYHQ Financial Viability

File Uploaded By: jg587813
File Uploaded On: 12/22/2014 12:12 PM

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: lm593241
Last Updated On: 12/22/2014 03:13 PM

Certified By: js589666
Certified On: 12/22/2014 03:28 PM
Lead Representative: John Sciortino

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	Reduce avoidable hospital utilization by 25%	To decrease costs of accessing healthcare and improve the patient experience by implementing 9 PPS projects focused on the needs of the community outlined in the community needs assessment. The improvements will focus on quality indicators such as PPAs, PPRs, PPVs, transfers, etc.
2	Utilize PPS partner collaborations	to address the healthcare concerns outlined and prioritized in the Community Needs Assessment.
3	Transform the healthcare of our community from reactive to proactive	to focus to prevention and proper utilization of healthcare facilities.
4	Expand on the expertise of our healthcare PPS partners	To increase access, improve quality, and generate collaborations for a healthier community.
5	Align healthcare providers, facilities, and community based organizations	utilizing evidence based outcome metrics and population health management strategies in order to decrease barriers of accessing healthcare and decrease the cost associated with care.
6	Maximize the benefits of care coordination and care transitions between PPS partners	to ensure consistency, communication, and accountability.
7	Implement a robust health information exchange platform and population health management system	to improve the management of chronic conditions with access to critical information for our providers.
8	Bridge the gap between behavioral and medical health	to establish a multi-disciplinary approach customized to the patient needs.
9	Establish performance dashboard measuring tools utilizing a centralized PPS Project Management Office (PMO)	to focus on rapid cycle evaluation, transparent communications, and effective accountability.
10	Create a culturally sensitive and adaptive healthcare market	to properly provide healthcare services to the diverse community that we serve.
11	Establish health literacy models	to expand or invent with a focus to chronic conditions and prevention for both behavioral and medical health with an emphasis to language and cultural barriers.
12	Identify high risk utilizers or utilization techniques within the healthcare community	to prevent improper utilization of the emergency department.
13	Improve quality indicators such as PPA/PPR/PPVs	to implement best practice standards for projects selected.

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

The NYHQ PPS aligned its strategies and priorities with the healthcare gaps and disparities identified in our Community Needs Assessment. Gaps included the lack of safety net providers limiting access to primary care needs for behavioral health services and needs

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for care coordination for long-term care patients. Disparities included disease category concerns for cardiovascular, HIV, and diabetes. Partners were selected to address the needs of our community and maximize the benefits to the healthcare community. Understanding that our community has complex healthcare needs, project selection was prioritized through a process of aligning community needs, disparities, and magnitude/impact to the community. The processes of partner and project selection, as well as the establishment of the PPS organizational structure, were formulated to ensure alignment with the needs of our community and ensure the success of our PPS. The organizational structure of the NYHQ PPS will utilize collaboration, communication, and accountability to manage the diverse population and meet many needs of our patients.

***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 of the NYHQ PPS is to improve the quality of the continuum of care with an approach utilizing collaboration, communication, evidence based medicine, best practice standards, and IT solutions. The PPS partners are committed to focused improvements that are culturally sensitive. Together, the PPS will create a patient-centric, effective, efficient, and fiscally responsible delivery system.

Innovation and integration are key to successful implementation and to the creation of sustainable healthcare models that adapt to the needs of the community. The healthcare market and community needs will continually evolve; the NYHQ PPS will be on the fore-front of healthcare changes while maintaining a focus of quality, compassion, and financial stewardship. The clinical, organizational, and technological models of our PPS will be developed with sustainability as the primary goal. The PPS will include strategies to avoid financial risk, implement emerging procedures and technology to reduce cost, quickly identify partners or processes that do not align, and negotiate with managed care organizations to align incentives of quality and outcomes in a value based payment method.

***Regulatory Relief:**

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

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

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

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

#	Regulatory Relief(RR)	RR Response
1	10 N.Y.C.R.R. § 710.1(c)(1)	Regulation to be waived is: Certificate of need review required for opening of an extension clinic, including a mobile health unit, or expansion of the capacity of an established facility. Project: 2.A.II. – Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Project: 3.A.I – Integration of Primary Care and Behavioral Health Services Components that are impacted: Increase Primary Care Practitioners with

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#	Regulatory Relief(RR)	RR Response
		PCMH Certification and/or Advanced Primary Care in northwestern Queens; Integration of Primary Care and Behavioral Health Services The NYHQ PPS Community Needs Assessment established the shortage of primary care and behavioral health providers in the Northwest Queens, consisting of zip codes 11368 Corona, 11355 Flushing, 11373 Elmhurst, 11377 Woodside, and 11385 Ridgewood. Expansion of the capacities of Mental Health Providers of Western Queens and HELP/PSI Queens Health Center are likewise necessary to facilitate integration of primary care and behavioral health within the PPS. Accomplishment of the requirements of projects 2.a.ii and 3.a.i will be impaired if the PPS partners are unable to cover the attributed Medicaid beneficiaries and those eligible throughout PPS's entire geographic area with respect to these projects. The PPS considered utilizing practitioners associated with non-established entities to meet this need, but determined that this would dilute services necessary to address other PPS geographic areas and project requirements. Directly applying/increasing the resources of established entities in this region is considered to be the most effective and efficient methodology to address this resource shortage. Patient safety is not implicated by this request because the expanded services would be provided by established entities, already authorized to perform such services, and which are already providing such services. The policies and procedures designed to implement this project plan will ensure that patient safety will be improved, rather than placed at increased risk. Both the state and the PPS governance structure will monitor these activities, including the achievement of project milestones and key quality metrics, and their success in accomplishing the DSRIP goals of increased access, higher quality care, and lower cost, further ensuring that patients' health is not only not placed at greater risk, but is enhanced by the program. The NYHQ PPS's rapid cycle evaluation mechanisms will be designed to uncover any unanticipated and undesired outcomes as quickly as possible, and the PPS Compliance Program will address this risk area and set up monitoring mechanisms, in conjunction with the rapid cycle evaluation, to prevent again any risk to patient safety.
2	10 N.Y.C.R.R. § 401.2(b) 10 N.Y.C.R.R. § 401.1(d) 10 N.Y.C.R.R. § 401.3(d)	Regulations to be waived are: Requiring an operating certificate to be used only by the established operator for the designated site of operation, with a temporary exception for emergencies; Requiring Article 28 facilities to be physically, administratively, and financially independent and distinct from other operations of any other provider or health facility, and Prohibiting Article 28 providers from leasing or subleasing a portion of that facility to a non-Article 28 facility. Project: 3.A.I – Integration of Primary Care and Behavioral Health Services Components that are impacted: Integration of primary, specialty, behavioral, and social care services through the co location of primary care practitioners and Article 28, 31 & 32 facilities. Under the DSRIP program, a provider established under either Article 28, Article 31, or Article 32 may provide primary care and behavioral health services under their single license. Two or more such established providers may also share space pursuant to an approved, written plan. To facilitate the implementation of this project, approval is hereby requested for project plan 3.A.I as the written plan permitting the co location of Article 28, 31, and/or 32 providers. Waiver of 10 N.Y.C.R.R. § 401.2(b) is requested to permit the Article 28, 31 & 32 providers to provide services outside of their designated sites of operation. Waiver of 10 N.Y.C.R.R. § 401.3(d) is

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#	Regulatory Relief(RR)	RR Response
		requested to permit NYHQ to lease space to physician members of the PPS to supplement and coordinate with the services currently available at its designated sites of operation. As an alternative, hiring and credentialing of additional NYHQ staff was considered. Patient safety is not implicated because the regulations for which waiver is sought are operational in nature. Further, patient safety is not implicated by this request because the PPS participants who provide the services will be licensed to perform such services, and will already be providing such services. The policies and procedures designed to implement this project plan will ensure that patient safety will be improved, rather than placed at increased risk. Both the state and the PPS governance structure will monitor these activities, including the achievement of project milestones and key quality metrics, and their success in accomplishing the DSRIP goals of increased access, higher quality care, and lower cost, further ensuring that patients' health is not only not placed at greater risk, but is enhanced by the program. The NYHQ PPS's rapid cycle evaluation mechanisms will be designed to uncover any unanticipated and undesired outcomes as quickly as possible, and the PPS Compliance Program will address this risk area and set up monitoring mechanisms, in conjunction with the rapid cycle evaluation, to prevent again any risk to patient safety.
3	10 N.Y.C.R.R. § 710.1(c)(3)(h)	Regulation to be waived is: Requiring administrative review for the relocation of an extension clinic (in this case the Mobile Asthma Van) to a site outside of the current service area of the extension clinic that does not include an increase in scope of services or clinical capacity. Project: 3.d.ii. – Expansion of asthma home-based self-management program Components that are impacted: Expansion of service area of NYHQ Mobile Asthma Van NYHQ currently has authorization to operate a Mobile Asthma Van. The Mobile Van has the capacity to perform many of the services that are instrumental to the accomplishment of the project requirements of Project 3.d.ii. Expansion of the service area of the Mobile Asthma Van is the most effective and efficient method to deliver those services to areas of high need, and the requirement to complete administrative review will delay implementation of this project. The NYHQ PPS considered utilization of non-established resources or the opening of an extension clinic to achieve the goals of this project, but neither approach would provide the ease or simplicity of the chosen methodology, and they would require the duplication of resources, resources that can be more effectively used in other ways to further the purposes of the DSRIP project plans. Waiver of administrative review would not impact patient safety because the Mobile Asthma Van has already been approved to provide the proposed services, and has been in operation delivering quality care for some time. All policies and procedures, training thereon, monitoring, and evaluation is already in place. In addition, the performance of the Mobile Health Van as part of Project 3.d.ii will be evaluated as part of the NYHQ PPS quality control and improvement process, further mitigating patient safety risk and enhancing effectiveness and quality of care, and the PPS Compliance Program will address this risk area and set up monitoring mechanisms, in

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#	Regulatory Relief(RR)	RR Response
		conjunction with the rapid cycle evaluation, to prevent again any risk to patient safety.

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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 NYHQ PPS will initially utilize the Collaborative Contracting model of governance. After evaluating the results of the CNA, composition of the network, and size of total attribution, the partners concluded that the Collaborative Contracting model was best to start the PPS. Reducing admissions and readmissions among hospitals, SNF, and home care; and managing cardiovascular, asthma, mental, HIV illnesses, palliative care; plus addressing geographic disparities of services were identified as priorities. The network is composed of 27 nursing homes, 6 home health agencies, over 225 primary care and behavioral health professionals who are primarily employed at partner entities, 1 community and 2 psychiatric hospitals, 1 LTACH, and a mix of post-acute acute and community based providers. Given the small size of the PPS and challenging community needs per the CNA, the partners preferred a governance model that facilitated immediate focus on achieving results that allowed for a phased-in progression to a more complex partnership structure.

After the first two years of operations, when the PPS is in control of results, the partners will evaluate other forms of organizational

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structures that will be better suited for contracting with multiple-payers using value-based payment models. This phased approach to a possible new structure will be critical for the success of the PPS. The collaborative contracting model is best suited for a small yet effective PPS.

In August 2014, a transitional governance structure was established for the application planning process with a PAC, Transitional Steering Committee, functional workgroups, project planning groups, and PMO. This structure will transition to that depicted in the attached organizational structure effective 3/1/15. The Transitional Steering Committee will convert to the Executive Committee and the functional work groups will convert into the formal IT/Data, Finance, and Clinical/Operations committees. The PAC and PMO will continue in the new structure as designed in June 2014. Functional work groups and project work groups will continue ad hoc. The responsibilities, membership, terms, and authority of each transitional and permanent committees have been discussed and adopted by the PAC and governance work groups.

The Transitional Steering Committee, PAC, and work groups have been populated and met monthly through the planning process. Each has contributed to the development of the Project Plan Application through engagement at monthly and ad-hoc meetings, and survey completion. The members of the transitional committees and work groups will be the pool from which the permanent committees will be populated.

Non-core administrative functions, such as human resources, finance, IT, communications, and compliance, will be purchased from NYHQ, allowing for quick ramp-up and implementation of PPS Project Plans. The PPS will have a defined identity and separate organizational structure within NYHQ that will focus on the business of the PPS. Core administrative functions will reside at the PMO within the PPS.

The clarity of the PPS partners' roles and responsibilities provided by the Collaborative Contracting model, governance structure combined with the resources of NYHQ, will enable the PPS participants to concentrate on the strategies necessary for a successful DSRIP program, including project plan development, implementation, reporting, results, and supporting the PPS' evolution towards accountability for patient and population outcomes.

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: **40_SEC021_SECTION 2 GOVERNANCE ORGANIZATIONAL STRUCTURE.docx**

Description of File

Organization Chart

File Uploaded By: sc593242

File Uploaded On: 12/22/2014 09:30 AM

***Structure 2:**

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

The Executive Committees and subcommittees will be composed of at least 5 members each. Members will be selected by the Executive Committee from existing transitional steering committee and functional work group members. Committee chairs will be ratified by the Lead Applicant. Committee members will reflect the network's provider categories: nursing homes, home health, physicians, community-based organizations, and hospitals required to achieve project goals. Committee members will be appointed by 3/1/15 with formal committee meetings starting April 2015.

Committee member selection criteria include understanding of the PPS' purpose, population health; participation in the PPS Projects; understanding of the Medicaid program, number of attributed beneficiaries, location, and good standing in the Medicaid and Medicare Programs.

The operational and administrative functions of the PPS will be housed in a Project Management Office (PMO) that will advise, work

closely with, and follow the direction of, the Executive Committee.

Several governance committees will oversee the PPS.

Lead Applicant is the PPS contract entity with the state. In collaboration with the PAC, Executive Committee, and Subcommittees, it sets the mission and ratifies the vision of the PPS. The Lead Applicant has ultimate responsibility for the outcomes of the PPS and has final decision-making authority on issues not covered in the contracts or resolved through a consensus based governance model.

