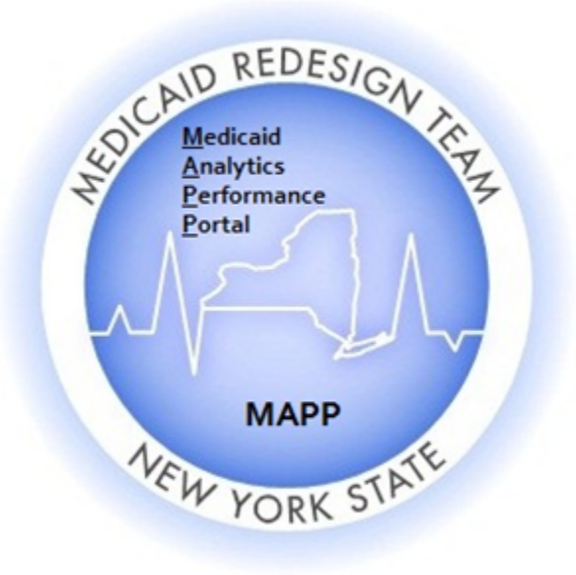
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Westchester Medical Center

Westchester Medical Center (PPS ID:21)

TABLE OF CONTENTS:

Westchester Medical Center (PPS ID:21)

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

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: **21_SEC000_WMC DSRIP PPS Lead Financial Stability Test Application Documents.pdf**

Description of File

WMC DSRIP PPS Lead Financial Stability Test Application Documents

File Uploaded By: lk494126
File Uploaded On: 12/20/2014 05:20 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: lk494126
Last Updated On: 12/21/2014 05:57 PM

Certified By: keenanj1
Certified On: 12/22/2014 08:51 AM
Lead Representative: June Keenan

Unlocked By:
Unlocked On:

Westchester Medical Center (PPS ID:21)

SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Create a patient centered integrated delivery system (IDS) in our region	There is a lack of coordination across the healthcare continuum in our region, with providers largely operating in silos, without the benefit of comprehensive patient information or ways to easily access critical community-based resources, perpetuated through reimbursement policies that reward providers on a fee-for-service (FFS) basis, rather than on their impact on health outcomes or quality of care. Under the current system, resources are wasted and patients often experience inefficient care or are unable to navigate resources to obtain appropriate care in a timely manner. Our Performing Provider System (PPS) will address these issues by creating a patient-centered IDS characterized by effective and targeted care management, integration of behavioral health and primary care services, expanded use of PCMHs and Health Homes, enhanced provider communication, and access to meaningful data to impact and inform patient care and treatment decisions.
2	Decrease potentially avoidable hospitalizations and unnecessary emergency department (ED) visits	Avoidable inpatient and ED utilization accounts for significant costs that may be otherwise avoided by linking patients to appropriate primary care services, promoting preventive care, and addressing social factors impacting patients' health. Our PPS identified significant "hot spots" of preventable hospitalizations and ED visits linked to prevalent conditions such as coronary artery disease and congestive heart failure. Our PPS will, through its 30 day readmission management, behavioral health crisis stabilization and other projects, implement care coordination and management services to direct patients to appropriate care, increase access to primary care and other services, enroll patients in Health Homes, and address social determinants that may prevent patients from managing existing conditions or improving their overall health.
3	Transform siloed delivery of behavioral and physical care in safety net to integrated model	Addressing the siloed system of behavioral health and physical care is a sub-component of goals 1 and 2, but is a critical goal of the PPS in its own right. Behavioral health conditions, including mental illness and substance use disorders, are widespread among the region's Medicaid high-need beneficiaries, many of whom also have chronic physical conditions. Additionally, a high percentage of patients with repeat ED visits in our region have unmet behavioral health needs. Our PPS will develop behavioral health crisis teams; advance comprehensive physical and behavioral health screenings across the PPS; develop tools and resources to support patient and engagement; expand care coordination and navigation support and develop shared care plans (when appropriate); and

Westchester Medical Center (PPS ID:21)

#	Goal	Reason For Goal
		both physically and virtually integrate medical and behavioral health in primary care sites.
4	Develop region-wide technology infrastructure for data sharing and communication between providers	A survey of our PPS providers' health information technology (IT) and electronic health record (EHR) capabilities found significant disparities in provider adoption and electronic access to health information. Without these capabilities, providers and community-based organizations are unable to effectively access and share information about the patients and populations they are treating, undermining care coordination and population health management efforts. Further, providers need actionable data to monitor quality and improve outcomes. Our PPS has identified a health IT and population health management strategy and infrastructure as a critical priority to enable participating providers to deliver the best care possible to assigned patients and achieve the goals of all DSRIP projects. This infrastructure will also be critical to tracking PPS and individual Participant and provider progress toward DSRIP goals and objectives.
5	Improve the overall health of the Medicaid and uninsured populations in our region	There are significant health disparities among our PPS' target patient population. Our region is characterized by densely populated urban areas, sparsely populated rural communities with suburban communities in-between, and pockets of great wealth and pervasive poverty. We have selected projects that focus on identified health challenges, for example: high rates of tobacco use; lack of primary care and behavioral health integration; and hot spots of diabetes and asthma. Through the CNA we identified critical community-based resources as well as gaps in needed resources to help bridge and coordinate patient care between the outpatient and inpatient settings and ultimately improve the overall health of the population. We established a cross-PPS Regional Clinical Council that will advance common clinical protocols and quality metrics and foster cross-PPS collaboration to ensure that "all boats rise together" in our region to best serve our residents and patients.
6	Advance the readiness and capacity of PPS Participants to enter into value-based contracts	The existing Medicaid FFS payment model rewards volume and frequency of services, rather than coordinated services that produce improved population health outcomes. As DSRIP drives PPS Participants toward improving outcomes and reducing avoidable utilization, payment models must also shift to reward providers based on value. Our proposed PPS funds flow model will begin this transition through provider bonus payments tied to individual DSRIP projects and program goals and objectives via mutually agreed upon metrics. The PPS intends for these bonus payments to shift Participants' focus from siloed services to comprehensive care management and encourage coordination and communication among Participants and providers. The PPS has actively engaged Medicaid Managed Care Organizations (MCOs) and plans to develop its IDS to enter into value-based contracts in years 3–5 of DSRIP and provide infrastructure to support accountable care organizations (ACOs) as they move to risk-based contracting.

***Formulation:**

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

Our PPS was formulated with input from the CNA, PPS Participants, and community-based stakeholders to ensure the PPS can meet the needs of the community and address identified health care disparities.

Our governance model is centered around an inclusive, transparent committee structure and process with representation of all partners. Within the PPS, four regional Hubs of providers and community-based organizations within defined geographic regions will work collaboratively toward implementing DSRIP and achieving targeted goals. Under the Hub model, our PPS will be able to quickly and effectively mobilize Participants and resources deeply familiar with the needs of the local population to address unique health care challenges and disparities. This model will also allow each Hub to benefit from centralized services operated by the Center for Regional Healthcare Innovation (CRHI), while determining and customizing their approach to rolling out such services and supporting project implementation.

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

Our CNA guided the selection of DSRIP projects and we have built an analytics capability to continuously assess the health status and needs of our population across DSRIP implementation.

***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.

Successful integration is an ongoing adaptive process rather than a one-off initiative. Skilled and trusted leadership at multiple levels and a culture of collaboration is required. Our PPS will advance provider-led, regional clinical, financial and IT governance that will improve care coordination to create one seamless system of care by leveraging the investment New York State (NYS) has made in IT, PCMHs and Health Homes. The first three years of DSRIP will allow us to develop the clinical and financial integration capabilities necessary to manage the health of populations. Within five years, we will achieve quality-based improvements and savings through measuring, understanding, and managing variation among clinicians. Our network will be capable of entering into value-based contracts both directly as the IDS and by providing the supporting infrastructure for regional ACOs to expand into Medicaid risk-based contracting. We are already working closely with Medicaid MCOs (the largest Medicaid plan in the Hudson Valley serves on our PPS Executive Committee) to advance innovative ways to align both benefits and financial incentives to reward outcomes and care improvement.

***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	14 NYCRR §§ 599.3(b), 599.4(r), (ab); 14 NYCRR §§ 800.2(a)(6), (14), 810.3, 810.3(f), (l)	Project(s): 3.a.i Reason for request: OMH regulations require Article 28 providers to obtain an OMH license if they provide more than 10,000 mental health visits annually, or if mental health visits comprise more than 30 percent of the provider's annual visits and the total number of visits is at least 2,000 visits annual (the OMH threshold). OASAS regulations require an Article 28 provider to obtain a certification from OASAS if it provides any substance abuse services. Under 3.a.i, Article 28 providers will increase their provision of both mental health and substance abuse services so that patients can receive physical and behavioral health services in one setting. It is highly likely that some of the providers participating in 3.a.i will cross the OMH threshold, and all Article 28 providers that provide any substance abuse services would be required to obtain OASAS certification. Requiring OMH and/or OASAS licensure would conflict with the goals of 3.a.i. Going through the certification process would be an unnecessary administrative burden. Further, having to comply with multiple licenses would force Article

Westchester Medical Center (PPS ID:21)

#	Regulatory Relief(RR)	RR Response
		28 providers to comply with new rules that would have little benefit to patients. For example, Article 28 providers are already required to maintain medical records that meet DOH standards; requiring their records to also meet OMH standards would not improve patient care. Forcing providers to comply will new and unnecessary administrative processes and rules will discourage providers from providing such integrated care. Potential alternatives: Providers could avoid OMH and OASAS licensure by keeping their provision of mental health services below the OMH threshold and avoiding any substance abuse care. However, it would likely be difficult for certain providers to stay below the 30 percent limit, particularly if they are located in areas with a high behavioral health need, and trying to stay within that limit could result in turning away patients needing mental health care. Although the draft Integrated Outpatient Services regulations could address some of these issues, this and related requests are being sought because it is unclear how those new rules might be implemented. Patient safety: Waiving licensure requirements is not likely to endanger patient safety because Article 28 providers are already required to comply with a detailed regulatory regime aimed at ensuring patient safety. Nevertheless, working with OMH and OASAS, Article 28 providers that increase their provision of mental health and substance abuse services under 3.a.i will examine their policies to determine if any further policies need to be developed to ensure patient safety given the service changes. If any further policies are required, they will be modeled on OMH and OASAS regulatory requirements.
2	10 NYCRR §§ 401.2(b), 401.3(d)	Project(s): 2.a.iv, 3.a.i Reason for request: Section 401.2(b) allows the operating certificate of an Article 28 provider to be used only by the Article 28 operator at the Article 28 provider's site of operation. DOH has interpreted this to mean that the operator must have exclusive site control and cannot share the site with another entity. Section 401.3(d) prohibits an Article 28 provider from leasing or subletting any portion of its facility unless the entity that leases the facility conforms with all of the requirements imposed on Article 28 providers. In effect, these two provisions prohibit Article 28 providers from sharing space with any provider not licensed under Article 28—including a physician group practice, a clinic licensed by OMH, or a substance abuse clinic licensed by OASAS. These provisions could also be interpreted more broadly and prohibit the sharing of space with any other provider, even if that provider does have an Article 28 license. These rules therefore conflict with the PPS's projects. Under Project 2.a.iv, the two hospitals that are creating medical villages are likely to share space with other providers, such as physician groups or Article 28 clinics. Under Project 3.a.i, some Article 28 providers are likely to share space with mental health or substance abuse clinics in order to capitalize on the expertise of those providers. Potential alternatives: Article 28 providers could avoid these rules by declining to share space altogether and instead rely on their own expertise to provide behavioral health care. While some providers in the PPS are likely to do so, others lack expertise in behavioral health care. This latter group of Article 28 providers would then be forced to refer patients to behavioral health providers in other locations, making it less likely that the patients would receive the care they need. Patient safety: The purpose of the relevant regulations is to ensure that an operator has control of the site and therefore can maintain an environment that is conducive to patient safety. Article 28 providers who receive these

Westchester Medical Center (PPS ID:21)

#	Regulatory Relief(RR)	RR Response
		waivers will have agreements in place with the leasing provider that give the Article 28 provider sufficient authority over the leased space to ensure patient safety in that space. Moreover, these providers will develop whatever written plan for the sharing of space that may be required by DOH. Finally, the providers will comply with federal regulations on shared space, to the extent they are applicable.
3	14 NYCRR § 599.5(c), 599.12(a)(6)	Project(s): 3.a.i Reason for request: The regulations cited above allow mental health providers licensed by OMH (Article 31 providers) to share program space only if they have a written space sharing plan that has been approved by OMH. As part of the behavioral health integration project, providers licensed by OMH are likely to share space with providers of physical health services. The PPS will develop a detailed implementation plan and timeline in DY1 that will indicate which providers are planning to share space, and assuming DOH approves that plan, DOH will approve the space sharing plans. Providers should not have to obtain a separate approval from OMH. Potential alternatives: Article 31 providers could follow the regulatory requirements and obtain OMH approval prior to sharing space. However, doing so could result in delays in the implementation of DSRIP projects, particularly since OMH resources may be stretched given the likely demand for such approvals as a result of DSRIP implementation. Patient safety: In cases where OMH providers do share space, they will develop a space sharing plan, and that plan will require that the OMH provider has sufficient authority over the leased space to ensure patient safety in that space. These providers will share the space sharing plan on request, and will modify the plans if OMH or DOH raise any concerns.
4	10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1	Project(s): 2.a.i, 2.a.iv, 3.a.i, 3.c.i Reason for request: When medical facilities seek to undertake certain projects, the certificate-of-need ("CON") regulations cited above require those facilities to submit applications to DOH, demonstrate a public need for their projects in the application, and obtain DOH prior approval before initiating their projects. The projects listed above are likely to require providers to undertake construction and service changes that would implicate the CON rules. In particular: a) Project 2.a.i requires a large investment in primary care capacity and some providers will need to expand operations in order to meet that enhanced capacity; b) Project 2.a.i also requires investment health information technology infrastructure, and some HIT investments enacted by providers—a group of providers that will most likely include residential health care facilities upon final implementation — will fall within the scope of CON regulation; c) Project 2.a.iv involves the decertification of beds at two hospitals and their replacement with primary care, emergency department, and observation unit services; d) Project 3.a.i will likely require construction and renovation at Article 28 providers to create new spaces for behavioral health care, and likewise some Article 28 providers may provide services at new sites, and e) Project 3.c.i may require the creation of new spaces to handle increased demand for diabetes services. DOH approval of the DSRIP projects and their implementation plans should be sufficient, particularly in light of the fact that the PPS has conducted a community needs assessment, and used the results of that assessment to inform its project selection. DOH should therefore waive the sections of the CON regulations that require a demonstration of need and financial review for the projects listed above (a limited architectural review of the projects under these regulations is still appropriate).

Westchester Medical Center (PPS ID:21)

#	Regulatory Relief(RR)	RR Response
		Potential alternatives: The alternative to a regulatory waiver would be to continue to require providers to demonstrate public need for DSRIP projects. Doing so, however, would be highly duplicative of the DSRIP application process itself, as DOH's approval of the above projects demonstrates DOH's belief that the projects are in the public's interest. Patient safety: Waivers of CON regulations would not implicate patient safety in this context. CON regulations are designed to prevent the overutilization of services. While overutilization of services can cause patient harm in some circumstances, the potential for harm is much more likely when providers seek to increase the provision of surgeries, imaging, and other intensive services. There is little threat to patient safety when there is a potential increase in the provision of primary care services, as the Public Health and Health Planning Council recognized in its December 2012 recommendation of eliminating CON review for primary care facilities.
5	OMH: 14 NYCRR §§ 551.6, 551.7: OASAS: 14 NYCRR §§ 810.6, 810.7	Project(s): 3.a.i Reason for request: Section 551.6 requires Article 31 providers who are licensed by OMH to undergo prior approval review if they undertake certain projects, including the establishment of a new satellite location and the expansion of caseload by 25 percent or more for clinic treatment programs. Section 551.7 requires a demonstration of public need as part of this review. Similarly, Section 810.6 requires Article 32 providers who are licensed by OASAS to undergo prior approval review if the provider offers services at a new location or increases capacity of a service where capacity is identified in the provider's operating certificate, and Section 810.7 requires the applicant to demonstrate public need for its project as part of the review. Project 3.a.i is likely to fall within the reach of these regulations. As part of behavioral health integration, Article 31 and Article 32 providers are likely to provide services at new locations—more specifically, they may provide care within an Article 28 facility. While establishing a new satellite location is technically subject to "E-Z PAR" review, in practice this process is not easy for providers: they must obtain a letter of support from a local government unit to demonstrate there is a public need for the project, and the process can be lengthy. Requiring prior approval review for the behavioral health integration project would be duplicative of the DSRIP process itself, since the PPS will already have to submit its implementation plan to the state for review. There is no need to impose a separate prior approval review process on top of the review process embedded into DSRIP itself. Potential alternatives: The PPS could avoid this requirement by relying on Article 28 providers to provide mental health and substance abuse services on their own. But Article 28 providers would need waivers to do so, as discussed above. Moreover, Article 31 and 32 providers have expertise on behavioral health care, and the PPS should have the option on utilizing those providers with a deep behavioral health knowledge base in its implementation of the behavioral health integration project. Patient safety: Foregoing a demonstration of public need will not have an impact on patient safety. To the extent OMH and OASAS have any concerns about Article 31 and Article 32 providers expanding their operations into primary care settings, the PPS will work with these agencies to develop policies to assure patient safety.
6	10 NYCRR § 600.9(c)	Project(s): All projects. Reason for request: Section 600.9(c) prohibits a medical facility from sharing gross income or net revenue with an individual or entity that has not

Westchester Medical Center (PPS ID:21)

#	Regulatory Relief(RR)	RR Response
		received establishment approval. This could be interpreted as prohibiting a hospital that receives DOH funds under DSRIP from distributing those funds to non-established providers who are in the same PPS. Such an interpretation would be contrary to one of the key elements of DSRIP: the distribution of funds by the lead coalition provider to other providers participating in the PPS. Potential alternatives: Alternatives are not feasible, since following a strict interpretation of Section 600.9(c) would prevent lead coalition providers from distributing state funds to the PPS participating providers. Patient safety: Waiving this regulation would have no impact on patient safety.
7	10 NYCRR § 405.9(f)(7)	Project(s): All projects. Reason for request: Section 405.9(f)(7) requires hospitals to ensure that patients may not be discharged or transferred to another location based upon source of payment. This regulation could be interpreted to prohibit hospitals from transferring their patients to other providers within the same PPS, since the hospital would have a financial relationship with the other provider. For example, if one hospital in a PPS were to transfer a patient to the lead coalition provider because the lead coalition provider specializes in treating the patient's condition, this could be viewed as a transfer based on source of payment since the lead coalition provider distributes DSRIP funds to the transferring hospital. Potential alternatives: Alternatives are not feasible. If Section 405.9(f)(7) were interpreted in this strict way, it would mean that hospitals could not transfer their patients to the lead coalition provider, and possibly other transfers would be restricted as well. This would harm patient care, as the lead coalition provider specializes in care that PPS patients need. Patient safety: To the extent that such policies do not yet exist, providers in the PPS will adopt policies and procedures to ensure that transfers to other facilities are made based on patient need and not based on financial relationships. Hospitals will be allowed to transfer patients to the lead coalition provider and other providers within the PPS, and they will be encouraged to do so when it is in the best interest of the patient. However, these policies will emphasize that providers should never transfer a patient based on source of funding when another destination is more appropriate for the patient's care.
8	DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)	Project(s): 2.a.i, 2.a.iii, 2.b.iv, 3.a.i, 3.a.ii, 3.c.i, 3.d.iii, 4.b.i, 4.b.ii Reason for request: Section 86-4.9(c)(8) prohibits freestanding ambulatory care facilities from billing for services provided off site. Section 401.2(b) allows an Article 28 to use its operating certificate only for services at its designated site of operation, which has been interpreted as prohibiting providers from providing services offsite. Sections 599.14 and 822-3.1(b) impose similar rules on mental health and substance abuse providers, respectively. Providers would benefit from the ability to provide services off site in carrying out multiple DSRIP projects. This ability would be particularly beneficial in carrying out Project 2.a.i: allowing facilities to provide care in alternative settings would help promote an integrated delivery system and would discourage facilities from providing care in silos. Under Project 2.b.iv, a visit from a patient's facility-based practitioner may be part of a strategy to reduce readmissions. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home under Project 3.a.i. Project 3.c.i aims to improve diabetes care, and facility-based practitioners may seek to provide services in the

Westchester Medical Center (PPS ID:21)

#	Regulatory Relief(RR)	RR Response
		home as part of that enhanced care. In short, providers seek the flexibility to provide needed care in the setting that is most conducive to treatment. Potential alternatives: The PPS could rely on providers that are licensed to provide services in the home or non-credentialed practitioners to provide home-based care under DSRIP projects. However, there likely will be instances where a patient needs a more intensive level of care and the services of a registered nurse, nurse practitioner, or physician employed by an Article 28 provider. Article 28 providers should have the ability to be reimbursed for these services when patients need them in their homes. Patient safety: Practitioners are required to protect their patients no matter the location of care, and therefore allowing those practitioners to provide services off site is not a threat to patient safety. To the extent that DOH believes that providers need to take measures to protect patients receiving care in the home, the PPS will work with DOH to develop provider policies in this area.
9	10 NYCRR § 766.4(a), (b)	Project(s): 2.b.iv, 3.c.i Reason for request: Section 766.4 allows doctors, midwives, and nurse practitioners to order licensed home care services, but it does not allow physician's assistants (PAs) to order such care. As part of their efforts to keep patients out of the hospital, the DSRIP projects listed above are likely to involve orders for home care. The provision of home health care can be part of a strategy to reduce readmissions (2.b.iv). Some patients who receive diabetes care are also likely to need care in the home (3.c.i). Allowing PAs to order home care as part of this project would make it easier for these providers to order such care and thus could potentially play a role in reducing inpatient admissions. Potential alternatives: PPS providers could avoid the need for this waiver by relying on physicians, midwives, and nurse practitioners to order licensed home care services. For providers that employ few PAs, complying with Section 766.4 is not a great concern. Some providers, however, rely heavily on PAs in their everyday practice. For these providers, forcing PAs to find the appropriate physician or nurse practitioner to order care would be an inefficient use of resources. Patient safety: PAs often are given the same scope of authority as nurse practitioners. Granting physicians' assistants the power to order home care—a power already granted to midwives and nurse practitioners—is not a danger to patient safety.

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

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.

Our PPS has established a strong and effective organizational and governance structure that will enable the PPS to evolve into an integrated and high-functioning provider network. Our PPS is implementing a Collaborative Contracting Model governed by a Master Hub and Services Agreement (MHSA) that will be entered into by and among (1) Westchester Medical Center (WMC), as lead applicant and fiduciary; (2) the Center for Regional Healthcare Innovation, LLC (CRHI), a central services organization established by WMC to provide centralized services and operational support to our PPS and it partners; and (3) the health care providers and organizations (Participants) that will comprise the PPS. The PPS and CRHI organizational charts are attached for reference.

Our PPS organizational structure was developed through a collaborative and transparent stakeholder process, overseen by a DSRIP Planning Executive Committee and Project Advisory Committee (PAC) that is representative of PPS Participants. The Collaborative Contracting Model was selected to maximize Participant buy-in over a broad geographic area and allow Participants to gain comfort with DSRIP before the PPS' evolution into risk-based contracting. This model will also allow Participants to retain their autonomy while

Westchester Medical Center (PPS ID:21)

enabling our PPS to quickly stand up the required infrastructure and contract for services that support DSRIP project implementation. To that end, WMC has made a significant investment to support the startup of our PPS (including the establishment and staffing of CRHI) and, as fiduciary.

CRHI will provide a range of centralized services to our PPS, including but not limited to: provision of clinical supervision services by hiring, contracting with and/or leasing clinical staff who will collaborate with care coordinators and health care professionals working with Participants throughout the PPS; information technology (IT) services necessary to support the PPS; providing or arranging for the provision of staffing necessary for the operation of the PPS; training Participant staff as necessary to support achievement of PPS goals; data analytics necessary to support PPS operations; and back office and administrative services necessary to support the PPS.

The contracting model allows for clear delineation of responsibilities and individual performance goals through detailed schedules and accountability for incentive payments and any supplemental payments for services rendered. It is also, in effect, a cooperative agreement as our PPS will be a learning system and both the central services organization and the individual participants will benefit from the flexibility and rapid course correction a Collaborative Contracting Model affords.

WMC, CRHI, and our PPS Participants are committed to a collaborative and transparent governance framework, which will exist at both a centralized and regional level and will play a critical role in governance and operations, guiding and informing development of PPS budgets and Participant incentive payment methodologies, clinical programs and protocols, and IT services and infrastructure. That framework will be supported by WMC as the fiduciary, which retains ultimate responsibility for fulfilling the terms of the PPS' contract with New York State (NYS). The PPS governing bodies are currently developing processes for monitoring and regularly assessing overall PPS and individual Participant performance relative to DSRIP goals, which will be critical to ensuring the PPS' success and positioning the PPS for an eventual transition to value-based purchasing.

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: **21_SEC021_WMC PPS Organizational Chart.pdf**

Description of File

PPS Organizational Chart and Center for Regional Healthcare Innovation Organizational Chart

File Uploaded By: lk494126

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***Structure 2:**

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

Our PPS governance is built around an inclusive, transparent committee structure that includes representation from a broad range of Participants. The structure features both centralized and localized governance, with the aim of maximizing Participant engagement, and balancing the need for a centralized structure with the necessity of meeting local needs and areas of focus. The PPS will be organized into four Hubs comprised of PPS Participants located within a defined geographic area. Participants with locations in multiple geographic areas may participate in more than one Hub.

Governance will exist at both the PPS and Hub levels. Our PPS will be governed by an Executive Committee, which will be supported by a Finance Committee, an Information Technology (IT) Committee, a Quality Committee, and other Committees as determined necessary and established by the Executive Committee (each a Committee, and collectively the Committees). A Nominating Committee will be responsible for recommending members of the Executive Committee, Committees, and Hub Boards (discussed below). All Committees will operate using a consensus-based process, which will build support and buy-in for decisions as they are made, making the PPS a more effective organization as a whole. The decisions made by the Executive Committee and various Committees will be binding upon all of the Hubs and their Participants. The PPS will also have a Project Advisory Committee (PAC), consistent with DSRIP requirements (discussed below), which will ensure that each Participant has a mechanism and venue for raising issues within the PPS governance structure.

Westchester Medical Center (PPS ID:21)

To ensure there is an opportunity for local stakeholder input and decision-making, and recognizing the large geographic area covered by our PPS, each Hub will have a Hub Board that includes representatives of Participants in the respective Hub. Each Hub Board will be responsible for review and approval of the relevant Hub Operating Plan and corresponding budget before such plans and budgets are sent to the Executive Committee and WMC for sign-off. Hub Boards will meet quarterly (and more often if determined necessary) to, at a minimum: review the Hub's progress against the respective Hub Operating Plan and budget; provide updates to the Executive Committee on the Hub's progress; and suggest changes to the Hub Operating Plan and budget to the Executive Committee as necessary.

In addition to establishing governance structures and processes at the PPS and Hub levels, PPS operations will be supported by CRHI and WMC leadership, who have significant experience implementing large-scale system transformation projects, as well as deep knowledge of the health care needs and challenges faced by our region's providers and residents. Our PPS will leverage these proven leadership capabilities, and the expertise of the CRHI program management office, to provide critical infrastructure to the PPS as it advances toward an integrated delivery system (IDS) and transitions from fee-for-service (FFS) to value-based payment.

We note that, as fiduciary, WMC is accountable to New York State (NYS) for our PPS' performance. Thus, WMC will have a failsafe oversight and ultimate approval of the PPS governance process, should any of its governing bodies come to a stalemate or should the success of our PPS be in jeopardy. However, the PPS will strive to achieve consensus-based decision-making as its primary mode of operations.

***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.

Our PPS will ensure successful clinical governance at the PPS level by establishing a Quality Committee comprised of clinical leaders from Participant organizations. The Committee will be charged with fostering the adoption of protocols and metrics at the provider level as well as monitoring and assessing PPS performance. The Committee may establish workgroups to address and advise the Committee on condition-specific issues and to address Hub-specific implementation. The Committee will be supported by CRHI staff who will gather evidence-based protocols and provide data and analysis for review by the Committee or its workgroups.

Recognizing that DSRIP allows patients to receive care from any provider, cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and the state. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council that supports the development of a regional system of efficient and effective care, patient safety, and continuous quality improvement.

The Council, including input from providers, payers, government agencies, and others, will review DSRIP project plans and implementation and make recommendations to align overlapping project approaches to minimize providers' implementation burdens and create consistent, high quality experiences for patients. The Council will identify region-wide care improvement goals and serve as a forum for sharing and evaluating proven and promising clinical strategies and practices.

Individual PPS compliance with Regional Clinical Council recommendations will be voluntary and the Council will not replace PPS- and Hub-specific clinical quality oversight. Participants in our PPS will be contractually obligated to comply with protocols established by the Quality Committee and adopted by the PPS Executive Committee

***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.

Our PPS recognizes its governance and structure will need to change as DSRIP objectives and goals evolve toward sustainability and value-based contracting. The initial operational structure will provide for centralized, transparent governance with significant local participation. Goals for DSRIP years (DYs) 1-3 will focus on providing oversight of DSRIP milestones, enforcing Participant obligations, evaluating/tracking PPS performance relative to established metrics, and developing the foundational capabilities and competences for clinical and financial integration. We envision a transition to value-based contracting before DY 5, with the goal of ensuring sustainable transformation. As the PPS evolves from program management to an established IDS with supporting processes and infrastructure to measure quality and outcomes, newly formed entities will likely be established as a vehicle for value-based contracting. In addition, our

Westchester Medical Center (PPS ID:21)

PPS plans to support ACOs and other PPS' in the region to access data and analytics capabilities necessary to successfully pursue alternate Medicaid contracting models.

Perhaps more importantly, a central pillar of our PPS' care transformation framework is to develop a learning organization. Our PPS will continually monitor performance and identify opportunities for improvement and transformation – including the effectiveness of our governance approach – regardless of the DSRIP year. We have adopted a Hub model precisely because it drives accountability to the point of care and fosters the development of true medical neighborhoods with local clinical leadership, serving the needs of residents. Our Hub governing bodies will be in regular communication with the PPS Executive Committee and with each other. We will learn from our successes and failures and share best practices through both formal and informal information sharing platforms. Our financial model includes funds for training and peer-to-peer networking and education.

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.

Our PPS will be governed by the PAC Executive Committee and various Committees. The Executive Committee will consist of between 15 and 25 representatives

The existing Planning Executive Committee will continue to serve as the PAC Executive Committee until a new slate of individuals is proposed for election by the Nominating Committee. The Planning Executive Committee currently includes representatives of: Westchester Medical Center (WMC), public health agencies, hospitals, federally qualified health centers (FQHCs), labor unions, mental and behavioral health associations, Health Homes, physician groups, home health and long term care, specialty care, and health plans. The Executive Committee is seeking representation from community physicians and a Medicaid beneficiary.

The Executive Committee will have three Committees in addition to a Nominating Committee: Finance, Quality, and Information Technology (IT). These Committees will support PPS operational planning and implementation, making recommendations to the Executive Committee for review and adoption. Other Committees may be convened on an as needed basis.

***Process 2:**
Please provide a description of the process the PPS implemented to select the members of the governing body.

In 2013 WMC began actively engaging clinical leadership and resources across the region in a collaborative, inclusive and transparent DSRIP planning process. From the beginning, WMC sought to engage individuals with relevant experience, reputations as leaders in the communities, and the ability to bind their respective organizations. The Executive Committee is a subset of the larger Project Advisory Committee (PAC) , which consists of one member from each PPS Participant, and serves to maximize stakeholder engagement and participation.

The founding Planning Executive Committee guided the planning process and the developed a governance structure for operations. Going forward, the PPS will be governed by an Executive Committee consisting of between 15 and 25 representatives, including at least one WMC representative and the Executive Director of the Center for Regional Healthcare Innovation (CRHI), serving ex officio. The remaining members of the Executive Committee will be Participant representatives, at least 50% of whom will be selected from among the members of the Hub Boards. By having Hub Board members serve on the Executive Committee, the PPS hopes to achieve an effective and streamlined governance structure, as well as informed governing bodies that are engaged in the implementation of DSRIP projects in their communities.

Following the submission of the DSRIP Project Plan Application and after consulting with the Planning Executive Committee, WMC will appoint the members who will comprise the Executive Committee as of April 1, 2015, for a one year term. Until this appointment, the existing Planning Executive Committee will continue to serve and function in its current leadership capacity.

Westchester Medical Center (PPS ID:21)

To ensure continuity, broad stakeholder group representation and a successful DSRIP launch, the initial operational Executive Committee will have significant overlap with the Planning Executive Committee, with the addition of stakeholders whose participation will ensure broad PPS Participant representation. The PPS intends to add to the Executive Committee members who represent small/solo physician practices, consumer advocates, and patients by the start of DSRIP year (DY) 1.

In each subsequent year, the Nominating Committee of the Executive Committee will identify candidates for open or vacating seats. The Nominating Committee will be charged with selecting candidates who have relevant education and experience, who are leaders in their communities and organizations, who are committed to the success of the PPS and DSRIP in general, and who are willing and able to make the time commitment necessary to ensure the meeting of PPS and DSRIP goals. Executive Committee members will serve staggered terms of two years and there no term limits. The governance structure and process has been documented in the PPS governance terms sheet adopted by the Executive Committee, available for review upon request.

A similar approach to that used to appoint the Executive Committee will be undertaken to appoint members of the Committees and Hub Boards.

***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.

Throughout the planning process, all Participants and interested partners have been invited to participate in and inform the development of the PPS, specifically through the Project Advisory Committee (PAC), Clinical and Program Planning Committee, and Business, Operations and Finance Committee and their associated workgroups. Our PPS leadership, including the Planning Executive Committee, WMC, and CRHI have taken care to create and maintain a transparent process with multiple feedback inputs (through surveys, focus groups, public comment periods, a PPS website, etc.) and to actively engage stakeholders, including community organizations, to ensure fair representation on the planning committees described above. During the DSRIP operational stage, every PPS Participant can elect one senior level executive to serve on the PAC in addition to opportunities to participate in Hub and PPS-wide clinical, operations and IT governance committees.

***Process 4:**

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

Coalition partners are included in our PPS organizational structure through the PAC, Executive Committee and other Committees. Our PPS has not limited its scope to health care providers, actively pursuing community based organization (CBO) and social services provider contributions in an effort to transform care on all levels. Partners will continue to be invited to serve on PPS Committees that will drive governance, operations, and DSRIP project implementation. Notably, governance at the Hub level will require coalition partner participation on Hub Boards and committees. Our CNA identified CBOs by county as well as gaps where CBO services are limited and may need to be augmented. Coalition partners will play a critical role in operationalizing recommendations from the DSRIP planning phase to ensure there are sufficient CBO services, and that CBOs are actively engaged, including through contracting where appropriate to advance program goals, in the operational phase.

***Process 5:**

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

Our PPS will implement consensus-based decision-making at all levels. Voting will require the agreement of a supermajority (75%) of the relevant Committee or Hub Board members. Our PPS believes that consensus-based decision-making will lead to good governance as it supports our key principles of transparency, accountability, and informed participation.

Actions by the Executive Committee that are consensus-based will be submitted to the fiduciary, WMC, for sign off. Actions by Hub Boards and Committees that are consensus-based will be submitted to the Executive Committee for review, and if approved, to WMC for final sign-off.

While WMC is the fiduciary and as a matter of process must retain the ability to serve as final sign-off on PPS decision-making, it does not intend to disrupt or block consensus-based decisions achieved by the Executive Committee, Hub Boards, or Committees. Rather, WMC will provide a failsafe to monitor any decisions or development that may harm the financial stability or overall health of the PPS and will

Westchester Medical Center (PPS ID:21)

serve as a convener and arbitrator in the unlikely event a governing committee fails to reach consensus.

***Process 6:**

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

For Hub Board or Committee actions that are not consensus-based, the relevant body will submit to the Executive Committee (EC) a summary of issues on which consensus has, and has not, been reached. The EC will work with the parties to reach consensus. If consensus is still not reached, the EC will prepare summaries of issues and a recommendation for WMC review. WMC will evaluate this proposal and work with the EC to establish consensus. In the rare case collaborative consensus cannot be reached, the fiduciary will determine the appropriate course of action. The same process will be followed if the EC cannot reach consensus on items of business. To address actual or potential conflicts of interest, the PPS will adopt a Conflict of Interest (COI) Policy that members must comply with. Members will be required to complete a COI disclosure statement on an annual basis. Individuals who report a COI must recuse themselves from participation in decisions involving the relevant conflict.

***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.

Transparency is a key principle of our PPS governance. The Executive Committee will ensure a transparency by posting summaries of and key materials from each meeting on the PPS website (www.crhi-ny.org) for public review. The Executive Committee and PPS leadership will also communicate important decisions and developments to the entire PPS through regular PAC meetings (in-person and via webinar), email and newsletter communications, and the PPS website.

The PPS website will feature a "partner portal" where PPS Participants and other stakeholders may post and share information relevant to DSRIP project implementation and progress, and a calendar with all PPS events and meeting information. All Committee and Hub Board charters will also be made publicly available through the PPS website; charters will describe each Committee or Hub Board's scope, membership qualifications, key deliverables, and an expected timeline for achieving deliverables and completing milestones.

***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.

Our PPS will continue to engage stakeholders, including Medicaid members, throughout the life of the DSRIP program. We plan to identify and appoint a Medicaid beneficiary to the PPS governing body during DY1 to provide important community and patient perspective.

Experienced CRHI communications staff developed a public-facing PPS website and newsletter which regularly update stakeholders on PPS developments. Our PPS will also work with Participants and CBO partners with experience engaging Medicaid members and plans to identify and replicate best practices across the region.