Executive Committee sets the strategic direction of the PPS in conjunction with the Lead Applicant. It oversees project implementation, sets standards for contracts and achievement of DSRIP milestones and metrics, ensures stakeholder engagement, provides for structure decision-making and dispute resolution, approves funds flow and budget and makes recommendations to the Lead Applicant, and establishes progressive compliance policy for non-performing partners.

The Executive Committee membership will be populated by 3/1/15. In turn, it will select the members of its subcommittees for an effective date of 4/1/15. The Executive Committee membership will include representatives of NYHQ and the PPS participants.

IT and Data Committee supports metrics, milestones, and reporting required to ensure clinical integration. It will work to achieve inter-operability of partner platforms and RHIO s (and state and MCO platforms as necessary) to share and utilize outcome data in real time. It will standardize data definitions; prioritize allocation of IT resources and joint IT investments; and recommend the selection of population health management applications and IT approaches. This committee will also oversee IT and data security and compliance, data storage and usage, IT costs, and data services.

Finance Committee will review the annual operating and capital budgets and will develop and monitor the funds flow distribution model, and oversee the inflow of DSRIP funds. It will monitor and establish a plan for the long term viability of the PPS and its partners, develop policies and procedures for the financial management of the PPS, and engage with internal and external auditors to arrange annual audits and required reporting.

The Project Management Office (PMO) team will be the operational driving force in supporting strategic planning, monitoring and accountability. The PMO team will partner with all PPS network entities to link business strategy to execution.

Clinical/Operations Committee sets standards for clinical care management (structure, processes, outcomes) using evidence based medical practice including the selection and implementation of clinical pathways to accomplish DSRIP goals. It will monitor, evaluate and oversee continuous quality improvement.

***Structure 3:**

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

The Clinical Committee will also achieve adequate clinical governance by setting the standards of clinical care and population health management, using operating values that are person-centered, evidence-guided, culturally appropriate, data driven, with consistency across settings of care. The Committee will be responsible for overseeing compliance with clinical milestones and metrics, initiating corrective action when needed. The committee will regularly review performance and project reports to ensure rapid detection of variances.

The Rapid Cycle Group housed in the PMO will report its findings and interact with the Clinical/Operations Committee to ensure findings are evaluated timely and corrective action taken within rapid time frames.

The financial incentive program will be a large driver of accountability. Participants' expectation of payment will drive the reality of accountability in all stakeholders.

Additional oversight will be achieved through these four subcommittees.

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1. Care Transitions across entities
a. Establish roles, standards, processes, and tools for care management
b. Analyze metrics to monitor quality, identify gaps, and recommend improvements

2. Clinical Programs
a. Identify current care processes and tools for priority clinical conditions (cardiovascular, asthma, depression, etc.)
b. Define common standards of care and care management
c. Analyze metrics to monitor quality, identify gaps and recommend improvements

3. Care of Complex Patients
a. Identify current care management processes, tools and resources for high-cost / high-need patients.
b. Define a common set of standards of care
c. Analyze metrics to monitor quality, identify gaps and recommend improvements

4. Patient Experience
a. Analyze metrics to monitor quality, identify gaps and recommend improvements
b. Design and Implement Medicaid a process for stakeholder engagement and communication

***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.

High performing health organizations exhibit joint accountability for populations served and are in control of outcomes to realize and surpass goals. This is achieved by quality management, openness of action, long term orientation, continuous improvement, and quality employees. These typically rank high in customer satisfaction, customer loyalty, employee satisfaction, quality, innovation, and complaint handling. The NYHQ PPS will strive to achieve success as a highly integrated delivery system through these leadership and management practices and through its collaborative contracting model. By incorporating partners into the governance structure and planning processes, by utilizing their talents and experience on the PPS governing committees, by requiring their participation in all aspects of DSRIP project design and implementation through the provider agreements, the Collaborative Contracting approach will lead to the continued development of a sense of ownership and cooperation in achieving the desired outcomes that will lead to a true collaborative, team-oriented environment.

NYHQ PPS will evaluate with its partners alternative structures during the third year of operations to determine if a different organizational model is appropriate to enhance the achievement of DSRIP goals. A possible structure will be the delegated authority model as described in the DST's Governance Guide, where partners form a jointly owned company and key governance responsibilities are delegated to the new company.

Section 2.2 - Governing Processes:

Description:

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

***Process 1:**

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

The Executive, Finance, Clinical, and IT committees will be composed of at least 5 members each to carry out the purposes of the committees and will include representation from the PPS participants. Each committee will have a Chair, Vice Chair, and Secretary, appointed to one year term by Lead Applicant for the first year of operations and can be re-appointed to additional one-year terms. In subsequent years, officers will be voted by committee members with ratification by Lead Applicant. Committee members will be appointed for three years in staggered terms. Committee chairs may also serve on the Executive Committee.

The role of the Committees is to oversee the PPS enterprise. Each Committee member is expected to exercise a duty of care and promote responsible governance. The Executive Committee, with assistance from the subcommittees, will oversee the strategic and

operating plans that implement the DSRIP Projects over the next five years and beyond. Committee members will safeguard financial resources for the PPS, will ensure legal and ethical integrity, will build a competent committee membership and will enhance the PPS' public standing.

***Process 2:**

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

Current Transitional and functional work group members were selected from PPS partners that have collaborated in the PAC and functional work groups since the inception of the NYHQ DSRIP process in June 2014. The Transitional Steering Committee and Functional work groups have been populated.

In August 2014, a transitional governance structure was established for the application planning process that included the already-existing Project Advisory Committee (PAC), Transitional Steering Committee, functional work groups, project planning groups, and PMO. This structure will transition to a permanent organizational structure effective 3/1/15. The Transitional Steering Committee will convert to the Executive Committee and the functional work groups will convert into the formal IT/Data, Finance, and Clinical/Operations committees. The PAC and PMO will continue with their same roles in the new structure. Functional work groups and project work groups will continue ad hoc. The responsibilities, membership, terms, and authority of each transitional and permanent committees have been discussed and adopted by the PAC and governance work groups.

The current Transitional Steering Committee, PAC, and work groups have been populated and been operational throughout the planning process. They have contributed to the development of the Project Plan Application through engagement at monthly and ad-hoc meetings, and survey completion. The members of the transitional committees and work groups will be the pool of candidates from which the permanent committees will be populated.

The committee structure will be the conduit through which many stakeholders can participate in the governance process. The membership of the Executive Committee and the subcommittees (PAC, Finance, Clinical, IT and Nominating) will be appointed by 3/1/15. The Executive Committee and each of the subcommittees shall be comprised of at least 5 members, a simple majority of whom shall be representatives of NYHQ, and will include nursing home, behavioral health, physician, and/or home health representation sufficient to achieve the respective committee's purposes.

A Nominating Committee will be convened annually for the purpose of making committee membership recommendations to the Executive Committee.

The Executive Committee will appoint members to the subcommittees and will submit names of Chairs to the Lead Applicant for ratification.

***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.

Coalition partners have been included in the PAC and Transitional Steering committee. Individuals from the PAC, Interim Steering Committee, and functional work groups will be considered for membership positions of the Executive Committee, Finance, Clinical/Operations, and IT/Data Committees. Recruited providers have been analyzed by categories for appropriate reflection and representation in the governance committees. The majority of provider categories in the network are physicians, nursing homes, home health, and hospitals.

***Process 4:**

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

NYHQ convened a coalition of potential partners on 3/28/14 to discuss DSRIP opportunities, concept of partnering, and preliminary project selection. This was followed by surveys conducted to identify providers interested in partnering and identifying preliminary project selections based on previous community health needs assessments. This coalition group continued to be engaged through subsequent meetings and informational phone calls until the PAC was formally organized on 6/12/14. Throughout this period, the coalition provided

guidance on DSRIP, organizational options, C N A, and project selection. Several members of the coalition became members of the Transitional Steering Committee and Project Work Groups. It will be a policy of the PPS to contract with all community based organizations that are needed to effectively operationalize the 9 selected projects.

***Process 5:**

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

The central standard for all PPS related decision-making will be the development of a consensus. Meetings will require attendance quorums and simple majority vote of attendees for approval of motions. The Committees will have odd number participation to promote tie breaks. Committee quorum is simple majority.

***Process 6:**

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

Policies to guide the operation of the PPS will be written so that stakeholders know how decisions will be made and conflict can be prevented. These policies include but are not limited to: Recruitment, Renewal, and Termination of Providers; Funds Flow Distribution; Committee Charters; Code of Conduct and Compliance; Data Use/Sharing/Handling Policy; Identifying and Managing Liability; Collaborative Planning; and Closed Meeting Section criteria.

Having specific authority will avert conflicts. For example, the authority of the Executive Committee is to approve and recommend to the Lead Applicant budgets and incentive fund distributions. All contracts and expenditures must be approved by the Lead Applicant. The role of supporting committees is advisory to the Executive Committee.

Subcommittees will escalate unresolved issues to the Executive Committee. The Executive Committee will escalate to the Lead Applicant. The Lead Applicant will escalate to the DOH.

***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.

Transparent governing processes will be achieved by the monthly announcement of meetings and distribution of prior minutes, agendas, and exhibits to committee members. Committee minutes will be submitted to the Executive committee monthly. After Executive Committee approval, minutes and exhibits will be posted on the NYHQ PPS website. Committee meetings are open to all stakeholders and will be announced on the website. The Executive Committee may enter into closed sessions for certain purposes as defined in the PPS governance policies. The criteria for closed sessions will be established in policy. Reasons closed session criteria to be included in the policy may be discussion of protected health information either clinical or human-resources related.

***Process 8:**

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

The Stakeholder Committee will be convened on a quarterly basis to provide general updates to the community on issues concerning beneficiaries, PPS progress, Medicaid and public health care topics, as well as to obtain feedback. The first meeting of the Stakeholder Committee took place on December 3, 2014, for the purpose of reviewing the CNA results and selection of DSRIP projects. The meeting format was a Town Hall. The meeting was widely announced in the community, was very well attended, with insightful questions from the audience. Timely announcements for Stakeholder Committees will be placed in local newspapers, newsletters, blast emails to community based organizations, and the PPS website. Mailing lists of attributed beneficiaries will be obtained from DOH to specifically invite Medicaid beneficiaries to Stakeholder meetings and when messaging of critical importance needs to be delivered.

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:

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***Committee 1:**

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

The PAC formed after its first Town Hall Meeting on 6/12/14, to develop the Project Design Grant application. The PAC was reconstituted after the funding of the NYHQ Design Grant was approved on 8/6/14. The PAC met again on 10/8/14 to consider several organizational topics including

• The transitional organizational structure through the end of December 2014 for planning purposes including the Transitional Steering Committee, Functional Work Groups, Project Work Groups.
• Invitations were extended to participate in Functional and Project Work Groups.
• Charters and participation procedures for Functional and Project Work Groups were reviewed.
• The proposed methodology for the CNA primary and secondary research was presented and discussed.
• Monthly PAC meetings would be a point of communication and review for all workgroups.

The PAC met again on 10/22/14 to consider the preliminary findings of the CNA. Guidance for next steps was provided. On 11/19/14, the PAC met to consider several topics:
• Project selection using a matrix that correlated CNA findings to projects. The matrix identified the need to change two of the previously selected DSRIP projects. Nine projects were presented altogether for consideration.
• The status of the Project Plan application was reviewed. Partners and project groups were focused on project-specific operational surveys.
• The Collaborative Contract Model of governance was proposed as the structure for the PPS. Rationale for the need to implement a straightforward model that maximizes the ability to achieve milestones and metrics with substantial collaboration was discussed.
• Next steps were identified: outlining performance expectations, completion of the PPS Partner Attestation, drafting the Project Plan application, and conducting community-wide stakeholder meetings to present the results of the CNA and project selection.

The PAC is composed of 35 members that represent a diverse group reflecting the composition of the network. It includes: 1 Labor, 17 SNF, 4 Home Health, 3 Clinics, 3 Behavioral health, 3 CBO, 1 Developmentally Disabled, 2 NYCDOH, 1 Hospice, and 1 Hospital. The network is composed of 27 nursing homes, 6 home health agencies, over 225 primary care and behavioral health professionals, 1 community and 2 psychiatric hospitals, 1 LTACH, and a mix of post-acute acute and community based providers.

***Committee 2:**

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

The PAC advises the planning, implementation, and oversight responsibilities of the DSRIP Project Plan. The PAC is broad and diverse and has the knowledge base to effectively advise the PPS on pertinent matters. The PAC also advises the Executive Committee on all elements of the Community Needs Assessment and the DSRIP Project Plans. The role of the PAC has worked well and will continue during the permanent organizational structure phase after 4/1/15. The PAC Chair will serve on the PPS Executive Committee.

***Committee 3:**

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

The PAC has been an integral part of the development of the PPS organizational structure and in the development of the CNA. As demonstrated in the previous chronology, the PPS was consulted when the transitional organizational structure was developed as well as the permanent structure to be implemented effective 4/1/15. The PAC was also engaged in discussions about the approach to be taken with the primary and secondary research. The PAC was engaged in evaluating preliminary and final results of the CNA. The PAC was also engaged in the selection of projects as a result of CNA findings.

***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 35 members that represent a diverse group reflecting the composition of the network. The PAC includes members in the following categories: 1 Labor, 17 SNF, 4 Home Health, 3 Clinics, 3 Behavioral health, 3 CBO, 1 Developmentally

Disabled, 2 NYCDOH, 1 Hospice, and 1 Hospital.

The network is composed of 27 nursing homes, 6 home health agencies, over 225 primary care and behavioral health professionals who are primarily employed at partner entities, 1 community and 2 psychiatric hospitals, 1 LTACH, and a mix of post-acute acute and community based providers. The PAC is broad and diverse and has the knowledge base to effectively advice the PPS on pertinent matters.

Section 2.4 – Compliance:

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

***Compliance 1:**
Identify the designated compliance staff member (this individual must not be legal counsel to the PPS) and describe the individual's organizational relationship to the PPS governing team.

The NYHQ Vice President for Regulatory Affairs and Corporate Compliance will serve as the PPS Compliance Officer and will sit on the Compliance Committee. The Compliance Committee will be formed and populated by 4/1/15 and will include one representative from the PPS Executive, IT/Data, Finance and Clinical Committees. The PPS Compliance Officer may also recommend qualified representatives from among the PPS partner providers.

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

The Compliance Officer will work with the PPS leadership in establishing regular audits to maintain compliance with regulatory standards. The compliance plan will include audits to ensure proper application of standards. The Compliance Officer will work with the PPS Executive Committee in identifying risk areas for monitoring within the PPS as part of an annual risk assessment. The Compliance Officer will establish an audit work-plan for the PPS to monitor incentive distributions against contractual requirements of PPS participation. This risk assessment will incorporate guidance from state and federal agencies. The Compliance Committee will receive reports from the Rapid Cycle Unit, as part of the PMO, relating to provider participation and compliance with PPS contractual requirements.

***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.

Staff will undergo compliance training on an ongoing basis to provide an understanding of laws applicable to the PPS. Training programs already exist at NYHQ for HIPAA, DRA, Stark, OSHA, OIG, OMIG, NYCDOH , NYSDOH, CMS, JC, HHS and ADA regulations and will be tailored to the PPS. Governance members will undergo compliance training. New training programs specifically required by DSRIP will be developed and taught to the appropriate individuals. The compliance program will be compliant with 363-d of the NY Social Services Law.

Training and education will be accomplished by: Web based program, general regulatory and compliance newsletters. Compliance Officer will meet with PMO staff, PPS governance committee members, and provider groups on a scheduled basis for education at least once a year. All other meetings will be scheduled via the compliance committee and regular schedule. Should additional education be required at any other time regarding new or updated information and or concern, such time will be provided.

***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.

Participating providers, Medicaid recipients, their advocates, and community members will be informed about how they can file a compliance complaint or raise compliance issues, including anonymously. This information will be communicated directly, through the website, or other public mechanisms. All reports will be evaluated for appropriate follow-up.

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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.

Financial reporting tailored to the business of the PPS will be developed and distributed monthly to the PMO executive staff and to the Finance, Clinical, Data/IT, and the Executive Committees for review. Actionable reports will be presented monthly. Reports will focus heavily on the achievement of milestones and metrics to ensure the financial success of the PPS enterprise. Reports will also be developed for the continued oversight of partners' financial sustainability.

The PPS intends to submit a grant application to the Capital Restructuring Financing Program for the purpose of purchasing technology that supports population health management and exchange of information across settings of care. This technology will serve as the foundation for actions and reports that will ultimately lead to quality decision-making by governance. Examples of desired features include: technology that would drive clinical decision support, incorporates care management and registries, facilitates stratifying patient populations, supports patient engagement, supports risk and financial management, and provides outcome data.

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

A dedicated accounting and reporting system will be established to record all transactions related to the PPS. This includes revenue, expenses, and distribution of funds. A comprehensive internal control program will be implemented as described below. Controls will consist of policies and procedures that safeguard assets, ensure accurate and reliable financial reporting, promote compliance with laws and regulations and achieve effective and efficient operations.

The finance function will develop an approach for negotiating contracts with multiple payers. In addition, an inventory of the 9 projects will be done to determine where specific negotiations are required. For example, Project 3.d.ii Expansion of Asthma Care at Home will require collaboration with health plans to implement the project.

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

The Finance Committee will engage External Auditors in overseeing the annual audit and reporting to the Executive Committee and to the Lead Applicant. The purpose of the external audit will be for external independent certified auditors to review and ensure that the financial records of the PPS are fairly stated according to accounting standards and to receive formal recommendations for accounting improvements.

The Finance Committee will also engage with NYHQ internal auditors to oversee internal reports on the effectiveness of risk management, financial and non-financial operations, as well as governance processes. It is expected that an internal audit program be developed each year for timely execution and reporting to the Finance Committee.

***Organization 4:**
Describe the PPS' plan to establish a compliance program in accordance with New York State Social Security Law 363-d.

The NYHQ PPS Compliance Program will be developed by the PPS Compliance Committee. The Compliance Committee will use the Lead Applicant's existing Compliance Program framework to identify compliance policies applicable to the PPS and create a PPS specific Compliance Program. The PPS Contract with partner providers will require each provider to comply with the PPS Compliance Program and policies. The Compliance Program will be identified to the public through a website or other method and will include an anonymous reporting mechanism. The Compliance Program will be targeted to only PPS activities and will not overlap with partner provider existing compliance programs. However, best practices from partners will be available to the Compliance Committee for inclusion in the PPS

Compliance Program.

Section 2.6 – Oversight:

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

***Oversight 1:**
Describe the process in which the PPS will monitor performance.

The Clinical/Operations Committee will evaluate performance monthly. The Rapid Cycle Unit (RCU) will be part of the PMO, composed of population health analysts, nurses, and medical director. The RCU will collect and interpret data and submit monthly actionable reports to the Clinical/Operations, IT/Data, Finance, and Executive Committees for oversight. The RCU will identify successes and challenges, and recommend issues for continuous quality improvement. The RCU will develop a set of reports to monitor milestone compliance, metric performance, and reporting timeliness. Monitoring will be done at the provider, beneficiary, and PPS levels. Input will be solicited from Medicaid recipients and uninsured community members in reference to provider performance and other pertinent topics.

***Oversight 2:**
Outline on how the PPS will address lower performing members within the PPS network.

Performance reports will be submitted to the Clinical/Operations Committee identifying under performing providers. This Committee will trigger the PPS' Provider Improvement Policy (PIP), beginning with remedial steps and potentially progressing to the termination process absent improvement. The PPS will work with the provider to identify and develop an improvement plan that will be submitted to the PPS by the provider. The policy will call for a process improvement time period of 6 months with performance evaluations at 9 and 12 months. If improvement is not achieved or non-compliance of processes continues, the Termination policy will be triggered.

***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.

The Termination policy will define potential adverse actions which will include under-performance. The policy will offer providers safeguards and due process. The policy will include hearings on recommended adverse actions, summary suspension, and provider contract renewal. The policy will define a Hearing Committee composed of peers and requirements for committee member presence and provider presence during the hearing. Processes for the hearing will include responsibilities of the parties, procedure and evidence, burden of proof, hearing officer, representation, deliberations, recesses/adjournment, and written report. Communication to provider of final determination will also be addressed. In case of termination, the policy will include communication about provider removal to the DOH and associated Medicaid beneficiaries. The policy will also include steps required by the DOH after their receipt of termination notice.

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

The PPS Compliance Plan described above will also include a policy for informing Medicaid recipients, their advocates, and community members about how to provide feedback about providers so the data can be used to inform the performance improvement, and provider renewal and removal processes. Specific suggestions for the means of communication to provide feedback will be shared with beneficiaries. These means include and are not limited to: telephone hot lines, website, community workers, and other providers.

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

Upon completion of the termination process the PPS will communicate in writing and other appropriate legal means to the DOH and associated Medicaid beneficiaries about the provider removal.

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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.

The NYHQ PPS recently completed a four-month, comprehensive, and collaborative development of a Community Needs Assessment (CNA). The PPS engaged Premier, Inc and the New York Academy of Medicine (NYAM) to assist in development of the CNA. Premier led the secondary data collection and analysis, while NYAM's expertise was utilized in the primary data collection and analysis. The primary and secondary data collection occurred simultaneously, but was well coordinated and frequently referenced one another. As issues were identified in the quantitative analysis, Premier reached out to NYAM to determine whether that same issue had been raised in focus groups. NYAM followed the same approach, contacting Premier to determine whether findings from the focus groups and interviews were supported by quantitative data.

NYHQ PPS' Community Needs Assessment was developed in accordance with the Guidance for Conducting Community Needs Assessments document provided by the New York State Department of Health. More than 80 community members provided invaluable information, data, and feedback during focus groups, and an additional 13 stakeholders participated in key informant interviews. Recruitment of these respondents was thorough and deliberate.

Partner feedback and awareness was a strategy of the NYHQ PPS to ensure alignment of partners with data collection and project selection. The Project Advisory Committee (PAC) convened on October 8, 2014 to discuss the proposed methodology and receive guidance and direction from partners. Preliminary findings and project selections were presented to the PAC on October 22, 2014 with a comprehensive matrix that outlined findings and project selection criteria. The final CNA was presented to the PAC on November 19, 2014 and a well-attended community town hall meeting was held on December 3, 2014. The town hall was in a public forum, had interactive dialogue, and reflected patron support of PPS direction.

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

The secondary data collection and analysis followed the process detailed in Guidance for Conducting CNA's. The process began with an analysis of community demographics. The majority of demographic data was downloaded from the US Census Bureau, American Community Survey, 2012. This was supplemented by NY State Department of Health data on Medicaid beneficiaries, the US Census Bureau's SAHIE, Neilsen Analysis, and the Cornell Center for Applied Demographics.

Community health status data was pulled from NYC Department of Health and Mental Hygiene's Vital Statistics and New York City's Community Health Survey 2012; NY Department of Health's Health Data, NY Department of Health's Regional Perinatal Profile, and NY Department of Health's Prevention Agenda Dashboard. Data was used to assess mortality and morbidity indicators, understand disease

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prevalence, analyze readmission rates and ER visits, review performance data, and review social determinants of health.

Data used to profile health care and community providers came from sources suggested in the Guidance document - including but not limited to NY State Department of Health's hospital, ambulatory surgery, hospital and home health profiles - or came from reputable sources such as the US Department of Health and Human Resources and NYC Department of Social Services. The NY State Department of Health Provider Profiles and the NYC Department of Planning Selected Programs and Facility Sites data were particularly useful in these sections of the assessment.

Quantitative data was complemented by information from 6 focus groups involving 82 Queen's residents. Focus groups were conducted in multiple languages, with 31% of respondents whom prefer to seek health care in a language other than English and 49% who are Medicaid beneficiaries. Focus groups allowed residents to discuss perceptions of health issues in the community, access resources that promote health, use of health services, and recommendations for change.

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	6	7
2	Ambulatory surgical centers	5	1
3	Urgent care centers	15	1
4	Health Homes	3	1
5	Federally qualified health centers	17	2
6	Primary care providers including private, clinics, hospital based including residency programs	1908	230
7	Specialty medical providers including private, clinics, hospital based including residency programs	1550	844
8	Dental providers including public and private	1220	1
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	2124	15
10	Behavioral health resources (including future 1915i providers)	120	96
11	Specialty medical programs such as eating disorders program, autism spectrum early	8	0
12	diagnosis/early intervention	68	0
13	Skilled nursing homes, assisted living facilities	32	34
14	Home care services	36	8
15	Laboratory and radiology services including home care and community access	67	0
16	Specialty developmental disability services	56	7
17	Specialty services providers such as vision care and DME	313	0
18	Pharmacies	96	3
19	Local Health Departments	1	1
20	Managed care organizations	20	2

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
21	Foster Children Agencies	5	0
22	Area Health Education Centers (AHECs)	1	0

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

***Infrastructure 2:**

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

Both primary and secondary data collection indicate that the service area is not over-bedded from an acute care perspective. The 2,369 service are beds is equal to 1.49 beds per 1,000 persons, which is lower than the state average of 3.0 beds per 1,000 and lower than the national average of 2.6 beds per 1,000. The NYHQ PPS is not suggesting growth in the number of hospital beds, as it recognizes that a low inpatient bed rate per 1,000 may be appropriate as focus shifts toward outpatient care and coordination of care. DSRIP focus on preventing readmissions should also reduce the demand for inpatient beds.

Hospitals provide emergency room coverage, however, most focus group participants reported that they dreaded going to the emergency room because they were afraid of long waits. The analysis identifies a shortage of 327 safety net providers, specifically a shortage of 188 dentists and 139 physicians. While there is a vast array of clinic offerings, not all are likely to serve Medicaid or uninsured populations due to insurance status as many of these are for profit urgent care and ambulatory surgery centers. Based on this data, there is a need for 22% increase in safety net providers focused to high-density Medicaid zip codes. Corona, Woodside, and Ridgewood currently have the lowest rate of safety net providers; therefore additional services should be directed to these areas.

Data showing the service area's low nursing home beds per 1,000 population (4.84 in the service area, compared with 5.30 nationally) is supported by nursing home occupancy rate data of 93% and higher. However, as with acute care beds, the NYHQ PPS is not recommending increasing nursing home beds, but instead believes that this number may be appropriate if care coordination and transitions of care improve and as home care is better utilized.

Data shows an immense need for behavioral health care. Behavioral health was identified as a need repeatedly in focus groups and key informant interviews. Despite 120 community-based residential and outpatient programs, behavioral health utilization of inpatient beds and emergency rooms remains high. The Medicaid Chronic Conditions database available via Health Data NY shows ~150k behavioral health admissions and ~216k behavioral health emergency visits annually in Queens County. This suggests lack of coordination and outreach suitable to the culturally and linguistically diverse residents of Queens. Furthermore, better coordination of behavioral health with primary care may help overcome identified barriers to care such as stigma associated with mental illness.

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

***Resources 1:**

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

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	17	2

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
2	Food banks, community gardens, farmer's markets	90	0
3	Clothing, furniture banks	2	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	14	43
5	Community outreach agencies	453	0
6	Transportation services	115	0
7	Religious service organizations	17	0
8	Not for profit health and welfare agencies	260	0
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	0	0
10	Peer and Family Mental Health Advocacy Organizations	47	2
11	Self-advocacy and family support organizations and programs for individuals with disabilities	387	0
12	Youth development programs	57	1
13	Libraries with open access computers	40	0
14	Community service organizations	93	0
15	Education	337	0
16	Local public health programs	1	0
17	Local governmental social service programs	6	0
18	Community based health education programs including for health professions/students	20	0
19	Family Support and training	3	0
20	NAMI	4	0
21	Individual Employment Support Services	5	0
22	Peer Supports (Recovery Coaches)	24	0
23	Alternatives to Incarceration	1	0
24	Ryan White Programs	5	1
25	HIV Prevention/Outreach and Social Service Programs	12	1

***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.

Feedback from stakeholders suggested that the first need of impoverished residents is housing, and the second need is for food. Participants in the study presented a contradictory picture of access to healthy food in Queens. Many described healthy food as being readily available, yet also described it as being unaffordable, thereby leaving many to rely on food pantries to address their dietary needs.