CRHI led a multi-PPS effort in our region to develop and promote a resident survey that received 4,777 responses as of December 1, 2014. The survey was in plain language and translated into the 5 most popular among the target population: English, Spanish, Portuguese, Yiddish, and French Creole. Survey responses will inform the PPS' approaches to engaging Medicaid members based on their identified needs.

Section 2.3 - Project Advisory Committee:

Description:

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

***Committee 1:**

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

Westchester Medical Center (PPS ID:21)

Our Project Advisory Committee (PAC) was originally formed in July 2014 following the submission of the DSRIP Planning Grant Application. The PAC consists of one representative of each PPS Participant, as well as representatives of organizations (such as community-based organizations (CBOs) and labor organizations) whose participation in the PAC is deemed desirable by the Executive Committee and Westchester Medical Center (WMC), or as otherwise may be required.

Each PPS Participant was asked to name one senior level representative to serve on the PAC. All Participants were also given the opportunity to name members to the PAC's Clinical and Program Planning Committee whose membership remained open throughout the planning process and to participate in any clinical workgroup to ensure broad input into the development and design of DSRIP projects. Meeting notes, presentation materials and, when applicable, webinar recordings were also made widely available through a PPS-wide newsletter and DSRIP website.

During the planning process, the PAC met approximately monthly to review progress, ask questions and provide input. The PAC and its Planning Executive Committee provided guidance and input related to the development of the PPS organizational structure and evaluated the establishment of Hubs to locally oversee and implement DSRIP projects. PAC members also participated in planning meetings focused on the DSRIP projects, specifically behavioral health, care management, and perinatal and early childhood development. The PAC's input during these meetings informed our PPS' project selection and ultimately, approach to implementation.

Going forward, the PAC will continue to include all PPS Participants and relevant extended network partners, including patient representation. By establishing an inclusive PAC, the PPS strives to ensure that all stakeholders are aware of issues and key initiatives of the PPS and the DSRIP program. urther, the PAC composition ensures that stakeholders across the region have a voice in the PPS.

***Committee 2:**

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

Our full PAC will meet at least twice annually to receive progress reports from PPS leadership, including the PAC Executive Committee and Hub-level governance, and provide feedback on DSRIP initiatives. The PAC will also receive regular communications regarding the PPS via newsletter, email, and the PPS website to ensure members are informed about initiatives and have the opportunity to remain engaged as the program matures and projects are implemented. PAC member organizations will also be encouraged to actively participate on committees and workgroups.

The PAC's advisory role is intended to: ensure all PPS Participants have input and an opportunity to participate in project development and implementation; create an inclusive process; engage all willing providers in the region (regardless of PPS alignment); engage non-provider Participants to ensure community voices are heard and considered throughout implementation; and facilitate and promote transparency and collaboration.

***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, through its Planning Executive Committee, played a central role in developing all aspects of our PPS organizational structure including clinical project selection and development, operational structure (including the Collaborative Contracting Model and development of a term sheet outlining governance and parties' roles and responsibilities of the), DSRIP funds flow, and workforce strategy.

The full PAC was also regularly updated on the CNA and its progress, and encouraged to provide feedback and participate in CNA efforts. For example, the PPS enlisted the PAC to reach target patient populations with its resident survey. The PAC also had the opportunity to review and comment on CNA findings, providing feedback on community-based organization workbooks for each county and disease prevalence maps highlighting hot spots across our region during an open comment period. PAC members were informed of the comment period via the PPS newsletter and website, as well as in PAC meetings

***Committee 4:**

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

All PPS Participants and partners, including providers and community-based organizations (CBOs), are eligible to participate in the PAC. Each organization may appoint one senior-level representative to the PAC. As a result, the PAC is a large advisory stakeholder body from

Westchester Medical Center (PPS ID:21)

which the PPS has, and will continue to, establish smaller Committees based on emerging issues, areas of expertise and availability.

Although direct overlap is not required, it is anticipated that there will be overlap among PAC members, Hub Boards, and, as needed, workgroups that oversee PPS operations, Hub operations, and other issues as they arise. This will not only permit our PPS to make best use of stakeholder resources, but it will facilitate information flows between PPS leadership and Participants, including medical care providers, CBOs, social service providers, beneficiary advocates and others.

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.

Patti Ariel, Chief Compliance Officer for Westchester Medical Center (WMC), will serve as our PPS Compliance Officer and will have a matrixed oversight of PPS leadership, including CRHI, with regard to DSRIP compliance. Ms. Ariel brings considerable experience and knowledge of organizational compliance policies and procedures, as well as the existing policies and procedures of the fiduciary and general knowledge of the regional health care landscape. She will be charged with operating and monitoring the PPS' compliance program and her team will provide regular reports and updates to the PPS Executive Committee.

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

Our PPS Compliance Officer Patti Ariel will work with CRHI VP of Operations Peg Moran to oversee implementation of a compliance plan and program to ensure proper oversight of the PPS and a process for identifying and addressing compliance challenges. The plan will address the: distribution of written standards of conduct and policies and procedures that promote the PPS' commitment to compliance and address specific areas of potential fraud; implementation of education and training programs for PPS Participants and their employees, agents and contractors; establishment and maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect anonymity and whistleblowers from retaliation; development of a system to respond to allegations of improper/illegal activities and enforce appropriate disciplinary action against individuals who have violated PPS compliance policies, applicable statutes, regulations or federal health care program requirements; use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and investigation and remediation of identified systemic problems.

***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.

Our PPS will develop and implement regular, effective education and training programs for PPS Participants, coalition partners, and their employees. Our PPS will model its compliance program on existing WMC programs, customizing each program to be relevant to PPS Participants and coalition partners. To the extent provider-specific compliance programs that are not used "in-house" at WMC are required, the PPS will work with relevant Participants, the PPS Compliance Officer, CRHI, WMC, and/or outside counsel as necessary and appropriate to develop the necessary program(s). The PPS anticipates implementing a comprehensive training program during DSRIP year (DY) 1 and completing initial training of all Participant and coalition partner employees within six months of implementing the program (by the end of Q2 in DY 2).

***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.

Our PPS will establish, publicize, and maintain a process, such as a hotline, to receive community members,' Medicaid beneficiaries,' and uninsured community members' compliance complaints. If an individual (or organization) feels their (or its) rights have been violated or

Westchester Medical Center (PPS ID:21)

that the PPS is acting in conflict with its obligations under DSRIP , the individual or organization may contact the PPS Compliance Officer in writing or via phone or email. Guidelines will be posted on the public-facing DSRIP website (and made available via hardcopy) to provide guidance on what constitutes an appropriate complaint. Our PPS will implement and publicize a non-retaliation policy with regard to complainants. We will also adopt policies and procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation. This guidance and process will be developed in partnership with the PPS Compliance Officer and vetted through the Executive Committee for adoption.

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.

Our PPS will support the financial success of the PPS through: establishment of a Finance Committee; identification of WMC and CRHI staff responsible for development and oversight of processes to support the financial integrity of the PPS; and establishment of controls to ensure compliance.

WMC will administer all DSRIP funds and disbursements and will follow standard WMC procedures to ensure compliance with appropriate financial controls. WMC has established a separate cost center and bank account to ensure proper accounting for DSRIP funds. Administrative and financial resources have also been engaged to manage DSRIP finances. Budgets and projected cash flows for DSRIP have been developed and will be continuously monitored to help the PPS understand any variances from those projections. Our PPS will implement a regular reporting structure and process to ensure the Executive Committee receives timely updates on the PPS' financial health and budgets.

The Finance Committee will focus on the development and refinement of DSRIP funding methodologies and the allocation of funding to PPS and Participant budgets, provider bonus payments, revenue loss and an innovation pool.

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

Our PPS will establish the following key functions within the PPS' financial organizational structure: the appropriate segregation of duties so that no one person can authorize, approve and disburse funds; transactions must be reviewed and approved by someone who has not initiated the transaction; implementation of a conflict of interest policy with respect to interested party transactions; appropriate maintenance of records and documents to substantiate transactions; appropriate supervision of activities; monthly top level reviews of actual to budget performance; and the operational review of metrics and other key performance indicators and controls over information technology (IT) systems both in terms of system access and application controls.

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

Our PPS plans to use both internal and external auditors as it models Westchester Medical Center's (WMC')s robust audit and control infrastructure. WMC's Chief Compliance Officer, Patti Ariel, will oversee internal audit staff and report to the PPS Executive Committee.

WMC's Internal Audit/Corporate Compliance Department will conduct risk assessments and develop an annual work plan. Audits will address areas of financial controls, HIPAA privacy and security, fraud and abuse, and billing reviews (to the extent relevant). The PPS Compliance Officer will develop and present to the Executive Committee an annual report of conflicts of interest, internal audit and compliance activities.

WMC's external auditors, Grant Thornton, while not expressing an "opinion on the effectiveness of internal control" have, over the course of their audit work over the last three years, consistently stated they have not found any material weaknesses or significant deficiencies with WMC's internal control program. WMC intends to extend this same level of rigor to our PPS.

Westchester Medical Center (PPS ID:21)

***Organization 4:**

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

The existing compliance program at WMC operates in accordance with New York State Social Services Law 363-d and WMC intends to overlay that infrastructure on the PPS to ensure that the appropriate controls are in place to safeguard the funds that will flow into and out of the organization. To the extent a gap analysis is needed to address any areas where the program will need to be built out to address the unique elements of DSRIP, WMC will conduct such an analysis and promptly work to close any gaps within the first quarter of DSRIP year (DY) 1.

Section 2.6 – Oversight:

Description:

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

***Oversight 1:**

Describe the process in which the PPS will monitor performance.

The Executive Committee will be responsible for establishing processes to monitor PPS performance and subsequently ensuring that Participants and coalition partners comply with their responsibilities under the Master Hub and Services Agreement (MHSA). Westchester Medical Center's SVP and Deputy General Council will monitor MHSA adherence. Our PPS is developing the required technical infrastructure to support a robust performance evaluation function capable of producing performance dashboards, under the direction of Helene Kopal, director of PPS-wide IT strategy. Once this capability is established, the PPS, under the direction of Dr. Deborah Viola, PhD, head of Health Services Research and Data Analytics for CRHI, will regularly monitor performance against metrics and measures established by the Executive Committee and Committees as relevant to their respective areas of expertise. Hub Boards will be charged with regularly monitoring and assessing Hub performance against Hub Operating Plans. These monitoring and reporting capabilities will be an important component of our PPS' rapid-cycle evaluation program and will enable the PPS to respond quickly to improve performance.

***Oversight 2:**

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

If, through performance monitoring, the Executive Committee or a Hub Board identifies low or underperforming PPS Participants, the Executive Committee or Hub Board will send a written communication to the Participant describing the identified instance(s) of underperformance and recommending, if appropriate, a 90 day corrective action plan. The underperforming Participant will subsequently develop and submit a corrective action plan setting forth remediation strategies with corresponding performance metrics and reporting schedules to the Executive Committee or Hub Board for review and approval. Once approved by the Executive Committee or Hub Board, the Participant will submit the specified reports on their progress and compliance with the corrective action plan. Failure to comply with a corrective action plan, may lead to the suspension of DSRIP funding allocated to the Participant, temporary suspension of the Participant's participation in the PPS, or, as a last result, removal of the Participant from the PPS. Procedures for review of a corrective action plan are below.

***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.

Failure to comply with a corrective action plan (implemented as described above) may lead to the suspension of DSRIP funding allocated to the Participant, temporary suspension of the Participant's participation in the PPS, or, as a last result, removal of the Participant from the PPS. To determine the appropriate course of action, the Executive Committee will convene a closed session meeting with the underperforming Participant to review and discuss the Participant's performance relative to the MHSA and corrective action plan. The Participant will be asked to prepare a formal response and justification as to its failure to comply for presentation to the Executive Committee. If the Participant's response is found unacceptable to the Executive Committee, it will prepare a formal recommendation to WMC that the Participant be removed, suspended, or that allocated funding be revoked. If WMC agrees with the Executive Committee's recommendation for removal, it will forward the recommendation to the New York State Department of Health (NYS DOH) and formally request the Participant's removal.

Westchester Medical Center (PPS ID:21)

Should a Hub Board identify a Participant that has failed to comply with a corrective action plan, it will write a formal recommendation to the Executive Committee recommending further action. The Executive Committee will review the Hub Board's recommendations and follow the process described above to determine the best approach for addressing the Participant's poor performance. At any point in the corrective action plan process, the Participant subject to the plan will be permitted to appeal the corrective action plan to the next-highest level of PPS governance, up to and including WMC.

Members of any Committee and Hub Board may be removed for cause upon the vote of 75% of the remaining members of the relevant Committee or Hub Board. Among other things, the termination of a Committee member's or Hub Board members' affiliation with a Participant will be considered cause for removal, if the relevant Committee or Hub Board determines that such removal is in the best interest of the PPS.

***Oversight 4:**

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

Our PPS will establish and publicize a formal feedback mechanism for Medicaid beneficiaries, their caregivers, and advocates to provide feedback about PPS Participants and providers. Specifically, the PPS will develop and distribute at all PPS Participant locations, brief notifications explaining a provider's participation in the PPS and implications for beneficiaries, where an individual may go to learn more about the PPS, and how to provide feedback on their experiences with a provider in the PPS. These notifications will be developed in popular languages and written at a sixth grade reading level. Feedback may also be submitted through the compliance hotline, via the PPS website and/or via a dedicated email address. Providers will be trained on procedures for sharing any feedback with the PPS in a timely manner. Beneficiaries will also be able to provide feedback to CRHI's patient engagement oversight team directly. While our PPS will seek to ensure seamless services to beneficiaries, the Executive Committee will monitor impact as the PPS evolves and may establish a patient task force or workgroup if needed.

***Oversight 5:**

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

Our PPS will establish a process for notifying Medicaid beneficiaries and their advocates when Medicaid beneficiaries' providers, including key specialty providers, are removed from the PPS, with an emphasis on patients who are enrolled in special DSRIP-funded projects or who receive enhanced care coordination services through the PPS. We anticipate following WMC's existing process for notifying a patient when their doctor retires from practice or moves to another facility. Beneficiaries (or designated surrogates of beneficiaries) participating in an ongoing PPS project or care coordination program will be called and sent written notice if their provider leaves the PPS and we will work with the beneficiary to identify and establish a relationship with a new provider. For advocates, the public and beneficiaries not participating in a project involving a provider leaving the PPS, notice of PPS network changes will be posted on the PPS' website.

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

Westchester Medical Center (PPS ID:21)

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

Westchester Medical Center (PPS ID:21)

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.

We recognize the integral role that a community needs assessment (CNA) plays in supporting the delivery of patient-centered, population-based health care. We were guided by the CDC's Community Health Assessment and Group Evaluation (CHANGE) toolkit. The needs and opinions of community stakeholders across sectors were gathered in a systematic way (e.g. surveys, focus groups, and key informant interviews) over a four month period that included compilations of data into workbooks, chart books, and map books. Our CNA utilized the power of geospatial data analysis to inform project selection and planning. Rigorous analysis of extant health, socio-demographics, and built environment data enhanced our ability to identify DSRIP projects that focus interventions on individuals and communities most in need.

To ensure broad representation across all community sectors, we met with and sought input from local teams established by each County Department of Health (DOH) as well as stakeholder focus groups. We collaborated with the other PPSs in our region and County DOH teams to coordinate local surveys about capabilities (e.g., health IT, community resources, health care resources, resident survey) to supplement what was available on secondary websites.

All data analyses and chart-, map- and work books were shared as they were developed with providers and stakeholders across the region through public meetings with County Health Commissioners and with local project teams. Our CNA staff participated in over 60 meetings. We posted all components of the CNA on our public facing website (www.crhi-ny.com) for an open comment period. At every stage of our outreach process we distributed flyers with scan codes to our website and emailed newsletters to all PPS Participants.

The foundations of CHANGE include commitment; working with local County DOHs fostered collaboration that will support future community health assessments required by the New York State (NYS) DOH.

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

Geographic information science (GISc) and spatial analyses were used to identify particular population-based health issues. Detailed-level SPARCS data provided by our academic colleagues at Iona College, along with Medicaid claims data accessed through Health.NY.Gov dashboard, combined with Census information, were mapped to identify community needs by prevalence indicators for major diagnostic categories. Using SPARCS data, we identified patients' emergency department visits, hospitalizations and readmissions and analyzed trends to identify negative quality indicators.

Conforming to our goal of improving population health, we isolated "hot and cold spots" (statistical clusters of zip codes with values higher or lower than expected). This approach was expanded to include variables from a range of other sources (e.g., ACS, Vital Statistics,

Westchester Medical Center (PPS ID:21)

Salient Data Portal, Dashboards) related to outcomes and socio-demographic determinants (e.g., poverty, English-speaking ability, race/ethnicity, employment, physical activity). We created and interactively mapped Narrative Profiles that to build stories about the health status, social, economic, housing and demographic characteristics of a neighborhood. Following the lead of Dr. Jeffrey Brenner of the Camden Coalition we posted our county-level and zip code-level profiles on our website so that community members and providers, who know their cities so well, can "begin to take the data and tell stories with the data. And that's an incredibly powerful tool for making change" (Dr. Brenner).

Additional analyses were undertaken based on stakeholder input and 4,777 community responses to a survey about access, health care experiences and health priority needs by county. Focus group participants were also helpful in directing us to additional community partners.

The CNA was informed by the data sources mentioned above in addition to those listed in the Reference Section of the attached CNA report, "One Region, One CNA.

Section 3.2 – Healthcare Provider Infrastructure:

Description:
Each PPS should do a complete assessment of the health care resources that are available within its service area, whether they are part of the PPS or not. For each of these providers, there should be an assessment of capacity, service area, Medicaid status, as well as any particular areas of expertise.

***Infrastructure 1:**
Please describe at an aggregate level existing healthcare infrastructure and environment, including the number and types of healthcare providers available to the PPS to serve the needs of the community. Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Provider Types.

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
1	Hospitals	51	11
2	Ambulatory surgical centers	685	0
3	Urgent care centers	27	2
4	Health Homes	14	3
5	Federally qualified health centers	66	5
6	Primary care providers including private, clinics, hospital based including residency programs	5048	1868
7	Specialty medical providers including private, clinics, hospital based including residency programs	43460	1551
8	Dental providers including public and private	366	73
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	129	57
10	Behavioral health resources (including future 1915i providers)	673	378
11	Specialty medical programs such as eating disorders program, autism spectrum early	0	7
12	diagnosis/early intervention	0	20
13	Skilled nursing homes, assisted living facilities	88	36
14	Home care services	177	118
15	Laboratory and radiology services including home care and community access	146	94
16	Specialty developmental disability services	144	26
17	Specialty services providers such as vision care and DME	474	1
18	Pharmacies	402	2
19	Local Health Departments	35	18
20	Managed care organizations	8	2

Westchester Medical Center (PPS ID:21)

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
21	Foster Children Agencies	1	1
22	Area Health Education Centers (AHECs)	2	2

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.