There is job assistance available in the service area, yet more may be required. The unemployment rate of 9.6% is higher than that of the state but lower than the NYC average. Employment impacts ability to not only afford health care, but also to afford healthy life choices.

As noted in the healthcare resources section above, geographic disparity of community resources is significant. Mapping of transitional housing availability, as an example, shows few or no options in the areas of highest Medicaid concentration. Any additional community resources should be rolled out not in areas with current providers, but should focus instead on pockets of the service area that are underserved (west and northwest portions of service area first, including Woodside and Ridgewood).

Key informants reported that Queens is often overlooked for funding to address policy, systems, and environments related to physical activity and nutrition. Rounds of state and federal funding have come into the city, and yet no specific projects were awarded in Queens. Analysis of the Creating Healthy Places to Live, Work, and Play (CHP2LWP) data suggests that the NYHQ PPS service area has not

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seized opportunities to create healthier places. Programs funded through this grant include initiatives aimed at increasing the accessibility and availability of fresh fruits and vegetables and maintaining community landscapes conducive to physical activity. These kinds of ventures are critical to the overall health of the NYHQ PPS community. By not receiving CHP2LWP grants, organizations in the NYHQ PPS community are missing out on funding that could dramatically improve the health of the community.

Section 3.4 – Community Demographic:

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

***Demographics 1:**
Age statistics of the population:

The NYHQ PPS service area has 1.6M people, which is approximately 71% of the total Queens County population. It is projected that the NYHQ PPS service area will grow by 65k people in the next five years, for a total of 1.66M people by 2020. Median age of the service area population is 37.8 years. One-fifth (20.7%) of the population is children, just under two-thirds (66.8%) is adults between the ages of 19-64, and 12.6% is adults 65+. This percentage of adults 65+ is smaller than that of New York City and New York State, but the median age of the service area is older than New York City and roughly equivalent to the state. The area has a large pre-Medicare population (ages 45-64), which has implications for health care delivery as the pre-Medicare population ages and the Medicare population (which utilizes healthcare at three times the general population) grows. Of the 692k Medicaid beneficiaries in the service area, 219k (or 31.6%) are children, and the remaining are adult.

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

The NYHQ PPS service area is exceptionally diverse. Queens County, and the NYHQ PPS service area is more racially and ethnically diverse than New York City and the state as a whole. Approximately 25% of the population is White, 14% Black, 27% Asian, 30% Hispanic, and 4% Other. The service area has a particularly large Asian population compared to other geographies ; more than 40% of all Asians living in New York City live in the NYHQ PPS service area. Language spoken closely tracks the racial and ethnic diversity of the service area. 38.4% of the service area population speaks primarily English, compared with 51.4% of New York City and 70.0% of New York State. These statistics are supported by data collected during focus groups. Approximately 31% of focus group participants preferred to seek health care in a language other than English. Many discussed how being limited English proficient impacted their health care experiences.

***Demographics 3:**
Income levels:

Queens County median income of approximately $62k is higher than the State median of $56k, and approximately equal to the New York City median of $63k. The NYHQ service area, however, has a much lower median income than Queens County, at $58k. Income levels in the service area are generally lower than comparative geographies. The percent of NYHQ service area households with a low income (less than $35k per household) is 44.1%. This rate is higher than the Queens County rate of 41.5% and higher than the state rate of 32.9%. Conversely, the rate of households with high income is lower in the service area than in the County or State.

***Demographics 4:**
Poverty levels:

Income, and related poverty data, varies widely across the service area. Queens County has a lower percent of families in poverty (14.4%) than New York City (19.9%) and New York State (14.9%). The NYHQ PPS service area has the same rate of poverty as the state, at 14.9%. However, within the service area alone, the percent of families in poverty ranges from 4.6% in Whitestone to 23.8% in one of the Jamaica zip codes. The geographic disparity of poverty is dramatic across the service area. Economic factors are a major barrier to access to health care. Focus group participants reported that they often delay or avoid seeking health care due to cost.

***Demographics 5:**
Disability levels:

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Within the NYHQ PPS service area, 147k persons, or 9.3% of the population, is identified as disabled. These persons are identified as having difficulty in one of six areas: hearing, vision, cognitive, ambulatory, self-care, or independent living. The service area rate of 9.3% is similar to the Queens County rate of 9.6%, and both rates are lower than the New York City (10.4%) and New York State (10.9%) averages. These disability rates are calculated on non-institutionalized persons.

***Demographics 6:**

Education levels:

Educational attainment is slightly lower in the service area than in comparable geographies, but this variance is small. The rate of service area population with a high school diploma or more is 79.1%, compared with 79.6% in New York City, 80.3% in Queens County as a whole, and 84.9% in New York State.

***Demographics 7:**

Employment levels:

Of the 1.6M people in the NYHQ PPS service area, 840k are in the labor force. Military presence in the area is small, so overall labor force essentially equals civilian labor force. Approximately 9.6% of the service area labor force, or 80k people, is unemployed. This rate is higher than New York State (8.7%) but lower than the New York City (10.2%) average.

***Demographics 8:**

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

In the NYHQ PPS service area, there are approximately 19k institutionalized persons. Of the approximately 19k institutionalized persons in the service area, less than five percent (3.9%) are children below the age of 18. The majority of institutionalized persons (60.1% are between the ages of 19 and 64, while the remaining 36.0% are 65 and older. According to the New York State Division of Criminal Justice New York Crime Report, 40,199 persons in Queens County were involved with the criminal justice system in 2012. This number fell slightly (0.7%) to 39,913 persons in 2013.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
40_SEC034_NYHQ PPS Demographics.pdf	12/20/2014 10:14:10 PM	NYHQ PPS Demographics

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 top ten leading causes of death in Queens County are: heart disease, cancer, flu and pneumonia, cerebrovascular disease (stroke), diabetes, chronic lower respiratory disease, accidents except drug poisoning, essential hypertension and renal disease, Alzheimer's disease, and suicide.

Heart disease and cancer are the leading causes of death across all racial and ethnic groups in Queens County. The racial/ethnic variation in rates for all deaths is dramatic. The heart disease rate for the White and Black population is almost two times the Hispanic population and more than two times the Asian population.

Cancer mortality rates have a similar pattern while the Black population has significantly higher diabetes and hypertension rates.

The Asian population has low mortality rates across the board, with cerebrovascular disease being the only area where rates approach

other races/ethnicities.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

Disease categories with the highest hospitalization include cardiovascular disease, mental health, and substance abuse, accounting for more than 356k annual admissions and more than 357k annual ER visits in Queens County.

Queens County had the lowest 2012 PQI rates of all New York City counties, with an overall composite score of 1481.7. Queens County 2012 risk adjusted PQI rates were generally lower than expected, and improved from 2011. PDI rates are favorable (pediatric PQIs), with an overall composite score of 235.0; however, the county's asthma and diabetes PDI rates have increased since 2011. Areas with higher than expected PQI rates include Woodside and Jamaica, and areas with higher than expected PDI rates include Forest Hills and Flushing. This data suggests that population in these areas may not access appropriate or timely ambulatory care. Potentially preventable readmissions (PPR) performance for all service area hospitals is higher than expected ranging from 6.16 to 7.50. Expected risk-adjusted PPR's range from 4.43 to 7.01.

***Challenges 3:**

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

New York City's performance related to potentially preventable emergency visits (PPV) is mixed. New York and Richmond Counties have higher than expected rates, while other counties perform better. Queens County observed rate of 26.97 per 100 persons and risk-adjusted rate of 30.84 are both lower than the expected PPV rate of 31.55. These rates are lower than other NYC boroughs and also lower than the New York State observed and risk adjusted rate of 36.08 oer 100 persons.

In total, Queens County had 247,000 potentially preventable emergency room visits on a base of 2.48M total emergency room visits (9.9%). Primary data collection identified that many respondents avoided going to the doctor unless they were sick and/or reported delaying healthcare due to cost. In both instances, the wait times to get an appointment were often lengthy and the respondents were left with the option of going to an emergency room. ER's were also reportedly perceived to be a place where the uninsured could not be refused care.

***Challenges 4:**

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

The most significant areas of concern for the NYHQ PPS service area from disease prevalence perspective are cardiovascular disease and behavioral health. These two diseases alone result more than 350,000 inpatient admissions and almost 360,000 emergency room visits annually in Queens County.

Approximately 281,000 Queens County Medicaid beneficiaries, or 30.7% of all beneficiaries, have cardiovascular disease, which is higher than New York State's rate of 29.2%. There was general consensus in focus groups and key informant interviews that heart disease and hypertension were among the health conditions that most affected the community.

The behavioral health data is just as alarming, and many members of the community believe behavioral health to be the most pressing issue facing the community. In Queens County, approximately 140,000 Medicaid beneficiaries, or 15.2% of all beneficiaries, have mental health disease. Approximately 31,000 Medicaid beneficiaries, or 3.4%, of all beneficiaries have substance abuse conditions. Among focus group and interview respondents, mental health was a prominent concern. Changes in the financings of behavioral health services have led to the recent closure of several community-based outpatient mental health clinics in Queens. The lack of community based mental health services only compounded difficulties seeking care caused by other factors, such as social stigma and lack of insurance or affordability.

While respiratory disease prevalence rates are lower than cardiovascular disease or behavioral health (approximately 74,000 Medicaid beneficiaries, or 8.1% of total beneficiaries), asthma specific rates are high.
The NYHQ PPS service area HIV prevalence rate is low compared with other disease categories and compared with other geographies; however HIV is significant concern in the area as newly diagnosed HIV case rate is nearly twice as high at 22.6 per 100,000 when compared to the Prevention Agenda goal of 14.7 per 100,000.

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***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:

For maternal and infant health indicators, Queens County performs moderately compared with New York City and New York State. Queens County has a higher percentage of births with late prenatal care or no prenatal care (7.5%, compared with 7.0% for the city and 5.5% for the state). The infant death rate is equal to New York City at 4.4 per 1,000 births, and lower than New York State's 4.8 deaths per 1,000 births – although the infant death rate in Queens varies from a low of 0.0 in Fresh Meadows to 14.9 in Jamaica. Queens County's teen pregnancy rate falls between the city and the state at 36.8 teen pregnancies per 1,000 pregnancies. With 91,015 total births in Queens County from 2010-2012, the teen pregnancy rate indicates that 3,350 babies were born to teen mothers.

Geographic variation in maternal and infant health is once again a major issue. Five zip codes in Queens County perform worse than New York City and worse than New York State in prenatal care, infant deaths, and teen pregnancy. These zip codes are in the neighborhoods of Jamaica, Corona, and East Elmhurst.

***Challenges 6:**

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

An assessment of health risk factors shows that although the service area population does not report engaging in risky behaviors to the extent that populations in comparative geographies do, there are still several areas of concern. According to the NYC Department of Health's Community Health Survey, one-fifth (19.5%) of service area respondents identified self-reported health as fair/poor, and the reporting of fair/poor health reaches 29.4% in Flushing and Clearview. While the overall average is lower than the New York City average of 20.8%, it is significant.

Obesity is a major issue that impacts the health of the NYHQ PPS service area residents, with almost one-quarter (23%) considered obese.

Approximately 8% of the population reports no routine check-up in two years or more, with almost 15% of the population in Bayside/Fresh Meadows skipping for two plus years.

Self-reported rates of smoking and binge drinking are lower in the service area than comparative geographies. The area's reported smoking rate is 14.9%, compared with a NYC average of 15.6%, and the area's binge drinking rate is 17.5&, compared with a NYC average of 19.6%.

***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**.

The community needs assessment identified numerous service gaps, the most significant gaps of which are outlined in this section. First, there is a critical need to improve behavioral health care access and coordination. Mental health and substance abuse result in 150,000 inpatient admissions and more than 200,000 emergency room visits annually. There are not enough culturally and linguistically appropriate community-based, mental health providers, nor is there appropriate coordination of behavioral health issues by primary care practitioners to address behavioral health issues before they become acute episodes, thereby utilizing high cost services.

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As outlined earlier, all service area hospitals have higher than expected preventable readmissions. This preventable readmissions data suggests that there is a significant need to improve care transitions across settings (e.g., from acute to post-acute or acute to home care).

Additionally, there is a significant need to better manage chronic conditions in ambulatory and home settings, as shown by the PQI, PDI, and ambulatory sensitive data.

Supply and demand analysis of service area providers shows a need to address the shortage of and geographic disparity of ambulatory resources (both clinics and physicians). There is an absolute shortage of safety net physicians and dentists in the service area. The overall shortage is exacerbated in some areas, particularly in zip codes such as Woodside and Ridgewood that have few clinics but high Medicaid density.
While there is not state-released data on this last issue, there is a definitive need for palliative care programming. According to the Dartmouth Institute for Health Policy & Clinical Practice, the PPS service area reports 20.1 inpatient days during the last six months of life for patients as compared to the 50th percentile of 9.2 inpatient days. The concentrated amount of inpatient days reflects a need for the development of clinical guidelines and collaboration to provide a supportive palliative care program.

In addition to identifying major service gaps, the NYHQ PPS CNA includes a comprehensive analysis of bed capacity, in terms of both acute care and nursing home beds. Ratios of beds per 1,000 persons indicate that the service area does not have excess beds. The 2,369 service-area, acute care beds are equal to 1.49 beds per 1000 persons. This is lower than the state average of 3.0 beds per 1000 persons, and lower than the national average of 2.6 beds per 1000. The 32 nursing homes in the service area provide a total of 7,727 beds. This translates to 4.84 nursing home beds per 1,000 persons, which is lower than the national average of 5.3 per 1000. Analysis of nursing home occupancy data, with occupancy rates around 93%, validates that there are not excess beds.

While there are enough overall acute care beds in the service area, the 150 behavioral health beds within acute care facilities are not nearly enough to address behavioral health inpatient volumes, leaving facilities to admit behavioral health patients to medical beds.