To better understand trends and the needs of our region, we identified zip code level hot spots using Medicaid beneficiary data across multiple disease morbidities. Community needs within our region vary considerably within zip code clusters. The region has slightly more hospital beds per 100,000 than New York State (NYS) (297 versus 289); current capacity will more than satisfy minor growth in demand. However, a mapping of our provider network led to a determination that within two areas of our region there is a need to realign certified bed capacity and augment this with additional primary care and coordination services. As a result, two hospitals have committed to create medical villages and close, convert, and/or consolidate inpatient and acute care capacity, taking into account the need for ambulatory care services.

There are significant shortages of: primary care providers (PCPs) (in some areas the rate of active PCP per 100,000 population is 90.8 compared to 120 in NYS); psychiatrists (in some areas as low as 15.7 compared to 36 in NYS), and other professionals to care for vulnerable populations and the homeless. Data indicate that 503 adults with severe mental illness and 477 with chronic substance use are in shelters across the region. Our PPS will work with Health Home partners to expand access to care to meet the needs of higher risk patients who do not currently qualify for care management from Health Homes. In addition, our PPS will augment primary care and prevention services by expanding capabilities and PCMH certification, supporting local care coordination through a combination of regional hubs and centrally providing population health management services. This expansion in services, which emphasizes primary care, prevention, and care management, will increase demand for primary care and behavioral health service providers, care coordinators and managers, and care navigators. To address these workforce implications our PPS has created a Workforce Workgroup to address retraining, redeployment, recruitment and hiring activities as part of our workforce strategy.

Foreign born residents represent a quarter of the population of some counties with Hispanic and Asian minority populations growing fastest. Health literacy challenges, as reported in a survey of 45 providers across the region, are most prominent in communities where English is not the main language and are exacerbated when an individual is not literate in his native language. A major unmet identified need in the region is for staff who are bilingual and from local communities. The PPS workforce strategy includes training that will be structured to address health literacy and cultural competency shortfalls, gaps in best practices and team-based care models.

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

***Resources 1:**

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

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	120	19
2	Food banks, community gardens, farmer's markets	48	7
3	Clothing, furniture banks	7	1

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	27	26
5	Community outreach agencies	252	17
6	Transportation services	13	5
7	Religious service organizations	71	2
8	Not for profit health and welfare agencies	123	37
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	22	14
10	Peer and Family Mental Health Advocacy Organizations	123	33
11	Self-advocacy and family support organizations and programs for individuals with disabilities	41	5
12	Youth development programs	92	11
13	Libraries with open access computers	142	0
14	Community service organizations	100	88
15	Education	650	15
16	Local public health programs	8	1
17	Local governmental social service programs	8	2
18	Community based health education programs including for health professions/students	126	15
19	Family Support and training	194	23
20	NAMI	8	1
21	Individual Employment Support Services	9	6
22	Peer Supports (Recovery Coaches)	7	5
23	Alternatives to Incarceration	6	1
24	Ryan White Programs	1	2
25	HIV Prevention/Outreach and Social Service Programs	50	15

***Resources 2:**

Outline how the composition of community resources needs to be modified to meet the needs of the community. Be sure to address any Community Resource types with an aggregate count of zero.

To better understand where community challenges are most prevalent we modeled our hot spotting and outreach approach using strategies developed by Dr. Brenner of the Camden Coalition. Our analysis allowed us to identify zip code hot spots more frequently represented than all others. We worked with local partners and health departments to assure survey distribution to members of the target Medicaid population in these neighborhoods. Respondents from these zip code hot spots represent 25% of our total survey respondents.

In a comparison of their results with the rest of the region, this group's responses suggest they are more likely to have visited the emergency department (ED) in the past year for care due to access issues. These communities also present with higher rates of asthma and smoking and lower rates of cancer screenings.

These data suggest a need to re-emphasize preventive care within communities in part by working through community-based organizations (CBOs) and supporting health education and messaging. Our PPS recognizes that we need to be more proactive with this type of outreach and have begun a process to use our public facing website to share community directories and the stories of our neighborhoods. For the most recent two month period our CNA webpage received over 1,500 visits. We have an opportunity to continue to leverage our collaborative "One Region, One CNA" process and work with the other PPSs in our region to develop and promote a "One Region, One Public Health Campaign" initiative.

We will work through community outreach centers and religious organizations to inform at-risk communities about prevention (e.g. tobacco cessation, cancer screening services) and assure that all messaging is language appropriate and culturally sensitive. We recognize a

Westchester Medical Center (PPS ID:21)

need to partner with local libraries if we are to be as effective in reaching all members of our neighborhoods, including school-aged children. We can build upon existing programs such as the New York State Department of Health (NYS DOH) Cancer Services Program (CSP) and connect local cancer screening services to patients and facilitate follow-up or the Center for a Tobacco Free Hudson Valley, an affiliate of the American Lung Association, to integrate tobacco dependence treatment policies into screening.

Focus group respondents identified several community-based programs to help with behavioral health issues including: Welcome Orange which emphasizes warm hand-offs to providers; the Mental Health Association (MHA) of Ulster which works with local law enforcement and nursing students to reduce fear and stigma about behavioral health issues; Westchester Jewish Community Services which offers a warm line with licensed behavioral health clinicians on call; and the Rose House peer run hospital diversion program. However, there are not enough of these programs to support the needs of the region. As one focus group participant noted, "We need to build on successes." Our PPS is doing this through local networks of providers and organizations (see table in Community Engagement section) to promote the sharing of best practices and address specific community service gaps.

Section 3.4 – Community Demographic:

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

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

The median age for our region is 42 years. Orange and Rockland Counties are our "youngest" with a median age of 36 years.

Adults 20-64 years of age represent the majority for each county, from 55-62%.

The aging population (≥65) in the region is expected to increase by 28.5% by 2020, outpacing NYS' projected growth of 22.4%.

Detailed breakdown by age for all counties is reflected in the demographics table attached to this section. Also included are county level profiles that detail the social determinants of health. We have also attached an analysis that uses the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage. The ADI is a factor-based index available at the zip code level that uses 17 U.S. census indicators and has been linked to hospitalizations and readmission rates. Four counties in our region have an ADI higher than the State. County comparisons by zip code indicate areas of high social and economic deprivation.

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

The majority of the population is White; the region has seen marked increases in minority populations. Westchester County's city of Mount Vernon has the highest urban concentration of African American residents in New York (60%). Hispanic and Asian populations are the fastest growing minority populations, with 74% and 64% growth across the region since 2000, respectively. Foreign born residents represent a quarter of the population of Rockland and Westchester Counties. The major language spoken is English, closely followed by Spanish, although in some communities French and Spanish Creole, Portuguese and Yiddish are dominant. For example, 10% of the population in Mt. Vernon in Westchester is Portuguese speaking. Health literacy challenges, as reported in a survey of 45 providers, are compounded when an individual is not literate in their native language and there is a need for bilingual staff.

***Demographics 3:**
Income levels:

Our region consists of densely populated urban areas contrasted by sparsely populated rural communities with suburban "bedroom" communities in between; numbers of households per county range from a low of 20,000 to more than 340,000. A microcosm of the U.S., our region has pockets of great wealth and pervasive poverty; median household income ranges from $40,000-$93,000. Thirty-percent have public insurance and an estimated 10% are uninsured. In cities across the region, one third of households spend two thirds of their income on housing costs.

The percent of the population with household incomes below the Federal Poverty Level (FPL) by county is: Delaware (14%); Dutchess

Westchester Medical Center (PPS ID:21)

(9%); Orange (11%); Putnam (5%); Rockland (12%); Sullivan (17%); Ulster (12%); Westchester (9%).

***Demographics 4:**

Poverty levels:

The percent of families living in deep poverty (incomes less than $10,000) ranges from 1.5% in Putnam to 4.9% in Sullivan County.

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

***Demographics 5:**

Disability levels:

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

Dual diagnosis of a developmental disability and mental illness represents close to 30% of individuals in New York State (NYS) with the dual diagnosis of autism and medical frailty. A within county look based on discussions with providers suggests that our region reflects similar trends.

***Demographics 6:**

Education levels:

Educational achievement varies, but on average nearly half of the adults in our region have completed high school or college. Men are more likely not to have completed high school. The percent of the population (25 years and older) with less than a high school diploma by county is: Dutchess (10.4%); Orange (11.4%); Putnam (8.0%); Rockland (12.7%); Sullivan (14.1%); Ulster (10.5%); Westchester (13.6%).

***Demographics 7:**

Employment levels:

The range of mean unemployment rates by county is within 5.4% to 6.4%, compared to 5.7% for NYS. Three caveats are worth noting. First, higher unemployment rates in some cities (e.g. Mt. Vernon, Spring Valley, and Kingston) mean that the percent of the population 16 years old and above not in the workforce has averaged 32-40% in the past few years. Second, when considered by race/ethnicity, unemployment rates are on average twice as high for Blacks and Hispanics compared to Whites. Finally, recent gains in employment reflect national trends and roughly one-third of the unemployed are considered long-term unemployed.

***Demographics 8:**

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

Vulnerable populations include individuals who are institutionalized, have been incarcerated or remain homeless.

There are three psychiatric centers in our region that provide comprehensive programs for those who require institutionalized care in the region, including one forensic center; one psychiatric hospital exclusively for children and adolescents; and one for adults 18 and older with serious mental illness.

County jails have a total capacity of 2,500 inmates and there are 12 state correctional facilities in our region. According to a report (2011) by the NYS Office of Probation and Correctional Alternatives, the total number of probationers in the region is 4,853.

Conservative estimates indicate there are 3500 homeless in our region. A housing study is included in our attached CNA report.

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

New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
21_SEC034_B1CommunityProfiles-SESBuiltEnvironment.pdf	12/15/2014 12:54:42 PM	County Community Profiles
21_SEC034_Demographic table_121114.xlsx	12/12/2014 08:55:24 AM	County Demographics Tables
21_SEC034_ADI_120714.docx	12/11/2014 01:51:29 PM	Area Deprivation Index

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:

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

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

SPARCS data indicate that among Medicaid inpatient discharges, the top five conditions are maternal/child, behavioral health, digestive, respiratory, and heart disease.

Age-adjusted preventable hospitalizations were below the 2017 Prevention Agenda objective of 133.3 per 10,000 population, with significant variation in rates ranging from 93.8 (Rockland) to 128.1 (Delaware). Ratios of Black non-Hispanics to White non-Hispanics in Dutchess and Westchester are 2.01 and 2.22, respectively, are significantly higher than the 2017 Prevention Agenda objective of 1.85 for these groups.

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

Based on Medicaid Inpatient Prevention Quality data, the overall composite indicator (PQI #90) for ambulatory sensitive conditions varies considerably across the region. For Sullivan the rate is 617 admissions per 100,000 population; in Orange the rate is 1,764 per 100,000.

Health risk factors are detailed in the Challenges 6 response below. We recognize that there are also social factors that drive health care. We utilized the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage that uses 17 U.S. census indicators and has been linked to hospitalizations and readmission rates. In our region, nearly 37% of the zip codes are above the State average. Using the ADI will provide our PPS with a snapshot of the broader social and environmental risk factors challenging our beneficiaries, help target our resources and inform patient care decisions.

***Challenges 4:**
Disease prevalence such as diabetes, asthma, cardiovascular disease, HIV and STDs, etc.:

Our prevalence estimates are based on SPARCS data (2008-2013). We considered the impact of disease for Medicaid beneficiaries (MBs) using data from the Medicaid Chronic Conditions file (Health.NY.Gov, 2012) and evaluated Prevention Agenda indicators (PA; 2012). Maps and tables are available in our CNA report.

Hospitalization rates for short-term diabetes complications per 10,000 are higher than the regional rate (4.3) in Delaware (4.9), Orange (5.9) and Sullivan (6.2). Large MB counts for those diagnosed with diabetes reside in southern through northwest Westchester and

Westchester Medical Center (PPS ID:21)

western Rockland; Orange; western Dutchess; Kingston in Ulster; and Monticello & Liberty in Sullivan. The wide distribution across the region suggests the need for chronic disease prevention.

Asthma clusters appear in Middletown, Newburgh, Poughkeepsie, Haverstraw, and southern Westchester. From 2012-2013, 7,434 people with asthma visited the ED, and 4,544 visited the ED at least twice. Asthma is the third leading cause of hospitalizations among young children. Clusters suggest a need for targeted asthma management.

Heart attack hospitalization rates per 10,000 were higher than statewide (15.2) in: Delaware (18.6), Orange (18.1) and Sullivan (24.4). Those with congestive heart failure are 80% adults greater than age 45.

Within our region white non-Hispanic women have a higher rate of breast cancer (White; 140/100,000) compared to Black non-Hispanic (Black; 116) but mortality rates are higher for Black women. Cervical cancer incident and mortality rates are twice as high among Black and Hispanic women compared to White. Black adults in the region also have higher incident and mortality rates for colorectal cancer. This data suggest the need to target cancer screening among racial/ethnic minority groups.

Respiratory cancer hospitalization rates reveal hot spots centered in Kingston; a cluster in southern Westchester; and small cluster in Somers. Cigarette smoking among adults is highest in Sullivan, Ulster, Delaware, Dutchess and Orange counties, exceeding PA objective of 15%. Among adults with behavioral health conditions, smoking rates average 32%. There is a clear need to evaluate adult smoking rates and expand programs such as Tobacco Free Action Communities.

Our analyses identified behavioral health (BH) clusters that include significant hot spots in Westchester, Dutchess, Orange, and Ulster. These areas have the largest count of MBs with serious BH disorders; the overwhelming majority of MBs (63-73%) with BH involvement did not have 1 BH outpatient visit within the past 12 months. Hospitalization hot spots appear in these areas as well and suggest that we need to focus on integration of primary care and BH services for this population.

According to NYS DOH, HIV cases have consistently decreased over the last few years. The region has an adjusted rate of 8.6 per 100,000, significantly lower than NYS. Westchester County has the highest rate (11.6). The regional rates for STDs are all significantly lower than NYS overall rates. The region has focused efforts on lowering these rates even further as indicated in county level community health assessments.

***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:

According to NYS Vital Statistics data, there was a decline in the number of women receiving care during the first three months of pregnancy in Orange, Ulster, and Sullivan Counties over a 10 year period. Orange County reported the lowest rate of 54.8% compared to the New York State (NYS) rate of 69.2%. Problematic areas for Births with Late or No Prenatal Care exist in six zip codes in Ulster, seven zip codes in Orange, 14 zip codes in Sullivan and eight zip codes in Westchester compared to NYS.

Compared to NYS, low birth weight rates for the region (live births under 2500 grams) were overall lower with the exception of Sullivan (9.5% vs. 8.1%). However, higher rates than NYS appear in certain zip codes throughout the region, particularly in Delaware, Orange, Putnam, and Westchester.

Infant mortality rates (per 1,000 live births) are lower for Whites than Blacks across the region and in most counties rates are also lower for Whites than Hispanics. Notably, the difference between White and Black rates range from 200-800%.

***Challenges 6:**

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

An analysis of the Prevention Agenda indicates there are 30 health status areas across all counties that are below NYS 2017 Prevention Agenda objectives and are in need of improvement. These include percentage of children with the recommended number of well child visits in government-sponsored insurance programs (the region's rate ranges from 60.8% to 75.1% compared to the 77% objective); adult smoking (smoking rates exceed the objective of 15% in five counties, with a high of 24.5% in Sullivan); and higher rates of adult obesity (24-32% compared to the objective rate of 23%).

Westchester Medical Center (PPS ID:21)

Age-adjusted suicide death rates per 100,000 are reported for all eight counties with rates ranging from 6.3 in Rockland to 17.6 in Delaware compared to the objective rate of 5.9. Putnam County also experiences an excessive amount of adult binge drinking (19.8 versus 18.4).

***Challenges 7:**

Any other challenges:

We analyzed patient volume and disease burden by zip code using data from the Medicaid Chronic Conditions file available through Open Health NY. We categorized disease by: Diabetes, Congestive Heart Failure, Coronary Atherosclerosis, Hypertension, Asthma, Chronic Obstructive Pulmonary Disease and Bronchiectasis, HIV Disease, Bi-Polar Disorder, Bi-Polar Disorder – Severe, Depression, Depressive and Other Psychoses, Depressive Psychosis – Severe, Schizophrenia, Chronic Alcohol Abuse, and Opioid Abuse. For each category we identified the top ten high volume zip codes. We tabulated for all categories how many times individual zip codes were represented; there were nine zip codes that were more frequently represented than all others. They are Mt. Vernon (10550), Yonkers (10701 and 10705), Kingston (12401), Newburgh (12550), Middletown (10940), Poughkeepsie (12601), New Rochelle (10801), and Spring Valley (10977). We combined this information with data from the American Community Survey to identify the broader challenges (e.g. social, economic, demographics) of population health in these communities. All of these areas demonstrate extremely high needs and potential gaps in care.

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**.

Our region has slightly more hospital beds than New York State (NYS) (297 versus 289 beds per 100,000) but the types of beds differ in several notable ways. The region has a higher proportion of physical rehabilitation, psychiatric and chemical dependence beds than the rest of NYS and fewer pediatric, pediatric ICU and general medical surgical beds. These differences are to some extent driven by specialty facilities in the region. In addition, the region lacks certain types of beds altogether such as transitional and swing beds. With 993,934 patient bed days available, and a projected increase of 243,162 days pre-DSRIP, assuming ideal capacity is 85%, increased admissions will not require additional hospital beds. Anticipating the impact of our DSRIP projects, our PPS will realign bed capacity with the expectation that bed utilization will be less than projected as a result of preventing unnecessary hospital admissions through enhanced access and usage of primary care.

The region has a slightly higher rate of nursing home beds compared to NYS (608 vs. 597 per 100,000). Closer examination at the county level reveals that 5 out of the 8 counties have rates lower than NYS: Putnam (322), Orange (380), Delaware (439), Rockland (566) and Sullivan (587). A report conducted by the Hudson Valley Pattern for Progress indicates a shortage of beds by 2040 as opposed to an excess, unless other community based alternatives are made available or we can improve the overall health of our population so that we can more successfully "age in place" and reduce the need for nursing home beds longer term.

Of the nine hot spot zip codes identified by the PPS, seven fall within defined Medically Underserved Areas (MUA) and represent a population of 344,100. These areas are all characterized as Health Professional Shortage Areas (HPSA) for primary medical care. Without changes in healthcare delivery, these areas will remain underserved and at risk.

Health and behavioral service gaps are evident across the region. Our PPS undertook an extensive inventory of the healthcare infrastructure with our partners' and local health departments' support. Partners that provide behavioral health services for the Medicaid population were mapped with health outcome data to aid in our analyses of capacity and location of resources. Results of this informed the need for crisis stabilization and related services across the region, with higher needs evidenced in our hot spots. Focus group responses suggest there are not enough Peer Support programs for patients with mental health and substance abuse issues and that peers need to be integrated into the care delivery and transition model, particularly for those who are transitioning from prison to communities or from homelessness into housing. Other service gaps identified include the need to increase the number of crisis respite beds and lengths of stay beyond 48 hours; establish follow-up procedures to check whether clients fill prescriptions and show up for appointments; increase number of care managers to reduce caseloads; expand hours and days of services to include evenings and

Westchester Medical Center (PPS ID:21)

weekends.

***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.

Causes for gaps in care encompass broader social determinants including higher poverty rates, lower levels of education, and high unemployment. These determinants when considered at a zip code level help us to characterize a neighborhood's risk. We utilized the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage based on 17 U.S. census indicators (refer to Demographics section). For example, within our hot spots, there are higher levels of depression and mood disorders when compared to the rest of our region; these areas all have higher ADIs compared to their county averages. Discussions with community stakeholders and focus group participants indicate that households are disproportionately stressed due to long waits for care; limited transportation options; homelessness; and interaction with providers who are often insensitive to language, cultural and disability-related challenges and needs.

These risk factors may also impact acceptability by community members and perceived quality of services. In a series of facilitated discussions with Medicaid, uninsured and insured consumers, Medicaid and uninsured respondents felt there was a "bias against them" exhibited by doctors who do not accept them into their practice; and when they are, the staff is often rude or they feel their wait times are longer. Some respondents indicated that when given a choice among household expenses, "Food comes first." Most respondents did not have an advocate who could help them navigate the system. Urgent Care centers and emergency rooms become preferred options due to long waits for appointments, and multiple appointments at disparate sites are a challenge due to transportation issues.

Survey responses corroborated the feedback from these discussions. Among Medicaid and uninsured respondents, who represent 31% and 10% respectively of our total (4,777), Medicaid respondents were almost twice as likely and uninsured respondents were 1.2 times as likely to have been to the ED in the past twelve months for care. Among reasons indicated for the visit, 33% of both groups indicated that their doctor's office was not open or their provider instructed them to go to the ED for care; almost 13% of uninsured respondents indicated that there was "no other place to go."

***Gaps 3:**

Identify the strategy and plan to sufficiently address the identified gaps in order to meet the needs of the community. For example, please identify the approach to developing new or expanding current resources or alternatively to repurposing existing resources (e.g. bed reduction) to meet the needs of the community.

In order to create the envisioned Integrated Delivery System (IDS), our PPS will consolidate facilities, reconfigure Emergency Departments (EDs), and enhance primary care service capacity. Within the PPS, two hospitals, Bon Secours Community Hospital (BSCH) and HealthAlliance, have committed to close, convert, and/or consolidate inpatient and acute care capacity.

BSCH proposes to realign its certified bed capacity with the expectation that bed utilization will decrease as a result of preventing unnecessary hospital admissions through enhanced access and usage of primary care. As part of this realignment, BSCH proposes to create a six bed observation unit, which will provide post-stabilization services appropriate for short-term treatments, assessment, and re-assessment of those patients for whom a diagnosis and a determination concerning admission, discharge or transfer can reasonably be expected within 48 hours. Having this unit will allow BSCH to improve the efficiency of the ED, properly triage patients, lessen overcrowding in the ED due to long waits for treatment bays and avoid unnecessary hospital admissions.

BSCH will develop an evidence-based transitional care program to link patients with a primary care provider, support patient self-management of health condition and coordinate and support patient receipt of necessary follow-up care. Linkages with community-based services will be used to help provide the supportive assistance needed to maintain the patient in the community, after any inpatient stay, to support the stabilization of the medical condition and patient confidence in self-management.

Our strategy to expand access to community primary care services and develop integrated care teams to meet the individual needs of higher risk patients region wide consists of leveraging existing Health Home care coordination resources; creating a Regional Quality

Council that will develop standardized protocols; and accelerating adoption of NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation.

Section 3.7 - Stakeholder & Community Engagement:

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

***Community 1:**
Describe, in detail, the stakeholder and community engagement process undertaken in developing the CNA (public engagement strategy/sessions, use of focus groups, social media, website, and consumer interviews).

We partnered with the County Departments of Health and the Departments of Mental Health and Community Services to establish local teams who can identify health care and community-based resources and provide outreach to groups affected by DSRIP. Working with county teams has assured representation from special population groups, other health care participants not part of our PPS, and representatives from critical sectors such as schools and work sites.

We also partnered with the other three PPSs in our region to prepare a single CNA - "One region, One CNA" and have actively collaborated through weekly calls and almost daily sharing of draft findings.

We conducted a survey of our region's residents to gather information and feedback about demographics and community health needs. The survey was drafted at a sixth grade reading level and reviewed and approved by health literacy experts. It is available online - https://www.surveymonkey.com/s/HVDSRIP - and in paper form in five languages prevalent among the region's residents: English, Spanish, Portuguese, French Creole, and Yiddish. As of December 1, 2014, the survey received 4,777 responses; significantly, 25% of these responses are from our nine hot spot zip codes. PPS partners have been placing survey fliers in local grocery stores, pharmacies, and clinics.

Forty-five providers responded to surveys on health information technology (IT) and/or cultural and health literacy including information on (1) any specific challenges that the PPS will need to address to ensure success; (2) potential solutions; and (3) approaches that could address the challenges. We also conducted focus groups as described below.

Our data analysts and CNA team attended more than 60 meetings and webinars to share findings described in the health challenges section. Prevalence maps, workbooks and survey results were shared with all community stakeholders at our website - http://www.crhi-ny.org/ - with an open comment forum available to gather feedback from community members and stakeholders.

Finally, we have kept our PAC and PAC Executive Committee current with monthly updates and shared findings with every DSRIP planning workgroup.

***Community 2:**
Describe the number and types of focus groups that have been conducted.

We conducted seven focus groups with over 60 participants representing over 30 organizations. Topics related to behavioral health were explored and included perceptions of current use of services, suggestions about how to better integrate services, and perceptions of current use of emergency departments (EDs). We conducted a dozen telephone interviews of experts from organizations, including groups like Gateway Community Industries and Hudson Link who work with the homeless and incarcerated or formerly incarcerated members of our communities or with individuals with developmental disabilities. We met with a group of 20 behavioral health providers and related community services in Putnam County. We also conducted three mini-groups of consumers to discuss barriers to access and health behaviors.

A detailed write-up of focus group results is included in our CNA report.

***Community 3:**
Summarize the key findings, insights, and conclusions that were identified through the stakeholder and community engagement process.

New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

Overall findings suggest the need to focus on care transitions, increase involvement of peers, integrate community stakeholders including local law enforcement and advocate for the development of more supportive housing. Consumers indicated a need for expanded primary care access and more information on where services are located within their communities. Several health literacy and cultural competency challenges were indicated including the inability of providers and staff to communicate in patients' native languages and an over-reliance and emphasis on written care documentation (vs. verbal or picture-based instruction).

When providers were asked: "What is the most critical IT capability you feel your organization is missing and requires in order to participate in DSRIP?" they indicated the following: ability to connect to a health information exchange (HIE)/bidirectional exchange of patient data from a regional health information organizations (RHIO); integration of primary care and behavioral health systems; interoperability among electronic health records (EHRs); and access to patient registries.

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

[Westchester Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Catholic Charities Community Services of Orange County, NY	A human service agency providing an array of services including chemical dependency services at several locations as well as a housing resource center.	Substance use treatment is an integral component of health and informs an individual's ability to access care along the continuum of services
2	Center for Tobacco Free Hudson Valley	Working to establish tobacco free outdoor areas and promoting the use of comprehensive strategies to reduce tobacco use and tobacco-related disease	Lowering exposure to tobacco will have a ripple effect on lowering disease & death rates related to respiratory conditions
3	Gateway Community Services	Gateway delivers effective treatment and recovery services to help people suffering from alcoholism, drug addiction, and related mental health issues	Advisement from organizations expert in serving the disabled population will support efforts to prevent ED visits
4	Hudson Link for Higher Education in Prison	This organization provides college education, life skills and re-entry support to incarcerated men and women to help them make a positive impact on their own lives, their families and communities, resulting in lower rates of recidivism, incarceration and poverty	Education on a variety of supportive issues dramatically increases clients' ability to achieve and maintain good health
5	Hudson Valley Cerebral Palsy Assoc.	A not-for-profit, human services org. and advocate that serves individuals with disabilities through their various programs.	Knowledge of specific disabling conditions ensures the development of programs/services to keep client's out of the hospital
6	Human Development Services of Westchester	A social service organization providing psychiatric, rehabilitative, residential, and community stabilization services to the residents of their county in order to achieve self-sufficiency	Managing the array of supportive services for clients' is known to reduce ER use
7	Lexington Center	A community-based service delivery center with several sites and programs serving the underserved population of those affected by substance abuse or chemical dependency	Substance use treatment is an integral component of health and informs an individual's ability to access care along the continuum of services
8	Mental Health Assoc. (in Orange, Rockland, Ulster, and Westchester counties)	A mental health association with a mission to promote positive mental health and emotional well-being through its services, education, and advocacy, including support to victims of sexual assault and other crimes. Intensive care management and housing are also services that are often provided.	Providing supports for the mentally challenged population significantly reduces the need for ED visits and unnecessary hospitalizations
9	Mental Health America of Dutchess	Mental health association promoting mental wellness	Provides an array of services and

Westchester Medical Center (PPS ID:21)

[Westchester Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		through education, programs, advocacy, and community supports. Provides care management for health homes.	supports to a very vulnerable population that needs additional case management.
10	NAMI	Provides support, education, and advocacy for individuals and their families that are affected by mental illness	Families are key to recovery & support for their struggles greatly impacts the success of their recovering family members
11	Nat'l Council on Alcoholism & Other Drug Dependencies	Provides education and support services through programs and resources for individuals dealing with alcoholism and substance abuse	Many of the Medicaid recipients have a dual diagnosis that includes substance use. These services support recovery.
12	Occupations, Inc.	Assists mentally ill and disabled individuals through a variety of programs, services, and providers: case management, employment services, resdiresidential opportunities, intensive psychiatric services, child welfare and emergency services.	A regional community-based rehabilitation agency that fosters the independence necessary for clients' to achieve maximal health reduce reliance on the medical system
13	PARC (Partner.Achieve.Reach.Connect)	One of 55 chapters of NYSARC, Inc. providing advocacy and programs for children and adults with developmental disabilities within their community	Clients and their families benefit from these core organizations that are available in most counties – supports independence in the community
14	People, Inc.	A peer-run not-for-profit that advocates for and provide services to people living with mental illness through various programs	Peer intervention is proven to be one of the most valuable components of a person's ability to recover and access services
15	Putnam Family and Community Services	A private non-profit community based agency providing mental health and chemical dependency services including their PROSper program	Improving behavioral health and supporting families are important determinants to overall health. Core county services such as this reduce reliance on the traditional medical system.
16	Search For Change	Provides rehabilitative services through its various sites for those in their community suffering from mental illness	Affordable housing and vocational services support clients in their recovery and ability to stay out of the ER and inpatient services
17	St. Christopher's Inn	A temporary homeless shelter for men in crisis, this org. provides rehabilitation and health care services through its various providers to facilitate healing on every level	Essential homeless shelters give clients in need a chance to access services more appropriate than the ER and inpatient services
18	Visiting Nurse Services in Westchester	Promotes and supports the health and sustenance of the independence of its residents of the counties they serve	Helping clients live in their own homes reduces the risk of emergency hospitalizations and need for other intensive care
19	Rockland Paramedic Services	A not-for-profit ALS first response service for their community	Provides quality emergency services that minimize the severity of medical emergencies.
20	Westchester Independent Living Center, Inc.	A not-for-profit community based advocacy and training center providing services to individuals with disabilities	Peers are an important part of recovery and ILCs provide help with all aspects of living, learning and earning.
21	Westchester Jewish Community Services	A non-sectarian, state licensed, not-for-profit agency providing services such as home health care and human services through their sites and providers for those in their community dealing with mental health, and developmental disabilities	Improving behavioral health and supporting families are important determinants to overall health. Core county services such as this reduce reliance on the traditional medical system.
22	Caring for the Homeless of Peekskill	Transitional housing, case management, housing placement assistance, service connections to mental	Access to housing is a significant determinant to health. Improving

Westchester Medical Center (PPS ID:21)

[Westchester Medical Center] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		health, employment education	housing access for Medicaid beneficiaries is key to health.
23	Family Service Society of Yonkers	Permanent supportive housing, home care services	Housing is a critical determinant to a client's ability to access other needed services.
24	Community Housing Innovations, Inc.	Emergency, transitional, supportive & rental housing as well as housing advisement	Improving housing access for Medicaid beneficiaries is key to health. They need the stability of a place to stay.
25	Dutchess County Community Action Agency	Nutrition and financial assistance, home energy assistance, case management	Providing an array of supportive assistance helps prevent crises that would otherwise need emergent health resources
26	Dutchess Outreach, Inc.	Emergency assistance, food pantry, soup kitchen	Medicaid and uninsured clients have day to day needs that require immediate assistance to keep them out of more intensive healthcare settings
27	Hope Community Services	Transitional housing, permanent housing, street outreach, soup kitchen, food pantry, community outreach/self-sufficiency program	Addressing immediate daily needs provides an entrée to learn more about the health care needs of this population
28	Larchmont/Mamaroneck Hunger Task Force	Food pantry serving Larchmont and Mamaroneck	Food is a key resource in the daily functioning of our target population
29	Mid-Hudson Addiction Recovery Center	Promotes recovery from alcohol and other chemical dependency issues through various residential services and programs	Residential substance use treatment is an integral component of health and allows time for clients' to learn health skills to keep them out of the ER/hospital
30	Pawling Resource Center	Food bank, medical loan closet, rides to medical appointments	Supports immediate needs and makes healthcare more accessible, a key piece of the PPS strategy
31	St. Peter's Neighborhood Dinner	Soup kitchen, vegetable and fruit distribution	Access to health food improves the ability of our target population to maintain optimal health
32	Children's Village – Sanctuary Program for Runaway,Homeless Youth&Transitional Independent Living	Emergency short term housing and transitional housing, street outreach, short term crisis stabilization for youth 12 to 21 years old	Focus on youth and young adults promotes early recovery skills that they can bring with them into their adulthood and reduce reliance on intensive medical services
33	The Guidance Center of Westchester, Inc.	Housing services (transitional, permanent supportive, supported, SRO), PROS, adult mental health and substance abuse treatment, vocational rehabilitation services	Affordable and stable housing, vocational and mental health services support clients in their recovery and ability to stay out of the ER and inpatient services
34	YMCA of Yonkers	Permanent supportive housing for men; including health education, chronic disease prevention, health and wellness programs.	Access to housing is a signfiicant determinant to health. Improving housing access for Medicaid beneficiaries is key to health.

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

Westchester Medical Center (PPS ID:21)

served by DSRIP projects.

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

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

[Westchester Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Integrated Delivery System (IDS)	Capacity to provide care across the continuum is variable across the region; there are insufficient resources for lower income groups and many higher risk patients do not qualify for care management services. Our IDS will be supported by a Medical Village and Health Home At-Risk Intervention program.	WMC Survey Potentially Avoidable Emergency Room Visits Potentially Avoidable Readmissions PQI/PDI Suite – Composite of all measures – AHRQ NYSOH Office of Performance Measurement and Evaluation. 2012-2014 https://data.ny.gov/Health/County-Mental-Health-Profiles-Beginning-2006/xgig-n5ch
2	Health Home At-Risk Intervention Program	We have identified patients with chronic conditions at risk for developing others who would benefit from care management services. We will expand access to care by leverage existing resources through our IDS.	https://data.ny.gov/Health/County-Mental-Health-Profiles-Beginning-2006/xgig-n5ch Salient Interactive Miner (SIM) Portal
3	Medical Village Using Hospital Infrastructure	Current capacity of hospital beds will more than satisfy minor anticipated growth in demand in the region; there is a growing need for ambulatory services. We will consolidate facilities and reconfigure emergency departments (EDs) to enhance primary care services to support the IDS.	Hospital Profiles - http://profiles.health.ny.gov/measures/view/10781#table-data Potentially Avoidable Emergency Room Visits Potentially Avoidable Readmissions PQI/PDI Suite – Composite of all measures – AHRQ NYS Office of Health (NYSOH), Office of Performance Measurement and Evaluation. 2012-2014 Ambulatory Service Centers, HCR Workbook

Westchester Medical Center (PPS ID:21)

[Westchester Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
4	Care Transitions to Reduce 30 Day Readmissions	Many patients are readmitted to acute care within 30 days; this is particularly true for substance abuse and mental health patients. Our PPS will leverage existing discharge services and identify and stratify high risk patients to coordinate care to prevent unnecessary hospitalizations.	Health Data NY - https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/iqp6-vdi4 NYS Office of Mental Health - PSYCKES
5	Implementation of Patient Activation Activities to Engage UI, LU and NU patients	Our data suggests there are increasing levels of uninsured within the region and a significant number of patients who are low utilizers of key prevention services (e.g. adult with routine check-ups). ED utilization also reveals the need to better activate patients. We will use the Patient Activation Measure (PAM) instruments as part of our outreach strategy.	WMC PPS Primary Data Collection – Survey, preliminary findings American Community Survey (ACS) Salient Interactive Miner (SIM) Portal Prevention Agenda - https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch
6	Integration of Primary Care and Behavioral Health Services	Behavioral Health disease is prevalent within the region; medical and behavioral health preventable readmissions and ED visits are significant in this group.	NYS Office of Mental Health – PSYCKES OMH – Patient Characteristics Survey (PCS) - https://my.omh.ny.gov/webcenter/faces/pcs/summary?wc.contextURL=/spaces/pcs&_adf.ctrl-state=x10h3v7xc_4&wc.contextURL=%2Fspaces%2Fpcs&wc.originURL=%2Fspaces%2Fpcs&_afrLoop=53945824538774 HANYS, SPARCS
7	Behavioral Health Community Crisis Stabilization Services	Annual ED visits are higher for behavioral health patients as are extended hospitalizations due to insufficient care alternatives within the community (e.g. mobile crisis outreach, peer supports). By filling service gaps and coordinating care we can reduce these unnecessary hospital visits.	WMC PPS Primary Data Collection – Focus groups OMH – Patient Characteristics Survey NYS OMH – PSYCKES WMC PPS Community Based Resources (CBO)Workbook & Health Care Resources (HCR)Workbook Health Data NY - https://health.data.ny.gov/browse?limitTo=datasets

Westchester Medical Center (PPS ID:21)