***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.

Socioeconomic factors are the underlying cause of many of the gaps in the NYHQ service area. High poverty rates in certain zip codes correlate precisely with high PQI and PDI rates, indicating that both accessibility and affordability are factors in preventable hospitalization. One zip code in Flushing has an extremely high poverty rate of 19.2%, and this same zip code has higher than expected overall PQI rates (adults) and PDI rates (children). The impoverished population struggle with accessibility and affordability of services, and this is corroborated through focus groups and interviews.

In addition, cultural and language barriers are prevalent in a community this diverse, and these barriers often result in diminished quality of care. One example is a focus group respondent who had gallbladder surgery and subsequent infections that left her ill for two years, which she believes is a result of the lack of understanding due to interpretation services.

There are numerous causes driving the need to improve access to and coordination of behavioral health services. High behavioral health prevalence rates and even higher behavioral health utilization are indicative of two issues. First, availability is an issue. There are not enough community-based, ambulatory resources for behavioral health patients. Second, accessibility becomes a driver, as some behavioral health patients are not accessing the community-based resources that are available. Focus groups and interviews identified barriers due to language, lack of insurance, and/ or stigma associated with behavioral health, and the resulting unwillingness of patients and families to seek timely, appropriate treatment for behavioral health issues.

Two of the identified gaps, the need for improved transitions across care settings and the need to better manage chronic conditions in ambulatory and home settings, may be caused by similar factors. In both instances, patients' understanding of the disease progression and treatment protocol has a significant impact. Stakeholders attributed problems with managing disease episodes to lack of health education and care coordination. Respondents also linked delays in raising health concerns or seeking treatment with concern over the cost of health care and their inability to pay.

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***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.

Several strategies will be used to address the issues identified with chronic disease management, access to care, care transitions and care coordination. The NYHQ PPS recognizes that this community has needs that span the range of socioeconomic and health status, prevention and wellness, acute and chronic, physical and mental.

--Ensuring that primary care physicians have the training and resources to play that role is critical, and increasing PCMH certification is a proven way to do so. Enhanced integration of physical and mental health, via primary care providers, is also required.

--Take a proactive role in the early identification and management of patients who may have difficulty with care transitions; particularly patients who leave acute care for skilled nursing. This strategy gets to the core of DSRIP goals in that it is aimed at reducing avoidable readmissions.

--Management of chronic disease will be addressed several ways. The first will attempt to address that disease state with the highest prevalence and utilization rates, cardiovascular disease, by working with high risk patients to address any barriers to managing the disease. The second aimed at the early identification and management of patients having difficulty managing their disease or disease episode at home.

--For two disease states where the data shows undesirable trends in newly diagnosed cases (HIV) and/or hospital utilization (asthma), disease-specific, evidence-based protocols will be employed to reverse these trends.

--Finally, a strategy will target palliative care in nursing homes, as this one initiative addresses three critical goals within health care, e.g., care quality, patient satisfaction, and cost of care.

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 NYHQ PPS engaged New York Academy of Medicine to conduct primary data collection in collaboration with numerous community organizations. The stakeholder and community engagement process involved:

● Key Informant Interviews: Twelve key informant interviews were conducted with 13 stakeholders. Each was asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population.

● Focus Groups: NYAM partnered with community based organizations and institutions to conduct 6 focus groups involving 82 Queen's residents. Sixty six percent of participants were female, and the average age was 53 years; 31% preferred to seek health care in a language other than English, and 49% were Medicaid beneficiaries. Focus groups allowed residents to discuss perceptions of health issues in the community, access to resources that might promote health (e.g., fresh fruit and vegetables, parks), use of health services, access to medical and behavioral health care, and recommendations for change. Participants received $25 in appreciation of their time and insights; partnering organizations received $500-$2000 depending on their level of involvement.

***Community 2:**

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

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NYAM partnered with community based organizations and institutions to conduct 6 focus groups involving 82 Queen's residents. Sixty six percent of participants were female, and the average age was 53 years; 31% preferred to seek health care in a language other than English, and 49% were Medicaid beneficiaries. Focus groups allowed residents to discuss perceptions of health issues in the community, access to resources that might promote health (e.g., fresh fruit and vegetables, parks), use of health services, access to medical and behavioral health care, and recommendations for change. Participants received $25 in appreciation of their time and insights; partnering organizations received $500-$2000 depending on their level of involvement.

***Community 3:**

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

Stakeholders and community residents expressed interest in community services that address the needs of residents holistically in order to prevent hospitalization and promote good health. Given the diversity in Queens, much attention was paid to the need for culturally and linguistically appropriate care, particularly within the hospital. A great deal of attention was given to the need for mental health services, and suicide was raised as a major concern. The growing shortage of community based mental health providers was attributed to changes in the financing of behavioral health. The lack of services only compounded difficulties seeking care caused by other factors such as social stigma and affordability. Participants also expressed interest in social determinants of health, particularly access to healthy food and housing, and sought services that could assist people with both. Participants offered recommendations for how to transform health care to better meet the needs of the community. Some gave idealist responses like "universal health care". Others suggested tested approaches that appeared to be successful, such as care coordinators and community health care workers.

In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.

[The New York Hospital Medical Center of Queens] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	AIDS Center of Queens County	Largest provider of HIV/ AIDS services in Queens offering case management, harm reduction and syringe exchange, health education, and prevention services, housing services, legal services, a licensed mental health clinic, and a food pantry program.	Key informant specializing in the needs individuals with HIV/ AIDS, including LGBT and substance users.
2	Asian Americans for Equality	Non-profit housing, social service, and community development organization dedicated to enriching the lives of Asian Americans and others in need.	Key Informant specializing in social service needs of Asian Americans; facilitated focus group with 11 Chinese speaking residents
3	Comunilife	Non-profit organization providing culturally competent health and social services, and affordable and supportive housing, including Article 31 mental health clinics.	Key Informant specializing in mental health and HIV services and housing, particularly for low income Hispanic communities and youth.
4	God's Love We Deliver	Tri-state leading provider of nutritious, individually tailored meals to people who are too sick to shop or cook for themselves.	Key informant specializing in programming and financing of medically tailored home delivered meals for critically ill individuals.
5	Kalusugan Coalition	Multidisciplinary collaboration to improve the health of Filipino Americans in NYC.	Key informant specializing in health and social service needs of Filipino community in Queens, and programs to increase physical activity and healthy eating.
6	Lexington Center for Mental Health Services	Provides comprehensive mental health and case management services for deaf individuals and their families.	Key informant operating an Article 31 mental health clinic and specializing in the health, mental health and social service needs of the deaf and hearing impaired.
7	Medicaid Matters	Statewide consumer-oriented coalition advocating on behalf of NY's Medicaid program and its	Key Informant specializing in provider and community base organizations

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[The New York Hospital Medical Center of Queens] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		beneficiaries.	perspectives of Medicaid beneficiary needs and interests.
8	Mental Health Provider of Western Queens	Provides community mental health services to children, families and adults through two Article 31 mental health clinics and 10 NYC public schools. Offers care coordination and case management, and is a licensed drug recovery program.	Key Informant specializing in outpatient mental health for children and families including immigrants.
9	New York City Department for the Aging (DFTA)	City agency offering advocacy, education, and the coordination and delivery of services for older adults in New York City. The lead agency implementing Age Friendly NYC to improve livability for older adults.	Key informants offering perspectives on DFTA programming and health and social service needs of low income older adults
10	One Flushing	A community based economic development center in Flushing, Queens.	Key Informant offering perspectives of residents and business communities in Flushing, where NYHQ is located.
11	Queens Community Board 11	Local government in Queens including Bayside, Douglaston, Little Neck, Auburndale, East Flushing, Oakland Gardens and Hollis Hills.	Key informant with professional specialization in home care and nursing, and vocationally in civic engagement around hospital closures and health education program.
12	Queensborough Hill Neighborhood Association (QHNA)	Body of concerned individuals and organizations dedicated to enhancing the quality of life of all who live, work, attend schools, or conduct business on "the Hill" and Flushing.	Co-facilitated a focus group with 16 residents affiliated with the QHNA civic association.
13	Silvercrest Center for Nursing and Rehabilitation/ Silvercrest Housing	A 320-bed skilled nursing facility offering long term care, rehabilitation, and ventilator care. In addition, it operates an 80 unit government subsidized senior housing facility.	Key Informant specializing in the management of a long term care facility and the health needs of its residents, as well as needs of residents living independently in senior housing; hosted focus group with 12 nursing home residents, and 13 residents of independent senior housing, including 3 who were Spanish speaking.
14	Sustainable Queens	A grassroots initiative to promote health and community engagement by integrating art, holistic wellness practices and ecological principles of building healing spaces.	Co-Facilitated a focus group with 17 predominantly Guyanese residents of Queens.
15	Urban Health Plan	Federally Qualified Health Center (FQHC) offering affordable, comprehensive primary and specialty care in Queens and the Bronx.	Key Informant offering perspective of FQHC serving immigrants in Queens; co-facilitated focus group with 13 Spanish speaking patients/ residents.

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.

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

[The New York Hospital Medical Center of Queens] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need enhanced management of home care patients, in order to avoid or reduce hospital readmissions.	All hospitals in the NYHQ PPS service area have higher than expected risk-adjusted preventable readmissions. Reducing hospital readmissions is at the core of DSRIP goals; however, this can be complicated with high-risk patients who have been discharged to the home setting. Evidence-based practice will target the early identification and management of patients having difficulty controlling their disease, thereby allowing patients to remain at home.	NYHQ Primary Data, focus groups and informant interviews, preliminary findings. Potentially Avoidable Readmissions - NYDOH
2	Need additional primary care physicians to manage patients in a comprehensive, coordinated manner.	The CNA found that patient needs span the range of socioeconomic and health status, prevention and wellness, acute and chronic, physical and mental. Managing all of these issues requires primary care physicians who have appropriate training and resources. PCMH certification is a proven method of ensuring physicians are appropriately trained to manage today's complex patients.	NYHQ Primary Data, focus groups and informant interviews, preliminary findings. PPVs - NYDOH PQI Suite, Composite of All Measures - AHRQ PDI Suite, Composite of All Measures – AHRQ
3	Need to improve transitions of care from hospital SNF, to avoid or reduce readmissions.	The higher than expected preventable readmissions for all service area hospitals indicates trouble with coordination and transitions of care throughout the community. Tracking a patient post-acute discharge, and while at a SNF, will assist in ensuring that the patient's health is well managed and will ultimately reduce avoidable readmissions.	NYHQ Primary Data, focus groups and informant interviews, preliminary findings. Potentially Avoidable Readmissions - NYDOH
4	Need enhanced management of high-risk patients to manage patient at SNF and not readmit to hospital.	Once again targeting the higher than expected preventable readmission rate in the community, this project is similar to the project outlined above in #1. Instead of allowing patients to remain at home, this project will focus on allowing patients to remain in the SNF setting, rather than returning to acute care. Evidence-based practice will target the early identification and management of patients having difficulty controlling their disease.	NYHQ Primary Data, focus groups and informant interviews, preliminary findings. Potentially Avoidable Readmissions - NYDOH
5	Need for enhanced integration of physical and mental health, via primary care providers.	High behavioral health prevalence rates and even higher behavioral health utilization in the community are indicative of two issues: (1) not enough community-based, ambulatory resources for behavioral health patients, and (2) some behavioral health patients are not accessing the community-based resources that are available. Focus groups and interviews identified barriers due to language and lack of insurance, as well as the stigma associated with behavioral health. Integrating primary care with behavioral health will allow for better management of patients with behavioral health disease.	NYHQ Primary Data, focus groups and informant interviews, findings. Mental Health Admits & ER Utilization - HealthData NY Substance Abuse Admits & ER Utilization - HealthData NY Suicide Death Rate - Prevention Agenda
6	Need for cardiovascular, evidence-based	Cardiovascular disease has the highest prevalence	NYHQ Primary Data,

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[The New York Hospital Medical Center of Queens] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	strategies to address chronic disease.	and utilization rates of any disease state in the NYHQ PPS community. Improving the health status of persons with cardiovascular disease, and thereby decreasing preventable utilization for cardiovascular disease, will inherently decrease overall preventable utilization. This project will by work with high risk patients to address any barriers to managing their cardiovascular disease.	focus groups and informant interviews. PQI All Circulatory Composite - AHRQ Cardiovascular Admits & ER Utilization -HealthData NY Age-adjusted heart attack hospitalization rate - Prevention Agenda
7	Need for evidence-based guidelines for asthma management.	Asthma-specific utilization in Queens County is high, particularly as it relates to emergency room utilization by asthma patients. Increasing medication adherence for patients with asthma, and using care management teams, has proven effective in reducing avoidable utilization by asthma patients.	NYHQ Primary Data, focus groups and interviews. Asthma ER Rate - Prevention Agenda Asthma ER Rate, Aged 0-4 Years - Prevention Agenda PQI All Respiratory Composite and PDI 14 Asthma - AHRQ
8	Need to increase early access to and retention in HIV care.	HIV remains an area of high concern in Queens County, as evidenced by a rate of newly diagnosed HIV cases that is almost two times higher than the State's Prevention Agenda goal. Increasing access to HIV care will be critical in fighting this formidable disease.	NYHQ Primary Data Collection, focus groups and informant interviews, preliminary findings. HIV Admissions & Emergency Room Utilization - HealthData NY Newly Diagnosed HIV Case Rate per 100,000 - Prevention Agenda
9	Need to integrate palliative care into the nursing home.	Palliative care is a significant issue in the service area with significant cost associated with inpatient days. Palliative care is at the core of health care's triple aim: cost, quality and service. The cost of palliative care is less than intensive intervention, quality of care is high, and patients and patient families experience high satisfaction in palliative care.	NYHQ Primary Data Collection, focus groups and informant interviews, preliminary findings. The Dartmouth Institute - Health Policy & Clinical Practice

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
40_SEC038_NYHQ PPS Community Needs Assessment Final .pdf	12/22/2014 12:29:24 AM	

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **NY Queens_Section4_Text_NYHQ DSRIP All Projects Master Document 12 21 14.docx**

Description of File

All Projects, text

File Uploaded By: sc593242

File Uploaded On: 12/22/2014 04:44 AM

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

Currently Uploaded File: **NY Queens_Section4_ScopeAndScale_FINALIZED DSRIP Project Plan Application _Scale Speed 12 21 14.xlsx**

Description of File

Scale and Speed for Projects

File Uploaded By: sc593242

File Uploaded On: 12/22/2014 04:45 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.