[Westchester Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			&utf8=%E2%9C%93&view_type=rich
8	Evidence-based Strategies to Address Diabetes	Data suggest high rates of diabetes especially among higher risk patients in the region. Community survey results indicate that 58% of respondents consider diabetes to be a top five health issue in their community; few respondents reported accessing nutrition or weight loss programs and less than half reported accessing diabetes testing services within the past 12 months. We will partner with Health Homes to serve as anchors for our PPS care coordination efforts.	WMC PPS– Survey, NYS OMH – PSYCKES Health Data NY- https://health.data.ny.gov/Health/Medicaid-Delivery-System-Reform-Incentive-Payment-/e2qd-mx59 OMH – Patient Characteristics Survey (PCS) https://my.omh.ny.gov/webcenter/
9	Evidence-based Medicine Guidelines for Asthma Management	When asthma and chronic obstructive pulmonary disease (COPD) are examined large numbers of hospitalizations are evident as are ED visits, especially among children within certain areas of the region. We will leverage existing work done by the Hudson Valley Asthma Coalition to expand community based programs, including those located within schools.	Health Data NY- https://health.data.ny.gov/Health/Medicaid-Delivery-System-Reform-Incentive-Payment-/e2qd-mx59 SPARCS Prevention Agenda - https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch
10	Promote Tobacco Use Cessation Among Low Socioeconomic Status (SES) and Mental Health Populations	There are high volumes of COPD/Bronchiectasis prevalent throughout the region with clusters of respiratory cancer hospitalization rates. Five counties have much higher adult tobacco use compared to the 2017 Prevention Agenda; adults with behavioral health conditions average smoking rates of 32%. We will leverage practices used in FQHCs to institute a tobacco treatment policy and protocol within the PPS.	SPARCS Prevention Agenda - https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch OMH – Patient Characteristics Survey (PCS) - https://my.omh.ny.gov/webcenter/
11	Increase Access to Chronic Disease Preventive Care and Management for Cancer	Low cancer screening rates are evident in the northern region of the PPS for breast cancer, cervical and colorectal. Respiratory cancer hospitalization rates suggest a need for lung cancer screening. We will partner with programs funded by the NYS DOH Cancer Services Program within the region.	Prevention Agenda - https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch

Westchester Medical Center (PPS ID:21)

[Westchester Medical Center] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			Health Data NY- https://health.data.ny.gov/Health/Medicaid-Delivery-System-Reform-Incentive-Payment-/e2qd-mx59
12	Transitional Supportive Housing	There are over 3,500 homeless in the region. Despite the recognized need, our PPS chose not to undertake this project since DSRIP guidelines prohibit the use of funds for new housing. Focus group participants indicate that housing and services that help people stay in their homes are critical supports for vulnerable populations including the disabled and those with behavioral health and substance abuse challenges. Our PPS will address these services where housing already exists and within our IDS.	WMC PPS Primary Data Collection – Focus groups, preliminary findings WMC PPS consultant findings, provider discussions Health Data NY - https://health.data.ny.gov/
13	Evidence-based Strategies to Address Cardiovascular Health	Cardiovascular disease (CVD) inpatient and CVD-related ER visits are significant in several parts of the region and is a leading cause of death. However among minority populations diabetes is as significant a concern. Our PPS chose Diabetes as a focus area over CVD. However, areas with large number of CVD beneficiaries are consistent with higher adult smoking rates and HTN. Our PPS will address these concerns through our Tobacco Cessation effort. Our two Medical Villages will target high need CVD areas in Orange and Ulster counties.	WMC PPS Primary Data Collection – Focus groups, preliminary findings WMC PPS consultant findings, provider discussions Health Data NY - https://health.data.ny.gov/
14	Increase Support for Maternal Child Health (MCH) and High Risk Pregnancies	The general area of western Orange and southern Sullivan revealed elevated risk for both pre-term and low birth weight births, which was also consistent with higher risk for late or no prenatal care. Lower Westchester also revealed consistent elevated risk for these same outcomes, particularly in Yonkers and Mount Vernon. Orange County has low rates of children with immunization series. However, our PPS could not select this project because our "gap to goal" for improvement on metrics is not wide enough. We are committed to providing MCH services through our IDS.	NYS Vital Statistics Prevention Agenda - https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ch

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
21_SEC038_GCommunityBasedOrganizationsWorkbook.pdf	12/16/2014 11:55:01 AM	Community-Based Organizations Workbook
21_SEC038_F_Health Care Resources_121014.xlsx	12/16/2014 11:52:53 AM	Healthcare Resources Workbook
21_SEC038_ECommunityProfiles_IncludingHealthOutc	12/16/2014 06:28:30 AM	Hotspots - 9 ZIPS community profiles

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

File Name	Upload Date	Description
ome.pdf		
21_SEC038_D3CRHI-Community-Needs-Assessment-Lower-Hudson-Valley-Seven-County-Disease-Prevalence-Clusters.pdf	12/16/2014 06:24:44 AM	Disease Prevalence Clusters - Map
21_SEC038_D2Bene_Summary_Tables_COUNTY_and_ZIP_PLUS_CANCERS_100214.pdf	12/16/2014 06:23:30 AM	Medicaid Beneficiaries Summary Tables
21_SEC038_D1Mapping Methodology for Medicaid Beneficiaries for Selected MDC_EDC VolByZip.pdf	12/16/2014 06:21:56 AM	Medicaid Beneficiaries mapping methodology
21_SEC038_CPrevalence Rate Mapping Methodology_SatScan Statistic.pdf	12/16/2014 06:20:55 AM	Prevalence rate mapping methodology
21_SEC038_B2HousingStudy.pdf	12/16/2014 06:18:22 AM	Housing Study
21_SEC038_B1CommunityProfiles-SESBuiltEnvironment.pdf	12/16/2014 06:16:27 AM	8 County Community Profiles
21_SEC038_A4HIT_HIE SurveyofCapabilities_InstrumentandResults.pdf	12/16/2014 06:15:26 AM	HIT and HIE - Instruments and Results
21_SEC038_A3DSRIP Organization Input Sheet_FINAL_CulturalCompetency.pdf	12/16/2014 06:14:36 AM	Cultural Competency
21_SEC038_A2CommunitySurvey_InstrumentandResults.PDF	12/16/2014 06:13:40 AM	Community Survey_ Instrument and Results
21_SEC038_A1Focus Groups_Recruitment ProcessGuidesandResults.pdf	12/16/2014 06:12:36 AM	Focus Groups Process and Results
21_SEC038_A_ONE REGION_FULL CNA REPORT_FINAL_120914.pdf	12/16/2014 06:11:55 AM	CNA Report

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

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: **Westchester_Section4_Text_Westchester DSRIP Project Plan Application_Section 4 Part I.docx**

Description of File

Westchester Medical Center PPS Project Plan Application Section 4 Part I

File Uploaded By: lk494126

File Uploaded On: 12/21/2014 05:54 PM

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

Currently Uploaded File: **Westchester_Section4_ScopeAndScale_DSRIP Project Plan Applications _ Scale Speed only _ WMC_Dec 21 version.xlsx**

Description of File

WMC PPS preliminary SpeedScale using Dec. 4 file; all numbers are draft and subject to change.

File Uploaded By: lk494126

File Uploaded On: 12/21/2014 04:16 PM

Westchester Medical Center (PPS ID:21)

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 care delivery and payment transformation envisioned by our PPS will have a significant impact on the approximately 43,749 health care employees in our PPS and the 115,910 health care employees across the region.

Our two Medical Village projects, which will promote clinical integration by reducing, reconfiguring, and repurposing two hospital facilities, will have the most immediate impact on staffing and will result in a net increase in positions at Bon Secours Community Hospital and a reduction of jobs at HealthAlliance. Our Domain 2 projects (which focus on system-wide transformation objectives, expanded Health Home services, reduction of 30 day readmissions, and patient activation) and our Domain 3 and 4 projects (which target chronic diseases)

emphasize ambulatory and preventive care. Collectively, our 11 projects will increase demand for primary care providers (PCPs), nurse practitioners (NPs), physician assistants (PAs), case managers, care coordinators and managers, care navigators, social workers, home health workers, nutritionists, and health information technology (IT) staff. We also anticipate that our two behavioral health projects will increase demand for mental and behavioral health providers such as psychiatrists, therapists, social workers and crisis intervention specialists.

A survey of 42 organizations across our PPS regarding anticipated workforce impacts revealed that PPS participants expect employment to increase across the entire health sector, with larger increases for case managers and community health workers.

Our emphasis on preventive care and behavioral health may exacerbate regional recruitment and retention challenges. With respect to recruitment and retention, a 2014 study found that our region's hospitals had difficulty recruiting and retaining care coordinators and nurse managers. The study also found that FQHCs in our region had difficulty recruiting substance abuse counselors, psychiatrists, and family/general practice physicians and retaining psychologists, substance abuse counselors, and community health workers.

Demographic changes within the region will also influence staffing patterns. Due to an aging population (an increase in those 65+ from 13.8% to 18.8% in 2020) and a growing minority population (since 2000, Hispanic and Asian population growth has been over 60%), demand for health care staff trained to care for an aging population and diversified group of patients is already a reality. The majority of our survey respondents indicated a need for bilingual staff. Similarly, in a series of focus groups with providers and community members, participants echoed the concerns that staff were not always able to communicate with patients due to language differences; in a number of our sessions, cultural competency on the part of staff was also raised.

To enhance and sustain patient-provider trust, our recruitment and retraining efforts will focus on local residents, particularly those in incumbent administrative or ancillary healthcare positions. We will create career pathways with portable, stackable credentials and progressive steps from entry-level jobs to in-demand occupations. For example, hospital food service, transportation, and clerical staff could acquire skills to serve as patient navigators and, with increased experience and training, become care coordinators and care managers.

Owing to our plans to increase the availability and utilization of population health management systems, certified electronic health record (EHR) technology, and health information exchange, we anticipate the need for hiring and training of process redesign experts, data analysts and statisticians, and programmers, technicians, and support for health IT and telemedicine systems.

***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.

To implement our DSRIP projects, we need a workforce that can meet an anticipated increased demand for primary care providers, home health aides, personal care aides, nurses, care coordinators, care navigators, and professionals working in occupations that extend patients' ability to remain in non-institutionalized settings. To minimize the impact of new skill requirements and shifting locations of care delivery, we will employ staff with workforce strategy experience, hire a proven workforce development organization, and leverage our Workforce Workgroup.

Our PPS has hired staff with extensive experience and skill in health care workforce policy, training, and redeployment efforts. Barbara Hill, Senior Manager, Program and Network Relations, has worked at 11199 SEIU at their Training and Employment Funds (TEF) and the Center for Health Workforce Studies, School of Public Health, SUNY Albany, as a consultant. She has also served on the board of the Catskill Hudson AHEC for 5 years. Ms. Hill will lead a CRHI team that will develop, publish, and periodically update a 5 year "Workforce Strategy and Roadmap" on behalf of our PPS; collect and update information on available positions; provide a centralized IT system to support rapid placement of candidates into training programs and available positions; maintain an inventory of position descriptions, recruitment materials, and position postings; and support the Workforce Workgroup.

We will also retain 1199 TEF as the lead workforce development provider. Using their expertise, we will identify and retrain at-risk workers for new and emerging positions; provide training to incumbent workers who need additional skills for existing jobs; and develop and

Westchester Medical Center (PPS ID:21)

provide training for new occupations. TEF will screen and contract with the most suitable educational vendors to deliver high quality, cost-effective training. TEF partners with the City University of NY to deliver training programs for college credit and for certificate programs that meet industry needs.

In order to address the workforce implications of DSRIP, our PPS created a Workforce Workgroup consisting of labor representatives, health care organizations, and workforce training organizations. The Workforce Workgroup, with the support of dedicated staff at the PPS, leads ongoing efforts to monitor, assess, develop options, and deliver implementation approaches in concert with workforce stakeholders to make retraining, redeployment, recruitment and hiring activities a high priority and as effective and efficient as possible. The Workforce Workgroup held its first meeting in November 2014 and anticipates meeting monthly in 2015 and quarterly thereafter.

An estimate of health care employment changes in the region between 2010 and 2020 forecasts the highest net changes in home health aides (increasing 42% from 12,660 to 18,060), personal care aides (increasing 50% from 8,940 to 13,420), and registered nurses (increasing 15% from 19,760 to 22,780). Physician and surgeons jobs are expected to grow by 18% from 6,270 to 7,390. These forecasts are misleading since our region currently has a lower rate of employment (6,409 per 100,000 population) for all health care sectors than statewide (6,537).

We are also experiencing shortages despite forecasted growth. A 2010 SUNY study concluded that the region was experiencing a shortage of doctors, particularly in primary care. The PPS' Workforce Workgroup, described in greater detail below, also identified a significant shortage of primary care providers in the region. Other studies have found shortages in particular specialties such as behavioral health and psychiatry. Combined with the recruitment and retention issues noted above, the physician and behavioral health specialist shortages could impede our ability to deliver prevention and primary care services, particularly in key "hot spots."

***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	3.9%
Retrain	72.8%
New Hire	15.6%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

Our PPS is fully committed to ensure that training is available and accessible for all workers who need new skills to meet DSRIP goals and the needs and requirements of our projects. Through our training efforts, employees will be equipped with the skills needed to maintain and grow in their jobs and provide high quality, patient centered care.

To identify, assess, and minimize the negative workforce impacts stemming from the implementation of our DSRIP projects, our PPS created a Workforce Workgroup consisting of union representatives, healthcare organizations, and workforce training organizations. The Workgroup leads a concerted and ongoing effort to monitor, evaluate, develop options, and deliver implementation approaches with workforce stakeholders to make retraining, redeployment, recruitment and hiring activities as effective and efficient as possible.

Westchester Medical Center (PPS ID:21)

The Workforce Workgroup held its first meeting in November 2014 and will continue meeting monthly through DY 1 and quarterly thereafter. With respect to retraining, the Workgroup will identify existing training efforts and lessons learned from local, regional, and national programs and provide recommendations on roles, responsibilities, program development, and communication strategies for curricula development and training programs.

Although our PPS Participants will retain ultimate authority regarding training decisions, we will encourage all participants to offer retraining on a voluntary basis.

The PPS will work with regional coordination efforts to identify workforce needs and then train and recruit talent to fill those needs. We will collaborate with our training partners including our lead workforce development provider (1199 SEIU), New York Medical College, local community colleges, residency and fellowship programs, the regional education systems. Our work will be undertaken in concert with public health agencies, Workforce Investment Boards in the region, and with the guidance of NY State Dept of Labor. We will seek multiple levels of training with portable, stackable credentials that provide progressive steps along the path from entry-level jobs to occupations in high demand.

Recognizing that many small to mid-sized providers lack the HR resources to support training on their own, CRHI will provide a centralized workforce capability that includes: the collection of available positions; staff to facilitate rapid placement of candidates into training programs; maintenance of an inventory of position descriptions, recruitment materials, and position postings; and communication and marketing services.

To implement "just-in-time" training, we will extend existing high quality training programs across the PPS region. Our training program will utilize Internet-based and alternative media learning modules and employ evidence-based adult learning methods. We are arranging programs to accelerate training of nurses, PAs, NPs, and technicians with local community colleges, universities and technical schools (e.g., Dominican College, Mount Saint Mary's, SUNY system, BOCES, etc). To ease learning for non-English speakers and meet the needs of our culturally and linguistically diverse workforce, we will seek customized training content that is translated and delivered in multiple languages via a linguistically diverse training team.

Our lead workforce development provider, 1199SEIU TEF will screen and contract with the most suitable educational vendors to deliver high quality training. Training will be conducted by expert clinical staff, experienced educators in adult learning theory, and organizational development experts. In addition, TEF uses the City University of NY wherever possible to deliver training programs that offer college credit or where high quality workforce and certificate programs meet industry needs.

***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.

Our PPS will strive to ensure that the workforce has the skills and salaries to provide high quality care that improves patient outcomes. Over time, the skill mix will change. While we seek to minimize the impact on the existing workforce, we anticipate a higher demand for staff in the ambulatory setting. Pay scales are historically different in ambulatory settings compared to acute care facilities. We will work with HR teams to determine current salary bands and future salary bands that result from retraining and certification within the strictures of partners' existing employee contracts. We also anticipate opportunities for skill enhancement, specialization and career growth as a result of training and new career paths.

We will benchmark salary bands/overall benefits. Before individuals are offered retraining, PPS partners will be expected to prepare position packets with a detailed comparison of current and target positions, including location, salary, benefits, role, responsibility, and training. We will ensure that retraining opportunities are incorporated into existing career tracks and that employees have a clear understanding of promotion potential and career trajectory.

***Retraining 3:**

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

Although our PPS participants will retain ultimate authority for decisions regarding staff who refuse retraining assignments, our PPS will encourage all participating organizations to adopt a standard policy whereby those who refuse retraining will have a prescribed amount of time to find alternative positions subject to existing contractual agreements.

Westchester Medical Center (PPS ID:21)

***Retraining 4:**

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

The Workforce Workgroup, which will provide the planning, development, and deployment of the retraining plan, is co-chaired by a labor representatives from 1199SEIU and includes representatives from multiple labor organizations (CSEA and NYS Nurses Association). We will also retain the 1199SEIU Training and Employment Funds (TEF) as the lead workforce development provider.

Further, regional labor organizations that are participating in our PPS are able to name a senior level executive representative to our PPS Project Advisory Council (PAC) and the PAC Planning Executive Committee includes a labor representative member, currently from the Civil Service Employees Association (CSEA). This ensures input from labor organizations partnering with providers in our region in our PPS' broader governance and priority-setting discussions related to DSRIP implementation decisions.

***Retraining 5:**

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

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	45%
Partial Placement	25%

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.

Our PPS is committed to ensuring that the region has a workforce with the skills needed to achieve the DSRIP vision and objectives. A critical element of our strategy is the effective, appropriate, and rapid redeployment of personnel into the vacancies and new positions that will be created as result of the healthcare transformation.

Because of the complexity and sensitivity of workforce redeployment, the PPS has hired staff with extensive experience and skills in healthcare workforce policy, training, and redeployment efforts. Barbara Hill, Senior Manager, Program & Network Relations. Ms. Hill has worked at 11199SEIU at the TEF and the Center for Health Workforce Studies, School of Public Health, SUNY Albany as a consultant. She has also served on the board of the Catskill Hudson AHEC for five years. Ms. Hill will lead a dedicated CRHI team that will develop, publish, and periodically update a five year Workforce Strategy and Roadmap (WSR), collect available positions; provide a centralized IT system to support rapid placement of candidates into training programs and available positions; maintain an inventory of position descriptions, recruitment materials, and position postings.

The PPS will be supported by a Workforce Workgroup which began holding meetings in November 2014 and will continue to meet monthly through DY1 and quarterly thereafter. The Workgroup supports the development of the workforce components needed to build and sustain an integrated, collaborative, and accountable health delivery system. With respect to redeployment efforts, the Workgroup will identify existing development, training, and redeployment efforts and lessons learned from local, regional, and national efforts and provide recommendations on roles, responsibilities, program development, and communication strategies for workforce recruitment, curricula development, training programs, hiring approaches, redeploying, and reductions.

We will also engage a workforce consultant to review and update the WSR and assess organizations' performance to their targets. The review will ensure that the existing workforce assessment is up-to-date, uses relevant information, and serves as a tool for planning and staff engagement. The strategy will be reviewed bi-annually by the Workforce Workgroup.

CRHI will work with PPS participants to identify areas where staff need to be added or redeployed. Subject to collective bargaining or civil service requirements, PPS participants will provide employment forecasts, departments with excess staff, and list of individuals, their shift,

Westchester Medical Center (PPS ID:21)

skill set, job title, and protected class status.

The PPS will retain a lead workforce development provider (1199SEIU TEF's redeployment) and leverage its redeployment experience. Our redeployment approach will: identify workers least likely to obtain jobs without retraining, provide individual assessments; offer a range of services including counseling/case management, and transitional services; provide counseling to deal with the stress, anger, fear and often denial of the dislocation; and deliver resume development and interviewing skills.

Workers identified or designated for redeployment will be offered training opportunities for job categories that we forecast will be in high demand, e.g., community health workers, outreach workers and medical assistants. Based on our experience with health transformation efforts, we have learned that entry level workers, such as food service, transport, and housekeeping, often have expertise needed in new and emerging jobs, such as bilingual skills and knowledge of communities with targeted for DSRIP services.

***Redeployment 2:**

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

Every effort will be made to keep employees "whole." We will coordinate the redeployment process across all PPS Participants, as well as labor representatives, to understand and document the impact of redeployment on staff compensation and benefits.

We will work with HR and function leads to determine who could potentially be redeployed and the support that needs to be provided to these staff. Details will be developed during DY 1, but before an individual is offered or selected for redeployment, our intention is that HR will prepare a position packet with a detailed comparison between the current position and the future position, including location salary, benefits, role, responsibility, and training requirements and duration.

***Redeployment 3:**

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

Although PPS Participants will retain ultimate authority for decisions regarding staff who refuse redeployment assignment, we will encourage all participating organizations to adopt a standard policy whereby those who are designated for redeployment are entered into a redeployment pool and will have a prescribed amount of time to find a position subject to existing contractual agreements.

***Redeployment 4:**

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

The Workforce Workgroup, which will provide the planning, development, and deployment of the redeployment plan, is co-chaired by a labor representatives from 1199SEIU and includes representatives from multiple labor organizations (e.g., the CSEA and NYS Nurses Association). Our PPS will retain a lead workforce development provider (1199SEIU TEF) and leverage its redeployment experience.

Further, regional labor organizations that are participating in our PPS are able to name a senior level executive representative to our PPS Project Advisory Council (PAC) and the PAC Planning Executive Committee includes a labor representative member, currently from the CSEA. This ensures input from the labor organizations partnering with providers in our region in our PPS's broader governance and priority-setting discussions related to DSRIP implementation decisions.

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.

Westchester Medical Center (PPS ID:21)

The DSRIP-driven changes, combined with an aging population, will create demand for primary care providers (PCPs), home health and personal care aides, nurses, care coordinators and navigators, and occupations that extend patients' ability to remain in non-institutionalized settings. Provided below are categories of positions and their anticipated roles in our DSRIP projects:

MD, DO, PCPs: To expand primary care services for patients in emergency departments and in the community

Specialties e.g., Pediatricians, OB/GYN, Oncologists, Surgeons, Podiatrists: To meet the needs of patients in clinics, multi-specialty clinics, as well as outpatient surgery centers

Care coordinators: To support patients effectively navigate the various services that are appropriate for their needs. These will be particularly important for patients with multiple and chronic needs. In addition, they will follow up for particular patient groups and will collaborate to identify and engage with low/non-utilizers

Population Health Management experts: To develop, manage, and monitor the creation of an integrated delivery system (IDS)

Human Resources (HR) professionals: To support all of the facilities, department, managers, and staff to effectively redistribute human resources required to implement DSRIP project objectives

Case managers: To identify and manage the appropriate length of stay from the emergency department to discharge to the outpatient location or home settings

Social workers: To increase the guidance and assistance to patients and their families before and after inpatient admission

Home health workers: To provide enhanced assistance to patients in their home and decrease unnecessary admissions and re-admissions

Allied Health professionals: To staff rehabilitation locations and support appropriate care in preparation for patients to be discharged from inpatient facilities

Nutritionist: To provide nutrition training and support for healthy diets and behaviors

Financial counseling staff: To assist patients obtain appropriate financial information and qualification for Medicaid

Paramedics and Emergency technicians: Early intervention with emergency patients to reduce the time to treat and unnecessary admissions that result from delays in ED

Translators/foreign language speakers: To assist healthcare communication, navigation, diagnosis, chronic disease counseling, etc.

RN/NA: To staff expanded primary care services

Physician Assistants, Nurse Practitioners & Family Nurse Practitioners: To staff clinics, multi-specialty clinics, EDs, as well as post-acute care

Communications/marketing professionals: To support the development and delivery of messages regarding the changes to regional healthcare delivery

Managers/Supervisors: To lead in new or redesigned departments, clinics/facilities, or functions

Ambulatory Care practice managers: To manage new or redesigned clinics, multi-specialty clinics, outpatient programs, and post-acute care

Mental health specialists, psychologists, MD psychiatrists: To provide expanded Mental Health services

Westchester Medical Center (PPS ID:21)

Process redesign experts: To work with departments/units to design/redesign the workflow, processes, procedures to assure efficient/effective delivery of healthcare

Data analysts and statisticians: To provide data collection, analysis, reporting, and monitoring to meet the needs of evidence based medicine, performance management, and DSRIP projects

Health information technology programmers and support: To support implementation and management of health IT systems

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	27
Physician	12
Mental Health Providers Case Managers	75
Social Workers	38
IT Staff	25
Nurse Practitioners	30
Other	146

Section 5.5 - Workforce Strategy Budget:

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

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	1,433,250	1,433,250	1,433,250	1,433,250	1,433,250	7,166,250
Redeployment	118,125	118,125	118,125	59,063	59,062	472,500
Recruiting	47,250	47,250	47,250	47,250	47,250	236,250
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.

Based on our implementation of 11 DSRIP projects, we forecast the need to retrain approximately 38,172 inpatient and outpatient staff and anticipate that 80% of healthcare job openings will be filled via redeployment opportunities and the remaining 20% via new hires.

State and federal programs that support training, education, and recruitment for healthcare workers will be leveraged through our PPS grants and funding team, led by Deborah Viola, PhD, that will develop applications for funding. Dr. Viola has 20 years of experience developing proposals for federal and New York State (NYS) health care programs.

We will work with the NYS Workforce Investment Board and other State and federal entities to assist in the implementation of our workforce strategy. The Doctors Across NY (DANY) website indicates that DANY is not currently accepting applications. We will monitor DANY, NY Primary Care Service Corp, the Health Workforce Retraining Initiative, and other programs for new rounds of funding. We will apply for NYS Department of Labor Dislocated Labor Training /National Emergency Grant as new funding rounds become available. In

Westchester Medical Center (PPS ID:21)

addition, we will participate in NYS Shared Work Program and pursue funds from the NYS Health Promotion Funds.

To assist physicians cover their education costs in return for working in our underserved areas in the western and northern rural regions, we will support applications to the National Health Service Corps. We are working with the Catskill Hudson and the Bronx-Westchester Area Health Education Centers (AHECs) to utilize their pipeline for prospective medical students and clinical trainees who are willing to work in the diverse rural and underserved areas in our PPS. These AHECs also provide cultural competency training to existing healthcare workers. We will also use the Center for Health Workforce Studies, SUNY Albany's NY Health Careers website to identify opportunities to retrain and place workers.

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.

To engage key stakeholders in the development of our workforce strategy, we created a Workforce Workgroup consisting of union representatives (1199SEIU, the CSEA, and the NYS Nurses Association), healthcare organizations, and workforce training organizations. The Workforce Workgroup monitors, assesses, develops options, and delivers implementation approaches. The Workgroup held its inaugural meeting in November 2014 and will continue to meet monthly at various locations throughout the region to receive local input through DY 1 and quarterly thereafter.

Our engagement strategy also includes the collection of data from key stakeholders. In October 2014, we released a survey to our PPS Participants assessing PPS projects' impact on retraining, redeployment, and new hiring. Via town hall meetings with and targeted surveys, our PPS will solicit public input to inform our Workforce Strategy and Roadmap.

***Engagement 2:**
Identify which labor groups or worker representatives, where applicable, have been consulted in the planning and development of the PPS approach.

Our planning and development process included the following labor and worker representatives:

•Maria Kercado, 1199SEIU Vice President
•Bonnie Reyna, 1199SEIU
•Cynthia Wolf, 1199SEIU Vice President
•Roger King, Westchester Medical Center Civil Services Employee Association representative
•Donna Hemmer, Nurse Manager, Westchester Medical Center Trauma ICU and New York State Nurses Association representative

***Engagement 3:**
Outline how the PPS has engaged and will continue to engage frontline workers in the planning and implementation of system change.

Our Workforce Workgroup has and will continue to include frontline workers in its deliberations and planning processes. Workgroup meetings will be open to the public and will continue to meet monthly at various locations throughout the region to receive local input through DY1 and quarterly thereafter. Via town hall meetings with and targeted surveys to frontline workers, our PPS will solicit public input to help with the annual updates for the five year Workforce Strategy and Roadmap.

***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.

Our Workforce Workgroup has and will continue to include stakeholders and workers in its deliberations and planning processes. Workgroup meetings will be open to the public and will occur monthly through DY 1 and quarterly thereafter. To maximize opportunities for stakeholder participation, we will hold Workgroup meetings in locations across the region.

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

The Workforce Workgroup has identified and documented workforce needs, opportunities, risks, barriers and potential solutions. Key obstacles and solutions included the following:

1. To address persistent provider gaps in rural areas, our PPS will develop and deploy aggressive recruitment and retention programs.
2. To correct any shortfalls in training programs, funding needs will be identified, prioritized, and addressed through a collective governance process that allocates PPS funds.
3. To ensure training programs meet the evolving DSRIP-driven staffing needs, our PPS will monitor employment needs and forecasts on an annual basis.

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.

Westchester Medical Center (PPS ID:21)

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.

An essential component of achieving DSRIP goals is the appropriate sharing of patient information. Our PPS will foster clinical collaboration and data sharing to the greatest extent possible while carefully adhering to federal and state laws that protect privacy.

Our PPS' experience with data sharing in the RHIO context will guide our approach. Our participants have served on the Taconic Health Information Network and Community (THINC) RHIO's board and the CEO of THINC serves on our Executive Committee. These relationships provide critical background for ensuring privacy of patient information while promoting health information exchange (HIE). We note that THINC RHIO is merging with Southern Tier Healthlink (STHL) to serve 11 counties as HealthlinkNY. This merger will bring additional functionality and experience to our region, including a robust HIE network. Our PPS will engage HealthlinkNY to support provider and patient outreach the benefits of RHIO connectivity.

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

As a condition of joining our PPS, each Participant will sign a data sharing agreement that requires adherence to federal and state privacy requirements, including requirements that: Data only be used for permitted uses under HIPAA; PPS patients have consented to the disclosure of their information; Certain alcohol/ drug abuse information is only exchanged in accordance with 42 CFR Part 2; and Data storage complies with HIPAA security standards. Our PPS will establish a formal program for data sharing compliance including a consent management standard and will provide privacy-law trainings, monitor Participant compliance, and require corrective actions when necessary. The PPS will implement an IT system that allows for tracking of patient consent to ensure privacy law compliance. The PPS will work with the local RHIO to provide oversight of patient consent tracking and management, including an annual audit conducted by the RHIO to ensure compliance with established procedures.

***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.

Westchester Medical Center (PPS ID:21)

Our PPS plans to make THINC/HealthlinkNY the central platform for sharing patient information, as well as leverage the RHIO's capabilities to establish direct connections where appropriate. RHIO access and direct connections will allow any provider to contribute and/or transmit patient information directly with another providing patient care. Providers with EHRs technically capable of interfaces and direct connections will be called upon to establish this functionality as soon as feasible; in fact, these connections are currently under way. Providers with limited EHR functionality or no EHR at all will be engaged by the PPS and the RHIO to establish direct connections that enable them to securely transmit information for patient care and utilize the RHIO's provider portal to access the community-wide centralized record. The PPS will support provider's efforts to connect to the RHIO to ensure they satisfy important patient centered medical home (PCMH) and meaningful use project requirements. Note that any access to the RHIO will strictly adhere to State and Federal privacy and consent requirements. Our PPS will provide guidance and assistance to participants in order to foster this exchange of information. We will identify specific data elements which are required to be shared by each PPS participant to support DSRIP projects. Our PPS will provide assistance to participants in selecting EHR vendors to ensure that standards related to these specific data elements and interoperability are met. Our PPS will also provide trainings to participants on how to use the RHIO and how to use both clinical and claims data to improve patient care, as necessary.

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.

CRHI, the PPS central services organization, has established a health services research and data analytics unit to collect and analyze population, patient, provider, and PPS Participant-level data. The unit will be responsible for processing, benchmarking, developing dashboards and comparative profiling reports, and conducting root cause analyses for programmatic, project, and clinical intervention successes and failures. The Director of Health Services Research and Data Analytics, Dr. Deborah Viola, a healthcare economist and former associate professor of Public Health at New York Medical College, will, with CRHI's executive leadership, oversee these efforts. The CRHI analytics team will regularly brief the PAC Executive Committee, Committees and Hub Boards on PPS performance, issues, and recommendations. The staff will also interface directly with WMC leadership should performance concerns be identified that may impact the PPS' receipt of DSRIP incentive payments.

CRHI's analytics unit will work with PPS and Hub leadership, including the Regional Clinical Council and Quality Committee, to define performance metrics, and implement a continuous reporting and evaluation process.

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

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

Our PPS will bring together clinical, demographic and social data with evidence-based care protocols and pathways to allow us to develop algorithms and predictive modeling to understand to what extent our interventions address gaps in care; more effectively engage patients; and improve health outcomes. Our PPS will acquire patient data in compliance with privacy and consent guidelines from multiple sources, including beneficiary survey, assessments by care managers, clinical data from partner provider EHRs, local RHIO/SHINY notifications and care summaries, and claims data from NYS or Medicaid Managed Care Organizations. We will develop quality improvement processes and assessments to consider these data at a person, provider and population level to enable outreach to individual beneficiaries, send feedback to providers on performance/underperformance and to continuously identify hot spots in need of greater

Westchester Medical Center (PPS ID:21)

resources or different interventions.

***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).

Using the Institute for Healthcare Improvement's Rapid Cycle Improvement Model and RE-AIM framework for evaluation, our PPS will ensure a culture of ongoing assessment and improvement. RE-AIM is designed to enhance the quality, speed, and public health impact of efforts to translate research into practice.

Data will be frequently reviewed by staff to inform ongoing project development and evaluation. Data-driven reports and dashboards will be shared quarterly with the Executive Committee and Hub Boards, and reviewed by the Quality Committee as often as monthly to ensure our PPS can quickly adjust processes when needed.

Hub Boards will work with CRHI provider relations staff and the CRHI Medical Director to share performance data with participants and to identify underperforming providers and develop corrective action plans. Overall PPS performance will be shared at least twice annually with the PAC and reports will be posted to the PPS website for public consumption and feedback.

***RCE 4:**

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

Well-developed performance monitoring systems, including rapid-cycle evaluation (RCE) and a culture of continuous learning and improvement are the basis of success for an integrated delivery system (IDS). We will track key indicators that measure performance and outcomes at different levels and use that information for service improvement and resource enhancement, rather than punitive measures. Our PPS will use these capabilities in an effort to be proactive, rather than reactive, in addressing the target population's changing health needs. RCE will enable the PPS to hold itself – staff, Participants, and providers – accountable for established metrics. Doing so will prepare us for participation in value-based payment models and, ultimately, risk sharing by linking compensation to indicator-based performance while promoting transparency and holding our PPS and our Participants accountable for health outcomes of the target population.

Westchester Medical Center (PPS ID:21)

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.

Our PPS will serve a large and diverse population across eight counties. The target population is characterized by: fast growing minority populations (Hispanic and Asian populations are the fastest growing, with growth rates of 74% and 64% respectively since 2000); disparities in educational achievement (the percent of the population with less than a high school diploma ranges from 8.0 to 14.1%); and ethnic communities of non-English speakers (e.g. 10% of the population in Mt. Vernon in Westchester is Portuguese speaking).

We relied upon surveys and focus groups to identify cultural competency challenges faced by providers and patients in the region. Results suggest that providers and staff often do not speak patients' native languages such as Spanish, Portuguese, French and Spanish Creole, and Yiddish; do not demographically represent the target patient population and may not have a sufficient understanding of the communities in which they are working; and lack awareness of the particular competencies and accommodations needed for special needs patients. Further, there are limited cultural competency resources and training/education programs available for providers and staff and it is difficult to measure the effectiveness of existing resources and programs; patients, especially non-English speaking patients, may be hesitant to access services and wait until an emergency arises to seek care or may not have access to healthcare services during normal working hours. Ethnic communities and their subpopulations each have unique cultural and dietary considerations that may contribute to health challenges.

We acknowledge that these challenges are only a subset of those facing providers and patients in our region. As our PPS aims to create a

culturally competent and responsive healthcare system, we will continuously identify and evaluate new and existing cultural competency challenges and develop strategies to address those challenges to ensure our PPS' success.

***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.

Our PPS will develop a comprehensive strategy and accompanying processes to ensure the development of a culturally competent organization and responsive system of care. Specifically, we will work with established workforce vendors, expand proven programs, and monitor and assess our performance relative to established metrics.

Our PPS plans to identify and contract with workforce vendors to provide cultural competency training to frontline healthcare workers and address specific challenges identified by PPS research, as well as work with and through PPS participants, such as FQHCs, that currently train and interface with providers. 1199 SEIU League Training & Employment Funds (TEF), a primary workforce vendor to our PPS, offers training programs on cultural competence and health disparities that may be extended to PPS providers and their staff.

Our PPS will also inventory and evaluate successful programs that may be expanded or replicated to improve the workforce's cultural competency. The PPS identified the following programs that are considered successful by network providers: The Mental Health Association of Rockland County offers "Train the Trainer" sessions on mitigating the impact of racism; The Community of Solutions Initiative, a program of the Orange County Department of Mental Health and Emergency Housing, offers provider communication tools for high utilizers facing alcohol and substance abuse problems; and Memorial Sloan Kettering (MSK) Cancer Center offers an "Immigrant Health & Cancer Disparities Service" to address disparities in access to cancer treatment and provide health education and other services to immigrants and medically underserved communities.

Finally, we will establish and report on short and long-term cultural competency goals through an assessment to be developed or identified by the PPS Quality Committee and coordinated with other PPSs through the Regional Clinical Council.

***Competency 3:**

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

Our PPS is in the process of identifying and evaluating community-based organizations to support its cultural competency strategy. The CNA inventoried available community resources across the region including, but not limited to: housing services, food banks, employment support services, religious service organizations, family support and training, local governmental social service programs, and transportation services. The CNA found the distribution of these and other resources vary widely across the region and many services are not available or accessible to the target population.

Our PPS plans to work closely and contract with local Area Health Education Centers (AHECs) that serve the region, specifically the Bronx Westchester AHEC for Westchester County and the Catskill Hudson AHEC that serves the remaining seven PPS counties. The local AHECs bring experience and knowledge serving our PPS region and are respected organizations with a history of enriching the healthcare workforce.

We will develop and maintain a comprehensive inventory of community-based organizations to ensure patients faced with social needs and barriers to receiving effective care are aware of and have access to resources and services that address the broader determinants of health. PPS care coordinators will have access to this inventory electronically and will connect beneficiaries to these resources to ensure their basic needs are cared for, allowing beneficiaries to better adhere to care plans and manage their and their families' health.