The NYHQ PPS goal, through a partnership with the 1199SEIU Training and Employment Fund, is to align the transformation and operational strategies of our partners and projects in order to provide exceptional patient care in the right setting while addressing the needs of the community and achieving the DSRIP goal of declining hospital utilization by 25%. Outlined projects will result in reduced demand for inpatient hospital workers and an increased demand for ambulatory care workers and community-based workers. Preliminary analysis shows that 100 licensed and 100 un-licensed NYHQ nursing staff will likely be needed to shift to outpatient or community roles as utilization declines by 25%. The PPS process of workforce planning and strategy will properly identify the levels of impact for staff based on redeployment, retraining and potential reductions. The following are major components of our workforce planning:

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Current & Future Talent Inventories and Assessments – Assess all PPS partners to include an inventory of current workforce as well as a projection of future needs for talent based on the deliverables of the DSRIP projects. The analysis will include projections of business cycle variations, healthcare environmental forecasting, anticipated staff retirements, current vacancies and vacancy rates, etc.
Succession Planning – Employees with lengthy tenure will be identified to properly map and forecast succession plans in order to adequately represent the changing workforce landscape.
Competency & Skill Assessments – Active staff will be evaluated based on their current position to identify competency and skill levels to validate current position or align redeployment options.

Leadership Needs & Development – Management positions are important to the process of accountability and will be a point of analysis and documentation for the PPS. Contingent Workforce & Backfill – Identify positions that require contingent workforce staff. Backfill does not equate to an increase of staff as it may be a basic designation of multiple duties for employees. Salary Market Analysis & Impact – A market analysis for the PPS will be completed to ensure alignment of compensation with that of job expectations.
Budget Forecasting based on Assessments – A budget by organization and project will be planned annually and include expenses for retraining and redeployment or reductions.

The implementation process will include an in-depth exploration and report to include a current state and future state of our PPS healthcare market according to workforce with the following data; number of staff by category, partner, and project, education levels and skillsets of each staff in categories, tenure of staff by category, recruitment need by category, and retraining options by category. The following categories are anticipated to be impacted by our project selection: Professional – MD, DO; Allied Health Professionals – NP, LCSW, etc. ;Clinical Support Staff – RN, LPN, MA, Home Health Workers, Lab Personnel, etc. ;Patient Support Staff – Social Workers, Nutritionist, Healthcare Counselors, Translators, Transport, Housekeeping, Dietary Workers, etc. ; Administrative Staff – Registration Clerks, Financial Counselors, Ward Clerks, Administrative Support Staff, Security personnel, Engineering Staff, etc.

The greatest impact will be to the categories of Clinical Support Staff and Patient Support Staff as the focus moves from an inpatient acute care treatment situation to that of ambulatory and home care. The focus will not only be to that of location, but also will include; sensitivity of cultural barriers and needs (translator services), care coordination, case management, and population health management to properly align categories of staff.

***Strategy 2:**

In the response, please include

- Please describe the PPS' approach and plan to minimize the workforce impact, including identifying training, re-deployment, recruiting plans and strategies.
- Describe any workforce shortages that exist and the impact of these shortages on the PPS' ability to achieve the goals of DSRIP and the selected DSRIP projects.

The PPS high level approach will focus to both union and non-union staff and will align goals of DSRIP projects with that of industry standards and improvement expectations. Along with workforce impact, our PPS will utilize diversity as a guiding principal to strive to reflect the dominant ethnic groups of patients and employees in our service area.

The Patient Centered Care Program (PCC) will be the strategy of the PPS and 1199SEIU to combine training and performance improvements and our commitment is to thoroughly analyze the need of each project to manage needs to re-deploy or retrain staff with a last resort being actual reductions. Organizations within the PPS will work with the Project Management Office and the 1199SEIU team by project to outline workforce impact in order to define budgets & workforce needs, facilitate system change, and empower workers throughout all aspects of the processes.

To achieve the fine balance of timing inpatient to outpatient workforce shifts with continuation of hospital services, the PPS's plan is to ramp up the outpatient services workforce and backfill with temporary professionals and locums, to allow maximum redeployment and retraining of the current inpatient workforce, who otherwise might be subject to job elimination.

Currently, the vacancy rate for the lead provider is 7.03% in primary care and 6.17% in other locations. By carefully managing the vacancy rate the PPS will be able to avoid reductions until the vacancy threshold is met.

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According to the Community Needs Assessment performed by the NYHQ PPS, neighborhoods with high volumes of Medicaid beneficiaries in the service area have the highest PCP shortages in Queens including Corona -29.5, Woodside -24.2, and Ridgewood -19.6. Increasing access to primary care and mental health professionals in these shortage areas is crucial. Recruitment and/or re-deployment of physician and ancillary providers will begin immediately after the workforce analysis completed during the Implementation phase, but existing shortages could delay accomplishing objectives outlined in primary care based projects.

***Strategy 3:**

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

Workforce Implication	Percent of Employees Impacted
Redeployment	20%
Retrain	50%
New Hire	30%

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.

The NYHQ PPS will partner with educational institutions to implement workforce training with a focus to industry standards, consistency, and quality of training for employees. The workforce training will be specific to position and allow for flexibility of partners based on Human Resource policies and practices. The training will be aligned with clinical expectations and job descriptions to make certain expectations for job categories across the PPS are consistent and are based on outcome measures. State expectations of licensure, such as continuing education, will be factored into applicable categories. All training programs will have clinical, operational, and technological aspects.

The Project Management Office (PMO) and 1199SEIU Training and Employment Fund (TEF) will be valuable resources to all PPS partner Human Resource departments to ensure fulfillment of retraining and education requirements to redeploy staff. The 1199SEIU TEF includes a multi-faceted approach to workforce that includes: Training and Upgrading Fund, Labor Management Initiatives, Job Security Fund, Home Care and Education Fund, and Registered Nurse Training and Job Security Fund. This multi-faceted approach, along with the unique variances among partners will allow for a comprehensive workforce education program with a focus of successful redeployment for all staff involved.

We will identify and corroborate existing education practices for redeployment. For example, the PPS lead, New York Hospital Queens, has a history of innovation in education with its NYHQ College which "provides strategic direction for orientation and training programs and offers a variety of work-related learning opportunities, on campus and at nearby locations. Its mission is to help employees to enhance professional development, to attain the highest levels of job performance, and to play key roles in achieving organizational objectives." The college is a solid foundation for clinical training that may be leveraged throughout the PPS, specifically for nursing home and home health workers.

A goal of the PPS is to expand on the expertise of our partners in order to maximize efficiency. Partners within the PPS who currently utilize published industry best practices, such as the CHW guideline mentioned above, will be asked to act as a lead with the aim of coordinating, aligning scope and functions, and recommend placement of guidelines throughout the PPS.

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The PPS focuses to build a robust redeployment solution that is standardized yet personalized to individual staff. The strategy must contain expectations that align with outcomes while utilizing compassion, respect, and integrity to complete retraining and redeployment. Aside from helping to retain valuable and dedicated employees with vast institutional knowledge, redeployment strategies save both recruitment and training costs, which can be substantial.

Retraining of redeployed staff will be mandatory across the PPS for staff who change job classifications or positions, locations, institutions, or care service lines. A formalized process of exceptions will be created based on a hierarchical approach with key managerial input and approvals. The exception process will outline the justification for the omission and include detailed plan of action for the staff to ensure proper skill and technology development.

As a part of a performance management strategy, the PPS will identify initial retraining expectations as well as re-occurring training expectations for all job categories. Policies from governing agencies that mandate training expectations for clinical staff will be adhered to based on an individualized approach by PPS partner, job category, and clinical service location.

***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.

During implementation planning the PPS will complete a risk assessment and gap analysis of the workforce landscape. Knowledge of the multi-disciplinary PPS system is vital to the successful implementation of the DSRIP projects. According to the comprehensive CNA, our service area is currently under bedded in hospital beds both acute and behavioral health. This fact supports the anticipation of neutrality or growth of our workforce platform.

The "Right Care in the Right Setting" emphasis will impact the workforce as we retrain and redeploy staff. An in-depth analysis of equity based on classification, skillset, and tenure will be essential to maintain an appropriate mix of workers while ensuring market equality of skilled professionals. The salary analysis will be completed as an active state and future state and will outline the progressive alignment of salary and benefits for those individuals who fall outside of the bell curve of equity for our PPS.

The NYHQ PPS will also partner with local universities, such as City University of NY, in order to establish collaborations with recognized educational institutions in order to expand our retraining program.

***Retraining 3:**

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

The process of workforce alignment will be transparent with communication among organizations to include bi-annual Employee Town Hall meetings to provide updates and establish forums for staff to engage. Professional and support staff that align with the vision of the PPS will understand the importance of job alignment and will engage with the process of retraining and / or redeployment. Those individuals who choose not to retrain or redeploy will be given a predetermined amount of time to find alternative positions either within the PPS or with outside organizations. The vendor partnership of the TEF will outline an alternative plan for these employees to help ensure proper placement into a position that aligns with the needs of the employee.

***Retraining 4:**

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

Labor representatives will play an active role in the planning, implementation, and ongoing maintenance of the PPS workforce strategy and program. Representatives of the 1199SIEU TEF have over 45 years of experience in healthcare workforce planning, training, consulting, and placement and will be intimately involved in all aspects of the build of the PPS workforce procedures. The labor representatives will bring vast knowledge, industry and local benchmarking, best practice procedures, as well as a voice of the workforce to the governing team of the NYHQ PPS. The expectations of all unions will be addressed by job classification to ensure full compliance with union contracts.

***Retraining 5:**

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

defined as those staff with at least 95% of previous total compensation.

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

Section 5.3 - WORKPLACE RESTRUCTURING - REDEPLOYMENT OF EXISTING STAFF :

Description:
Please outline expected workforce redeployments.

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

The healthcare of our service area faces increasing demands from an aging population which are compounded with the chronic workforce shortage of clinical staff to support an evolving system. This fact lends itself to an important strategy of redeployment as qualified talent are scarce. Alignment of clinical strategy with workforce skill set, tenure, and institutional knowledge is key to improving outcome metrics that center on the DSRIP Triple Aim as well as properly identifying redeployment options for staff.

The process for identifying redeployment needs will focus on efficiency, quality, and rightsizing. The strategy listed at the onset of this document will properly detail our workforce landscape and allow the team to confidently make decisions for the future state of our staff. Each HR will manage the incorporation of the changes into existing practices to ensure consistency. In partnership with our Human Resources vendor, 1199SEIU TEF, we will establish an integration plan as well as a communication plan that will raise awareness of the plan for workforce. DY0 will have a substantial focus to workforce integration plan which will allow for alignment of staff changes to that of the integration plan outlined in project applications.

The actual process of redeployment will be dependent on the PPS partner's Human Resource existing practices and will include reports and dashboards which tie back to the overarching workforce strategy & analysis. The consistency of process will cultivate as a sub-committee is formed from the PAC to properly manage the Human Resources expectations.

***Redeployment 2:**
Describe the process and potential impact of this redeployment approach, particularly in regards to any identified impact to existing employees' current wages and benefits.

The potential impact of redeployment within our workforce integration plan will primarily affect those providers or staff in an inpatient acute care setting as we focus to move care to ambulatory care settings of clinics or homes. All employees identified for redeployment will receive adequate information regarding the new position as well as have access to organizational leadership to review the position and ask appropriate questions in order to make an informed decision. Career coaching will be available and managed at the organizational level with the HR vendor and PMO as a resource. A predetermined amount of time will be identified based on the position and project to ensure alignment with the project implementation timing.

As redeployment options are outlined for staff, salary and benefits will be reviewed to ensure proper placement within a position that limits the negative impact on staff. The full intent of the PPS is to keep the workforce whole while managing annual budgets across the partners and the PPS as a collaborative unit.

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

Redeployment will be mandatory. The ramifications of existing employees who refuse their redeployment will be identical to that of employees who refuse retraining. PPS partners strive to ensure employees make informed decisions but anticipates that some may choose not to redeploy. For those who choose not to redeploy, our HR departments will work with the staff to identify other internal PPS positions or they can go to the open market to identify their next career home. Data pertaining to redeployment rates will be tracked and monitored on the human resources aspect of the PPS dashboard. The vendor partnership of the TEF will outline an alternative plan for these employees to help ensure proper placement into a position that aligns with the needs of the employee.

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***Redeployment 4:**

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

Labor representatives will play an active role in the planning, implementation, and ongoing maintenance of the PPS workforce strategy and program. Representatives of the 1199SIEU TEF have over 45 years of experience in healthcare workforce planning, training, consulting, and placement and will be intimately involved in all aspects of the build of the PPS workforce procedures. The labor representatives will bring vast knowledge, industry and local benchmarking, best practice procedures, as well as a voice of the workforce to the governing team of the NYHQ PPS. The expectations of all unions will be addressed by job classification to ensure full compliance with union contracts.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

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

***New Hires:**

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

The thorough analysis and process of creating a workforce integration plan will adequately prepare the PPS partners with key information to make difficult workforce decisions based on the healthcare need of our community. Along with retraining, redeployment, and reductions, there will be situations of new hires due to fill of vacancies or the addition of new positions both with no option to internally fill.

The job categories listed below have the potential for new hires:

Professional – MD, DO, PhD, etc.

Allied Health Professionals – PA, NP, LCSW, etc.

Clinical Support Staff – RN, LPN, MA, Home Health Workers, etc.

Patient Support Staff – Case Workers, Social Workers, Patient Navigators, Nutritionist, Healthcare Counselors, Translators, etc.

Administrative Staff – Registration Clerks, Financial Counselors, Practice Managers, Process Improvement Experts, Public Health Management Experts, etc.