Section 7.2 – Approach to Improving Health Literacy:

Description:

Health literacy is "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions". Individuals must possess the skills to understand information and services and use them to make

Westchester Medical Center (PPS ID:21)

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.

As part of the CNA, our PPS conducted focus groups and surveys of consumers, providers and community-based organizations to identify health literacy challenges and innovative programs that address them. Among the challenges identified: Inability of providers and staff to communicate in patients' native languages; Reliance and emphasis on written care documentation (vs. verbal or picture-based instruction); and Lack of education/health literacy courses available to providers and staff.

As a result of the extensive inventory of provider and community resources identified in the CNA, our PPS is positioned to address the above challenges and accommodate the health literacy of patients in all of its DSRIP projects. First, we will integrate health literacy into DSRIP implementation efforts and evaluation measures, underscoring the importance of health literacy for all PPS Participants eligible for bonus payments. The Quality Committee will establish health literacy measures and targets for each DSRIP Year to assess our PPS and individual Participants' progress toward achieving health literacy for the target population.

Second, our PPS will pursue a series of initiatives to promote health literacy, including but not limited to: recruitment of bilingual health educators, medical interpreters, and staff to fill identified gaps; development of care plans and other patient and caregiver-facing materials at no higher than a third grade reading level and translated into prevalent beneficiary languages (i.e., Spanish, Portuguese, Yiddish, and French and Spanish Creole); partnership with community-based organizations serving non-English speaking or low literacy populations to increase awareness of available health care services and promote general wellness and prevention strategies; identification and integration of effective health literacy programs and leading patient-engagement practices into PPS Participants' policies and protocols; and identification and use of bilingual peers to act as champions and "go to" resources in their communities.

Third, our PPS will adopt a set of common organizational values and evaluation measures that place the patient at the center of the care model. This framework will be coordinated by our PPS Quality Committee and, to the extent possible, Regional Clinical Council to ensure a common health literacy standard as patients seek care across the region. We will measure its progress against short and long-term health literacy goals through an assessment to be developed or identified by the PPS Quality Committee and coordinated with the other PPSs through the Regional Clinical Council. Our PPS will also continuously collect patient feedback through care coordinators, a PPS hotline, and online feedback forms to identify areas of need as well as examples of progress and effective practices.

Finally, our PPS is in the process of identifying and evaluating community-based organizations to support its health literacy strategy. We believe that community-based organizations are best positioned to promote health literacy among their peers and clients. As PPS beneficiaries seek services to address social determinants, our PPS will work with community-based organizations to introduce health care services appropriate for their clients. Our PPS also plans to work closely and contract with local Area Health Education Centers (AHECs) that serve our region, specifically the Bronx Westchester AHEC (BWAHEC) that serves Westchester County and the Catskill Hudson AHEC that serves the remaining seven PPS counties. The local AHECs bring experience and knowledge serving our PPS region and are respected for enriching the healthcare workforce. They may also draw upon the substantial health literacy resources of the National AHEC Organization.

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

Description:

Westchester Medical Center (PPS ID:21)

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.

Westchester Medical Center (PPS ID:21)

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.

Our PPS will distribute DSRIP payments via two pools: a Service Obligation Pool and a Community Good Pool.

The Service Obligation Pool will support implementation of the DSRIP program and projects. Funding will be shared between the central services organization (CRHI) and Participants. WMC will also be compensated for its role in administering DSRIP funds. Contingency funding will be reserved as a cautionary measure. The Community Good Pool will support Participant bonus payments based on Participants' achievement of DSRIP goals and project milestones, offset revenue loss resulting from DSRIP implementation, and fund an innovation pool to which PPS Participants may apply for funding to enable their transition to value-based payment.

Our PPS includes Participants across a broad clinical spectrum and all Participants are eligible for funds from both Pools. Specifically, Service Obligation funding will be distributed based on project-specific implementation budgets. Participants may receive funding at the outset of a project to support initial startup activities (i.e., staffing, resources) and receive additional funding upon timely completion of project milestones. The PPS is prepared to support Participants needing greater upfront funding because they lack required infrastructure or clinical capabilities.

Participant's performance relative to established clinical and quality metrics will drive their ability to draw down bonus payments from the Community Good Pool. The PPS will monitor needs for revenue loss and innovation funds on an individual basis. If revenue loss or innovation funding is not exhausted, it will be shifted into provider bonus payments.

As all Participants are eligible to participate in the Pools, the PPS will not allocate funding based on provider specialty. The distribution of funding will vary based on projects, Participant contribution, and Participants' achievement of agreed upon performance goals. However, performance goals will be standardized by provider type.

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

The PPS governance structure will drive and provide oversight for the distribution of funds. The Finance Committee is charged with development of DSRIP program and project budgets and Participant bonus payment allocations. Each Hub Board will also develop and review Hub-level budgets specific to local project and resource needs and recommend project-based milestones for Participant bonus payments. All budgets and Participant bonus payment recommendations, as well as corrective action plans for Participants that fail to meet expectations and established metrics, will be subject to Executive Committee review and approval.

The Executive Committee and WMC will review and approve revenue loss and innovation pool funding. Participants requesting compensation will be required to submit documentation of their losses/needs and business plans demonstrating their path to sustainability beyond temporary funding.

Our PPS' approach for distributing DSRIP funds is based in a common contractual understanding between each Participant, WMC as the fiduciary, and CRHI, to the Participant's project goals, the measures against which each Participant will be evaluated, and the schedule of available funding. The approach balances the need to support infrastructure and implementation costs with the desire to motivate Participant performance and achievement of DSRIP goals and project milestones through Participant bonus payments. It also affords Hubs the ability to oversee local project implementation and identify/address their unique needs.

The established governance process and internal financial and audit controls will drive the PPS to closely manage its budget, while still affording the PPS flexibility to evaluate and adjust its funds flow methodology over the course of the program and as different categories of expenditures change over time.

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	11.5%
2	Revenue Loss	3%
3	Internal PPS Provider Bonus Payments	80%
4	Contingency Fund	2%
5	Administration	.5%
6	Innovation Pool: Partners may apply for bridge or innovation funding to enable their transition to value-based payment arrangements. The Finance Committee will develop criteria and an application process for the distribution of funds, subject to the approval of the Executive Committee.	3%
	Total Percentage:	100%

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

Description:

Westchester Medical Center (PPS ID:21)

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

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

☑ Please click here to acknowledge the milestones information above.

Westchester Medical Center (PPS ID:21)

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.

Our PPS understands the importance of the overall financial health of the PPS and, as a result, the need to identify and address providers in the network that are financially fragile. To evaluate the PPS financial landscape, the PPS surveyed its network to assess individual Participants' financial health and identify Participants who are or may become financially challenged or at risk for financial failure. The survey, which was distributed to all PPS Participants, addressed Participants': Reserves (i.e., 15 days' cash and equivalents); Assets that may be monetized; Access to resources from affiliates, foundations, and others that may be accessed to sustain operations, if needed; Current payer mix (i.e., commercial, Medicare, Medicaid, uninsured, self-pay, and other); 2012 and 2013 financial results; and Annual patient volume for 2013, 2012, and 2011.

In addition to the above quantitative assessment, we surveyed Participants relative to the impact participation in the DSRIP initiative and implementation of DSRIP projects may have on their financial health. The Finance Committee will complete an extensive review of survey responses and, if necessary, request additional information from Participants at the outset of DY 1.

Our PPS also worked closely with its two medical village project Participants to assess the short and long-term financial impact of facility and bed closures on the Participants and their ability to transform to value-based payment models with the PPS. We will continue to work with these Participants throughout DSRIP to ensure they achieve financial stability and have access to the resources required to transition to actively participate in the integrated delivery system.

Westchester Medical Center (PPS ID:21)

***Assessment 2:**
Identify at a high level the expected financial impact that DSRIP projects will have on financially fragile providers and/or other providers that could be negatively impacted by the goals of DSRIP.

DSRIP will financially impact PPS Participants as they work to achieve the stated goal of reducing avoidable hospital use by 25% over five years, resulting in revenue losses for some PPS Participants, especially hospitals. Our PPS anticipates the implementation of DSRIP projects may have the following negative financial impact on Participants: Costs to effectively implement and support DSRIP projects, including capital costs, may exceed funding available to individual Participants, requiring Participant investment without PPS reimbursement; Reduction in fee-for-service payments for inpatient and emergency department (ED) admissions due to redirection of patients to primary care and other appropriate outpatient care settings; Reduction in overall inpatient volume coupled with increased outpatient volume that may require shifts in workforce and retraining or recruiting to support outpatient services; Temporary productivity loss for some primary care physicians as they transition to advanced primary care models; and Uncompensated time of Participant executives and leadership engaged in DSRIP Committees, Hub Boards, and other "in-kind" activities.

While the PPS has identified the above potential negative financial impacts, it also anticipates that DSRIP will enable service and business line growth for many PPS Participants, especially with respect to primary care.

We understand that DSRIP funding will not protect financially fragile institutions and plans to implement a process to ensure early identification of PPS Participants that are at risk of becoming financially fragile to mitigate risk to the PPS' services and performance. Key elements of the PPS' proposed process include: (1) continuous monitoring of PPS Participants' financial health through annual financial assessments and quarterly financial reporting as part of PPS performance reporting; (2) establishing a Financial Assessment and Restructuring Workgroup of the Finance Committee to work with financially fragile institutions on restructuring plans and/or identify alternative mechanisms to ensure critical services remain available and accessible to beneficiaries; and (3) efficiently allocating DSRIP funds to sustain critical PPS services.

Our PPS will allocate revenue loss funds to Participants that are able to demonstrate the negative financial impact of the DSRIP initiative and a corresponding plan to use DSRIP revenue loss funding as a "stop gap" in the short term while the Participants implement changes to ensure their long term viability. We will require Participants to document their long term viability and business plans when seeking revenue loss funding. Participants that are unable to demonstrate overall viability will be advised to consider merger or restructuring plans.

Our PPS has already undertaken considerable efforts to understand the financial state of Participants in the medical village. We are confident that each Participant's leadership fully understands the implications of the medical village project and are committed to active participation in the other ten DSRIP projects. As the medical village project rolls out, our PPS will work with each Participant to actively monitor revenue losses and, to the extent feasible, allocate adequate compensation to ensure their operations remain viable.

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.

Our PPS will pursue financial sustainability through the development of a strong governance structure and sound clinical programs that improve health outcomes and lower costs. We are committed to creating a strong organizational and clinical foundation to ensure we are prepared to pursue value-based and alternative contracting arrangements with Medicaid Managed Care Organizations (MCOs) through integrated delivery systems, accountable care organizations (ACOs) and other collaborative provider shared-accountability models. Because our PPS spans eight counties, we recognize it may not be feasible or desirable to enter into value-based contracts on behalf of all Participants and, as a result, we anticipate setting up new or supporting multiple existing risk-bearing entities in years 3 – 5 of DSRIP implementation to enable appropriate contracting arrangements with local MCOs. Like our PPS' approach to clinical program implementation via Hubs, we recognize that local circumstances and needs may prevent a singular approach to sustainability and some

Westchester Medical Center (PPS ID:21)

arrangements may be acceptable in one region but not another; this may also be driven by the presence of MCOs in some, but not all, PPS counties. Risk-bearing entities will also carry forward the responsibility of sustaining DSRIP outcomes after the conclusion of the Program.

Our PPS will further outline our plans for financial sustainability as we prepare the Implementation Plan and begin program operations. Our PPS' financial sustainability plan will outline the PPS' funds flow methodology as well as anticipated measures and reporting schedules for Participants. The Finance Committee will oversee these planning efforts and regularly revisit and update the financial sustainability plan to address our PPS' changing needs and actual performance/funds flow throughout the program.

***Path 2:**

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

The PPS Finance Committee will develop and administer an annual assessment to monitor the financial stability of each Participant, including more frequent monitoring for financially fragile Participants. Participants will also participate in quarterly financial reporting as part of the PPS' efforts to monitor performance. If a Participant is identified as financially fragile, the Financial Assessment and Restructuring Workgroup will work closely with the Participant to understand the impact of DSRIP projects on the Participant and identify strategies to ensure availability of critical services throughout the program.

To ensure fragile safety net providers will achieve a path of financial sustainability and transition to value-based payment models, our PPS will create an innovation pool to which PPS Participants may apply for funding to enable their transition and mitigate potential losses/financial challenges when transitioning away from their existing business model. The Finance Committee will develop criteria and an application process for the distribution of funds.

***Path 3:**

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

As the conclusion of DSRIP nears, our PPS will develop and negotiate alternative Medicaid contracts with the goal of sustaining and improving outcomes post-DSRIP. We understand the State's intent to migrate at least 90% of MCO provider payments to value-based payments by the end of DY 5. In anticipation of this transition, our PPS will seek out value-based contracts with MCOs beginning in DY 3, focusing on subpopulations within the PPS through pilots or other demonstrations. Our PPS will first pursue shared savings contracts followed by risk sharing contracts. We will seek to expand any existing value-based MCO contracts with Participants as the PPS matures.

To the extent that risk-bearing entities form within our PPS to support local or Hub-based contracting with payers, these entities will also begin the transition to value-based payment in DY 3. Our PPS will provide these entities with administrative services and infrastructure to participate in value-based contracts.

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.

Our PPS' vision for value-based reimbursement is grounded in key principles that underlie its governance and organizational structures, specifically: transparency; scalability and flexibility; alignment of payment policy and quality goals; and evaluation and technical assistance.

We engaged local Medicaid Managed Care Organizations (MCOs) in our DSRIP planning efforts with the goal of involving the MCOs as our PPS establishes its governance and clinical models, as well as initiating discussions about future payment arrangements. Hudson

Westchester Medical Center (PPS ID:21)

Health Plan is represented on the Planning Executive Committee and CRHI leadership has hosted meetings with Fidelis Care and Affinity to discuss DSRIP efforts and PPS sustainability goals. Once operational, our PPS will convene a Sustainability Taskforce with key MCO stakeholders charged with identifying, testing, and evolving sustainability strategies for the PPS. The Taskforce may address such alternative payment arrangements as pay-for-reporting, pay-for-performance, shared savings, and capitation, and look for models of successful arrangements within the region and nationally. We believe the State will be a critical partner as we work to define the relationship between MCOs, PPSs, and risk-bearing entities.

***Strategy 2:**

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

Payment transformation will assist our PPS to achieve a path of financial stability by transitioning Participant and individual provider compensation to value and outcomes-based methodologies from existing fee-for-service arrangements. Because the full scope of services providers currently offer their patients is not sufficiently reimbursed by Medicaid, value-based payment will aim to reduce providers' reliance on fee-for-service reimbursement and afford them flexibility and assurance to deliver the best care possible with the ultimate goal of improving the target population's health and reducing costs.

Our PPS will financially reward providers as they successfully implement DSRIP projects through provider bonus payments as well as, ultimately, shared savings and/or risk-based contracts. Recent Medicare ACO demonstrations have proven significant opportunity for realizing shared savings among integrated delivery systems experienced in population health management. At the outset of its transformation, our PPS plans to pursue shared savings arrangements before pursuing risk sharing arrangements. This will allow the PPS to test its performance in value-based arrangements as well as internal quality and cost reporting mechanisms to ensure it is equipped to gauge performance and appropriately structure future risk sharing agreements. To achieve sustainability of DSRIP programs, the PPS will look to move beyond shared savings in out years.

Payment transformation will also support financially fragile safety net providers by identifying new sources of revenue based on the providers' performance, rather than their existing business models that do not reward providers based on the quality or total cost of care provided to patients. Financially fragile safety net providers will work with our PPS Quality and Finance Committees to identify and redeploy resources that are not currently being used at the top of their scope or are no longer driving revenue. Repurposing and retraining resources, if necessary, may increase the providers' capacity where we have identified critical needs, thereby driving patients back to the providers for newly available services and subsequent payment.

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.

Westchester Medical Center (PPS ID:21)

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.

Our PPS has engaged partners with proven population health management skill sets and will build upon these skill sets to enable rapid deployment of DSRIP projects. Specifically, Crystal Run Healthcare, a multispecialty group practice, is a key PPS Participant and brings significant population health management capabilities. Crystal Run is a NCQA Level 3 PCMH and was among the first 27 accountable care organizations to participate in the Medicare Shared Savings Program. Their demonstrated population health management capabilities have allowed Crystal Run to enter into value-based payment arrangements with commercial payers and a Medicaid Managed Care Organization (MCO), covering approximately 50% of the group's primary care patients.

Our PPS Lead, Westchester Medical Center (WMC), its Maria Fareri Children's Hospital and PPS Participant Children's & Women's Physicians of Westchester (CWPW), have a long history of collaborating on regional pediatric health improvement projects. WMC and CWPW coordinate a regional perinatal network of 19 community hospital Neonatal Intensive Care Units (NICUs), focused on enhanced access to services and improved perinatal outcomes. We also have experience educational programs focused on modifying patient behaviors for better outcomes. For example, a WMC program that teaches parents about the dangers of shaking infants was recognized by the American Journal of Pediatrics as a low-cost prevention program that can substantially reduce newborns' risk of sustaining head injuries from shaking.

Our PPS also includes 3 of the region's largest FQHCs and all 3 of the region's Health Homes, each of which have demonstrated experience in improving quality of care for populations with chronic conditions.

Our PPS Participant Dominican Sisters Family Health Services, a home nursing agency, received CMMI Innovation funding for its work to improve care transitions from inpatient discharge to home settings, reduce readmissions and improve outcomes.

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 the workforce is an important goal for our PPS, and we intend to contract with the 1199SEIU League Training & Employment Funds (TEF) as our lead workforce strategy vendor. TEF has a track record of: evaluating and selecting appropriate training vendors to meet employer and worker needs; writing curricula; working collaboratively with employers and unions; and training providers to design and deliver high quality programs. Since 2001, TEF has successfully offered statewide training and education programs to over 76,000 workers with a 97% completion rate.

TEF is comprised of nine funds that our PPS will be able to access. Five of the funds will assist our PPS to achieve our strategy of retraining, redeploying, and recruiting workers due to restructuring changes. Fund staff have programmatic expertise in the nursing home and registered nurse areas and, in addition to program staff, the funds have an administrative infrastructure that will deliver and report on PPS activity and related expenses.

Westchester Medical Center (PPS ID:21)

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 funds offer ongoing services such as development program workshops to develop facilitation skills, conflict resolution skills, and progressive leadership as well as data interpretation training.

Our PPS Workforce Workgroup, co-chaired by a health system partner and a labor representative, will also evaluate additional workforce training vendor needs over the next six months as part of a comprehensive training and development offering to our PPS participants. To support our PPS and ensure we have access to required resources and programming, TEF will also collaborate with other designated workforce vendors.

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

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

DSRIP PPS Organizational Application

Westchester Medical Center (PPS ID:21)

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

Primary Lead Provider Name: WESTCHESTER MED CTR
Secondary Lead Provider Name:

Lead Representative:	June Keenan
Submission Date:	12/22/2014 08:51 AM

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