It is anticipated that with the nine projects selected by the NYHQ PPS new hires will be concentrated in the categories of Professional, Allied Health Professionals, and Patient Support Staff. According to the CNA Health Care Resource Provider gap analysis, the NYHQ service area has a shortage of professional providers (cumulative of primary & specialty care) totaling 327 providers. Projects are focused to either population health management indicators, site of care, or disease management and will have a designated number for targeted and engaged populations that is less than the service area as a whole, it is not anticipated that the PPS needs to fulfill all 327 providers. The actual number of new hires needed will be identified during the implementation phase and will be analyzed based on performance benchmarks, access, and patient need.

The NYHQ PPS HR Vendor selected will play a key role in identifying new hires with the analysis mentioned to ensure proper representation of the healthcare market of our service area.

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	4
Physician	3
Mental Health Providers Case Managers	10
Social Workers	1
IT Staff	2
Nurse Practitioners	10

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Position	Approximate Number of New Hires
Other	38

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	115,514	87,873	60,232	42,095	26,334	332,048
Redeployment	1,188	0	0	9,504	21,384	32,076
Recruiting	72,000	72,000	3,000	3,000	3,000	153,000
Other	0	0	0	0	0	0

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

The NYHQ PPS recognizes the diversity of the PPS partner and employee base and will work on an individual basis with each partner to outline the State programs that will require additional review or applications. The State program process will be managed by the Project Management Office with direct communication and expectations outlined by the Finance Committee and the Executive Committee. The potential to utilize existing state programs will be incorporated into the implementation planning that is due March 1, 2015 and will focus to the PPS goals in order to leverage and maximize the DSRIP funding.

The PPS understands the complexity of the funding sources; state & federal, and recognizes the need to thoroughly outline the plan and expectations of partnering existing state programs with the DSRIP program. Programs such as Loan repayment, Ambulatory Care Training, and Health Workforce Retraining Initiative will be included in the implementation planning. The programs will be utilized to maximize the benefit of retraining and recruitment in order to fill the need of the PPS.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

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

The workforce strategy was developed in concept and internally distributed through the governing PPS body for feedback and revisions. The PPS Lead worked with the 1199SEIU team to discuss DSRIP workforce needs, benchmarks available, resources available or needed, and a plan to partner in order to be successful for our DSRIP projects. A Town Hall meeting was held on December 3, 2014 to outline the Community Needs Assessment as well as the project selection process. The meeting was well attended by PPS partners, CBO's, labor representatives, politicians, and employees.

***Engagement 2:**

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

The labor representatives of 1199SEIU were consulted during the planning and development, along with multiple HR Directors of our PPS partners to ensure a balance of union & non-union representation. A community Town Hall meeting was held on December 3, 2014 where a number of staff and labor representatives attended to understand the needs of our community as well as the progress being made for the DSRIP application.

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***Engagement 3:**

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

The NYHQ PPS team understands the importance of transparency and communication to all levels of the workforce. One important goal for our workforce process is to ensure that the front line staff are engaged and are supportive of our changes as we implement the DSRIP projects. In an effort to maximize exposure, bi-annual Town Hall meetings will occur to encourage the staff engagement and ensure communication of strategy and happenings to all involved. The Town Hall meetings will be open to all PPS partners and will be focused to those topics that affect staff.

A detailed plan has been created to outline the communication plan and channels which will align communication needs by partner or employee type. The plan outlines communication channels to ensure proper flow to partners and employees and includes technological options such as an interactive website that will be a resource and provide another avenue of communication with a questions/answers section. The plan will be implemented and managed through a Communications Sub-Committee which will include frontline staff.

***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 PAC and Communications Sub-Committee will focus to ongoing communication to all stakeholders within our PPS and service area. The following are the overarching strategies detailed in the communications plan:

Educate audiences on purpose, value of transformation
Build a Transformative Community: facilitate knowledge-building and transfer among PPS members
Position locally-led transformation program as a matter of pride, quality, recognition and opportunity
Leverage the Community Needs Assessment as the evidence base for transformation prioritization
Encourage transparent communication that will help alleviate anxiety about impending changes

The PAC and Executive Committee of the PPS will be charged with proactively identifying and resolving barriers pertaining utilizing the stakeholder engagement process as one of many tools.

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.

The NYHQ PPS' Data Sharing and Confidentiality Plan will implement HIPAA, NY Privacy and Security laws, and Human Subjects Protection laws. The Plan will be developed and governed by the IT/Data, Clinical/Operations, and Audit Committees. There will be a symbiotic relationship between the three committees to ensure transparency, rapid cycle evaluation, audit, and accountability. A high-level gap analysis will be initially completed to compare current policies and procedures to the latest regulations and guidelines and will outline threats and vulnerabilities to inform new policies or procedures. The Plan will ensure individuals' rights to control the use of their personal health information and will include: minimum necessary access standards, staff training, patients' rights to access information, notice of privacy practices, acknowledgement of authorizations, disclosures, business associates' agreements, employee sanctions, data risk mitigation, and whistle blower protections.

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

Agreements that ensure alignment and cooperation of data sharing and confidentiality will be executed to promote confidential and secure exchange of information, including the Data Exchange Application Agreement between DOH and the PPS. Business Associate Agreements and Data Use Agreements between PPS partners and providers will also be executed. Provider Participation Agreements will specify privacy and security requirements and will also cite requirements to implement the privacy and security policies and procedures.

Agreements will be managed by the PPS IT Committee and executed by the Executive Committee with direct interaction of legal counsel to ensure proper execution and compliance.

IT security training will be mandatory for PPS partner staff to ensure regulatory compliance. Training will be outlined by the IT Committee and include items such as HIPAA training and PPS data sharing policies. Training will be outlined by job categories and role expectations.

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***Confidentiality 3:**
Describe how the PPS will have/develop an ability to share relevant patient information in real-time so as to ensure that patient needs are met and care is provided efficiently and effectively while maintaining patient privacy.

The NYHQ PPS will promote the sharing and use of relevant patient data to improve population health. To promote the broad exchange of real-time information, all participating providers and partners in the PPS will be required to participate and exchange information through Healthix (RHIO).

According to the IT survey, the majority of the PPS participants have electronic medical records. The Healthix limited medical record option will be offered to providers with paper records. The PPS will also participate with SHINY-NY to promote the real-time exchange of data across New York. The privacy and security policies will also apply to all stakeholders involved in real-time data sharing and will be included as a clause in the Provider Participation Agreement as well as the requirement to participate with Healthix. The RHIO will also exercise its own privacy and security controls.

The IT Committee will outline protocols and guidelines that will be monitored that include training, use, and accountability. The compliance of the guidelines will be formally reported to the Executive Committee on a quarterly basis.

Clinicians and staff will be trained to notify the PPS Medicaid members of the NYHQ PPS, how and why their data will shared and used in the PPS, and how they may opt out. Notice of Privacy Practices will be extended to beneficiaries by the PPS to implement the data sharing "OPT OUT" model which is consistent with the NYS standard. A denial of a RHIO consent will constitute an active denial and be processed accordingly by the PPS partner, IT Committee, and Executive Committee.

Section 6.2 – Rapid-Cycle Evaluation:

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

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

***RCE 1:**
Identify the department within the PPS organizational structure that will be accountable for reporting results and making recommendations on actions requiring further investigation into PPS performance. Describe the organizational relationship of this department to the PPS' governing team.

The Rapid Cycle Unit (RCU) will be part of the PMO, composed of population health analysts, nurses, and medical director. The RCU will collect and interpret data and submit monthly reports to the Clinical/Operations, IT/Data, Finance, and Executive Committees for oversight. The RCU will identify successes and challenges, and recommend issues for continuous quality improvement.

The focused objectives of the RCU will be:

Identification of Care Gaps. Prevention and disease management protocols to improve health and achieve metric results

Stratification of Population. High risk individuals to receive disease management and case management, Low risk to receive prevention initiatives

Patient Engagement. Strategies to involve patients in their care and take responsibility for their own health

Outcomes Measurement. Reports and training programs will be held to teach them how to access information more frequently for effective management practices and to identify rapid solutions

***RCE 2:**

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

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

The RCU will evaluate performance at the PPS, project, and provider levels. Monthly and quarterly reports metrics will compare PPS results to baselines, goals and peers. Trends will be analyzed for the current period, including an 18-month baseline and 18-month projection. Industry benchmarks and/or internal best practice benchmarks will be included as a part of the analysis.

Reports will be developed for each provider by project, and include progress on metrics that each provider influences, estimates of incentives, with recommendations for focus and improvement.

Information derived from partner interviews, onsite program reviews, claims data & electronic health records will be used to conduct analysis of population health management practices to improve the health of the attributed population and achieve DSRIP goals.

The PPS population will be studied in total and by subgroups as required by each of the nine projects.

***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).

A highly functioning PPS is in control of outcomes. The PPS's RCE program with CQI processes will actively detect and address variances in performance at the accountable level: provider, partner, project, and population. The RCU will be a champion for outcomes control and will seek and engage providers timely to ensure relentless action in achieving DSRIP goals.

Monthly reports will be given by the PMO to the Executive Committee and will be distributed to all other committees in an electronic format.

The RCU will create action plans for projects or partners that have below-expected performance indicators according to their qualitative and quantitative reviews. The action plan will include an analysis of the performance, benchmarks, recommendations for improvements, and re-assessment timelines. The PMO will report the action plans monthly to the Executive Committee to ensure transparency and actions as deemed appropriate.

***RCE 4:**

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

Ongoing evaluations of the effectiveness of the nine project plans will be driven by quantitative and qualitative data. Evaluations will also be made of providers' ability to report metrics, overall population health, avoidable hospital use, and implementation of population health management techniques across the network. Providers will be benchmarked against industry goals and peers.

These evaluations will identify initiatives for continuous quality improvement (CQI), to be spearheaded by the RCU and conducted with the providers who are accountable for relevant outcomes. Several cycles of PDSA (plan, do, study, act) may be conducted on a single issue or multiple issues creating a rapid cycle for performance improvement.

The information gathered by the RCU will inform partners and committees of educational opportunities or learning collaboratives that could be created to share best practices and improvement planning.

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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 NYHQ PPS is committed to reducing health disparities and increasing access for our dynamic service area. Queens is an incredibly diverse county, with the racial/ethnic groups (White, Black, Asian, Hispanic and other) each comprising of 18-30% of the population. According to the Community Needs Assessment, almost half a million Queens County residents are not US citizens, which translates to over 350,000 in the NYHQ PPS service area. As outlined in the CNA, such diversity leads to several challenges that the NYHQ PPS will address with a well formulated Cultural Competency Plan:

Language Barriers – During focus group conversations, patients expressed concern that hospitals, specialists, and behavioral health physicians who are linguistically and culturally competent are not available.

Immigration Status – The large immigrant population (22.1%) and high uninsured rate (19.2%) for the county indicate that residents may avoid seeking medical care for fear of deportation and/or cost.

Behavioral Health Stigmas – Concerns regarding the social stigma of behavioral health issues; this, coupled with the low number of providers available in the county, has led to high utilization of the ED and med/surg inpatient beds for behavioral health care.

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Alternative Medicine – Food as medicine, for example, was a cited as a preference compared to traditional medicine during focus groups but the there is a lack of affordable healthy food for residents in the NYHQ service area.

***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.

NYHQ PPS will work to ensure cultural competency for staff and providers throughout the PPS system. In recent years, the PPS Lead, NYHQ, has successfully worked on initiatives to improve breastfeeding rates in the Asian population, held focus groups to determine community needs by racial/ethnic group, and received the 2007 Roslyn Savings Grant to develop a cultural competency program for NYHQ staff. As the lead institution, NYHQ will bring these experiences to partner with the PPS as a whole to create a cultural competency plan that continues to support previously successful initiatives, provides expanded language services to patients, and promotes cultural competency and sensitivity among staff. The NYHQ PPS will achieve these goals by:

- Engaging the 24 member multi-ethnic, Community Advisory Council (CAC) as a liaison for the community at large in addition to increasing the number of local CACs that can target specific ethnic communities and areas of high concentration for those groups

- Creation of a training program for staff PPS-wide pertaining to the importance of cultural competency and how to incorporate cultural sensitivity into daily work practices

- Providing industry best practices to ensure high quality service to all patients among all of the partner institutions

- Leveraging the NIH Clear Communication tools on cultural competency, health literacy and language access to ensure new initiatives are successful (dashboard tool)

- Leverage current strengths of providing translation services, incorporating ethnic practices into care, web portals in four languages, and places of worship for different faiths

- Align recruitment of new Professional providers and clinical support staff across the PPS system with the strategies outlined in the Cultural Competency Plan

- Establish a robust Communication Plan that will address the diversity of our partners and patients

***Competency 3:**

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

The NYHQ PPS will engage with vendors that have experience in cultural competency training, such as Dynamic Training Inc., Sodexo, or TeamSTEPPS to develop training programs for providers and staff. These cultural competency training programs, such as TeamSTEPPS, are modeled with the 'train the trainer' philosophy. This would enable staff from the PPS partners to attend training and then take what was learned during the model and teach their colleagues at their organization. This model engages PPS staff on multiple levels as the staff will be able to learn in a classroom environment, learn from their peers, and finally implement the tools learned in their daily workflow. In addition to these training programs, the PPS will also work with their 12 community based organization (CBO) partners to engage the front line workers who are in the field and have firsthand knowledge of the need for cultural competency in the Queens County population. The key stakeholders from the CNA will provide council as to which CBOs have expertise in cultural competency to enable the PPS to leverage those groups to help close the gaps identified in the CNA. Finally, the recruitment process for new physicians and staff across the PPS will be aligned with the cultural competency plan for the PPS. The NYHQ is committed to improving cultural competency and health literacy as improved communication with patients' leads to improved health outcomes and mitigate the disparities illustrated in the community needs assessment.

Section 7.2 – Approach to Improving Health Literacy:

Description:

NYS Confidentiality – High

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

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

***Literacy:**

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

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

The goal of the NYHQ PPS is to provide effective, equitable, understandable, and respectful quality care that is responsive to the needs of our service area that has vast beliefs, practices, and languages. The PPS will accomplish this goal by building a system that promotes health equality through policy, practice, and resources by building governing structures that are responsible to the population NYHQ PPS serves. The NYHQ PPS serves an incredibly diverse population, where over 50% of the people in the county speak a language other than English at home. The multitude of languages spoken in Queens creates a language and understanding barrier which is noticeably prevalent in the healthcare system. This barrier creates a hardship for non-English speaking patients who need to navigate the complex healthcare system. In order to increase health literacy, the PPS will engage community health workers, support interpreter services, as well as continue to monitor patient satisfaction scores relevant to understanding and health literacy. In addition, the ASKMe 3 principles of teach back will be the foundation to improving health literacy in the PPS. The PPS will work collectively to provide educational materials in pictogram format to improve patient's compliance with medication and other self–management behaviors.

NYHQ PPS strives to embed health literacy into the design, implementation, evaluation, and improvement of care processes across the continuum. One of the goals of the PPS is to facilitate the autonomy of patients; the PPS will strive to enable patients to be both capable of self-management as well as responsible for their own health. At the same time, the PPS recognizes the responsibility of their care teams to educate, assist and encourage patients to reach this potential.

The PPS will improve health literacy for its patient population through several mechanisms, including:

- ASKMe 3 teach back which promotes patient advocacy by encouraging patients and caregivers to ask questions
- Establishing culturally and linguistically appropriate goals, reports, and policies to include all partners
- Engaging community health workers who are both from culturally similar backgrounds as well as from the local neighborhoods to help with patient navigation and healthcare comprehension
- Providing guidelines on best practices for the PPS by standardizing evidence-guided tools (i.e. medication adherence, self-management, written informational and education materials, patient activation, etc.)
- Leveraging existing resources, such as the NYHQ Chinese Health Initiative, as a tool and guide for providing care to a diverse population
- Investigating other sources of English as a Second Language (ESL) instruction and work with local Community Advisory Councils to plan and deliver ESL within target neighborhoods

As health literacy is integral to patient safety and quality of care, the NYHQ PPS plans to leverage several resources to close the gaps identified in health literacy for Queens. Addressing health literacy problems, in both the micro and macro views of the DSRIP plan, NYHQ PPS believes that it can achieve the goal of 25% reduction in avoidable ED visits and inpatient admissions as well as improve the health of the patient population. The PPS will work with community based organizations to develop educational tools listed above. In addition, CBOs will help to promote the ASKMe 3 campaign; studies have shown that people who understand health instructions make fewer mistakes when they take their medicine or prepare for health procedures.

Increased compliance to medications and procedure preparations means patients may get well sooner and have increased capacity for

managing chronic health conditions. Improved self-management, compliance, and understanding will aide in the goals for inpatient and ED visit reductions.

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

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

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

Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

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

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

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

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

The fund distribution plan is based on these guiding principles: align incentives with DSRIP goals, incent providers to make desired changes in practice patterns, simple, transparent and fair, consistent with PPS governance structure and legal constraints, no more that 5% of the funds can go to non-safety net providers.

A distribution model was developed starting with a bottoms up budget analysis by project, including revenue (DSRIP incentive earnings) and operating costs by project for 5 years of operations. Budget elements included revenue estimates based on project valuation and expense projections for work required at the PMO, workforce training expenditures, and expenses at the project level. For the fund distribution model provider categories impacting the projects were identified to determine the payment pools.

The model calculates each project's maximum valuation per DSRIP formula. Building on that valuation, NYHQ PPS's distribution plan is project specific. The overall incentive/bonus payment fund set at 47% of the PPS valuation, after allowance for PPS administrative expenses of 53% which is composed of PPS administrative costs (14%), project specific costs (14%), compensation for lost revenue (15%), costs for uncovered services (5%), and a contingency/penalty reserve (5%).

The incentive payment fund will be distributed to the provider partners by project. Specific incentive metrics will be based on outcomes that ultimately contribute to achieving DSRIP goals creating alignment. For the first two years, providers will be incented on reporting the metrics that they will be incented for results in subsequent years.

Distribution among clinical specialties:
Provider categories impacting each project, i.e. nursing homes, physicians, home health, behavioral health, and others were identified to determine the payment pools. Metrics that are fitting each project and provider category were selected to design the specific payment

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mechanism to providers in each pool. For example, in the Asthma project physicians may be incented on the ratio of long-term controller medication to short-acting medication helping patients remain healthy which ultimately reduce avoidable admissions.

Fund distribution ties to governance structure:
The Finance Committee is charged with developing, implementing, and monitoring the incentive fund distribution process and refine it to promote the success of the PPS program. The Finance Committee members reflect the composition of the provider network. The actions of the Finance Committee are transparent and are approved / vetted by the governing body. The Finance Committee will also be tasked with reporting non-performing providers to the Clinical/Operations Committee. Both these committees report to the Executive Committee, which makes recommendations to the Lead Applicant and establishes progressive compliance processes for non-performing partners.

How the approach promotes DSRIP goal achievement:
The PPS has selected projects addressing the specific healthcare needs of its service area, and has recruited a local provider continuum qualified to pursue the DSRIP goals. The NYHQ PPS incentive fund distribution plan is designed to align the bonus payments with the successful achievement of the specific DSRIP project performance metrics, i.e., providers are incented (both individually and as a system) to change practice patterns to conform with DSRIP goals. Failure to achieve the DSRIP goals translates into the elimination of bonus payments.

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	14%
2	Revenue Loss	15%
3	Internal PPS Provider Bonus Payments	47%
4	Costs for Services Not Covered	5%
5	Contingency/Penalties	5%
6	PPS Administration	14%
	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

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

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

☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

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

NYHQ PPS evaluated the requirements of each of the 8 projects within Domains 2 and 3 and identified the potential impact on providers associated with each project. Three projects are primarily associated with nursing homes and one with home care that directly and quickly reduce avoidable hospital admissions, readmissions, and ED visits. These projects severely impact hospitals in the network. Nursing homes are somewhat negatively impacted. Home care and other providers stand to gain from these projects. Four projects are associated with care management processes in the ambulatory setting which will reduce avoidable hospital use and negatively impact hospitals and nursing homes, and positively impact other providers such as primary care, home health, and community organizations.

Given these assumptions, hospitals and nursing homes were prioritized to evaluate their financial condition and future risk of financial failure. Publicly available cost report data, audited financial statements, and surveys from these entities were analyzed. Other providers associated with ambulatory-related projects will be evaluated during the implementation planning phase. Results will be discussed with partners.

Using a methodology inspired by the NY DSRIP financial stress test for Lead Provider, financial ratios were calculated to measure the financial health of each partner. The expected utilization and financial impacts of each project on providers participating in that project are being mapped. Juxtaposing each provider's current financial status against the impact map will define the financial landscape of the NYHQ PPS, and illustrate the relative financial strengths and weaknesses within the network. Following the financial forecasting and cash flow

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analyses will be conducted in collaboration with the partner at risk of financial failure. This model will help identify fragile providers that are or will be at risk of financial failure. The model will be run semi-annually.

***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.

NYHQ is expected to bear the brunt of the utilization and revenue declines associated with the DSRIP goal of a 25 percent reduction in avoidable hospital use over the next five years. The hospital is conducting a detailed analysis of the potential impact that achieving this goal will have on its overall operations, including bed occupancy, emergency department traffic, staffing levels, variable cost reductions, contribution to margin and profitability. Quantifying these impacts will dictate the magnitude of NYHQ's challenge to continue to survive and will define its approach to value-based contracting with payors.

Skilled nursing homes are expected to gain utilization as hospitals successfully mitigate readmissions from SNFs, and as they substitute lower intensity and lower cost SNF services for expensive and intensive inpatient hospitalization. However, the SNFs themselves may also experience utilization and revenue reductions as home health services and palliative care alternatives are promoted within the continuum of patient care.

NYHQ PPS has collected and analyzed financial information for all of its 27 SNF partners. Aggregate profits for these providers in FY 2013 approached $18 million; six of our SNF partners reported financial losses in FY 2013. Operated efficiently, the vast majority of SNF businesses in the service area have demonstrated their ability to produce sustainable positive net incomes in the current environment.

NYHQ PPS will work with the SNF partners that have experienced recent financial losses to help them identify the causes of their challenges, and mitigate as necessary.

A revenue loss reserve, funded from the DSRIP incentives, will be set aside as compensation for partners that lose utilization. The impact mapping exercise will provide an estimate of each partner's annual exposure to DSRIP-induced losses.

Similarly, we expect that several of our providers may be financially fragile, and require an infusion of funds to support their operations during the initial years of the DSRIP. Once the assessment is fully completed, the PPS will reach out to those in danger of failure to discuss a plan of action.

While these providers should ultimately benefit from the additional DSRIP-generated utilization and financial gains, they may need upfront assistance to acquire the additional staff, equipment and/or working capital to accommodate their new caseloads. NYHQ PPS will measure, and continuously monitor its partner financial performance.

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.

DSRIP-goals are clearly articulated, as are its expectations for changes in healthcare delivery practice patterns and behaviors, associated success metrics and the corresponding financial incentives. An advantage of this DSRIP initiative to redesign the healthcare delivery system is that the PPS network has a defined time horizon in which to design, model, test and refine their adaptations to the evolving payment environment. Network participants, working together, will learn how to best achieve the performance metrics and incentive payments in a financially protected setting, assuming performance is in control. Partners are aware that the incentive funds are temporary but the changes in practice patterns will be permanent.

***Path 2:**

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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.

NYHQ PPS is in the process of mapping the financial landscape of its partnership network, measuring current financial health of providers, assessing the potential utilization and financial impacts of each project on every provider, and identifying weaknesses. This tool will also allow each partner in the PPS to anticipate its post-DSRIP financial position, and discover potential challenges and opportunities for its operations after the final incentive payment. For example, as the sole acute care hospital in the PPS, NYHQ expects to incur reduced inpatient admissions, patient days, and ER visits. The hospital's options for adapting to this shift include shifting multipayor contracts to value-based while reducing variable costs (staff redeployment and supplies), consolidating or reconfiguring nursing units, accelerating its investment and implementation of IT. Smaller providers in the network may not have the flexibility and economies of scale to adapt but will remain key players in the continuum. During the DSRIP timeframe, these providers will be able to draw on designated incentive funds as they build capabilities to accommodate additional DSRIP-induced demand for services.

***Path 3:**

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

By the end of the five-year DSRIP incentive period, NYHQ expects that its PPS, in response to the DSRIP incentives, will have reconfigured its delivery system infrastructure, practice patterns and partner behaviors in order to adapt to the evolving payment environment, thus sustaining DSRIP goals and outcomes into the future. This delivery system transformation will be continued through new value-based payment contracts that would be in place with multi-payers to continue the population health management discipline and other DSRIP practices implemented during the five year program. The DSRIP initiative will have demonstrated to all the players in the delivery system that innovative solutions with aligned financial incentives can produce less costly, higher quality outcomes.

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.

The vision is for the partners and managed care organizations to identify a reimbursement model that allows for a financially responsible transition into value-based payment. The PPS's financial team will immediately begin modeling value-based payment reforms to identify models best suited for individual provider categories and the PPS as a whole and will present models to the Finance Committee during the second year of operations. Financial models to be considered include performance incentives, episode of care bundles, shared savings. Total cost levels vs. revenue will be carefully monitored. Models for risk sharing will be developed to determine if one-side or two-side risk taking or sub-capitation are models that should be considered by the PPS.

Criteria for the new payment model will include and not be limited to the following principles:

- It is person-centric and supports the health delivery transformation discipline being implemented through DSRIP.
- Adequately incentivizes prevention, coordination and integration of services.
- Reimbursement is sufficient to cover services as compared to peer groups.

A readiness assessment of the PPS network to take risk will be conducted during the second year of operations to inform negotiations processes with payors. Regulatory approvals for risk-transfer arrangements will be explored as well. Discussions with payors will be held after DOH and MCOs develop its new DSRIP payment arrangements.

***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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As the PPS matures in implementing its population health management practices and implements project requirements, the utilization of acute and long-term care will be reduced and will create income deficits under the current FFS payment system. Payor's will gain from these practice improvements. Therefore, the PPS and its partners will negotiate a balanced approach to payment transformation. New payment models will be explored with managed care organizations that appropriately incentivize the new delivery model. By the end of the DSRIP period, all providers, including the financially fragile safety net providers, would have adapted to the new value-based metric-focused business model. Income deficits created by the transition from the old to the new delivery and financing models would be clearly identified and resolved through the new payment model. Ideally the new payment model will provide sufficient funds to cover efficient well-coordinated health delivery services with a mix of adequately funded base pay plus performance incentives. Both the delivery and payment sides would have appropriately benchmarked performance metrics to continue to offer a highly performing system for Medicaid beneficiaries and the uninsured.

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.

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.

Minimizing the negative impact to workforce during project implementation is of the up-most priority for the New York Hospital Queens (NYHQ) Performing Provider System (PPS). Our PPS intends to partner and contract with the 1199SEIU Training & Employment Funds (TEF), as the lead Workforce Strategy Vendor, to align the strategy of process and outcome improvements with the impact and opportunities to the workforce pool. The vast knowledge of the TEF will allow our PPS partners the opportunity to thoroughly analyze and plan the workforce impact to include strategic planning of changes, salary analysis, and employee training opportunities, etc. The TEF is an experienced entity that will align PPS goals with the worker needs by writing curricula, working collaboratively with employers, unions, and providing training that aligns with the high quality delivery system of the PPS.
TEF core services include: Labor-Management Transition Teams that provide counseling, as well as preparation in resume and interviewing skills, employee needs assessments, intake and orientation sessions, and short-term training to enhance the skills of affected workers. TEF addresses restructuring efforts by assessing industry needs and worker skills and creating programs that meet the needs of both employers and workers. Development program workshops will be used to develop facilitation skills; conflict resolution skills, and progressive leadership. In addition to a research component to train on data interpretation, and keep stakeholders informed of emerging trends, innovations and best practices.

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 The New York Hospital Medical Center of Queens that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: NEW YORK HOSP MED CTR QUEENS
Secondary Lead Provider Name:

Lead Representative:	John Sciortino
Submission Date:	12/22/2014 03:26 PM

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