Design Grant Questionnaire

Please answer each of the following questions thoughtfully and concisely. Note that you will only be able to enter your responses within the grey form fields, and that many, if not all, of these forms have word limits.

Contact Information

Please provide contact information for the individual completing this questionnaire. Note that as this questionnaire will be used to assist NYS DOH in determining whether your PPS will receive the second design grant award payment, please note that the individual certifying this questionnaire should be the CEO, CFO or comparable level personnel.

Date: October 15, 2014

Provider Name**:** Westchester Medical Center

Contact Name: June Keenan, Senior Vice President, Delivery System Transformation

Contact Email: keenanj@wcmc.com

Contact Phone: 914-326-4201

PPS Status

The following questions relate to whether your PPS is continuing to finalize formation, and intends to complete your own DSRIP Project Application due on December 16, 2014.

1) Does your PPS plan to submit a DSRIP Project Plan application as a standalone PPS on December 16, 2014*?* If your PPS does not intend to continue operating as standalone PPS (e.g., your PPS has dissolved due to merger with another PPS or has decided to cease participation in the DSRIP program), your answer to this question should be 'No'. *If 'Yes', please skip the next two questions and complete the rest of the Design Grant Questionnaire. If 'No', please continue to the next question in this section.* (*3 character limit)*

YES

2) Is your PPS merging with another PPS? If yes, please explain in detail your plan to integrate and support the merged PPS (e.g., please describe specific projects and activities). If awarded a second design grant payment, please provide a narrative explaining your intentions with the funding awarded. If your PPS is not merging with another PPS and is planning to cease participation in the DSRIP program, please answer 'No' to this question and answer the next question. *(3,000 character limit)*

YES. The emerging PPS led by HealthAlliance of the Hudson Valley will merge into the Westchester Medical Center (WMC)-led PPS. HealthAlliance has been an active participant in planning efforts related to the WMC-led PPS, including serving on the Executive Committee of

our PAC, the Business, Operations and Finance Subcommittee and the Clinical and Program Subcommittee and is a partner in our Hudson Valley regional community needs assessment (CNA) process.

We anticipate a seamless integration of the HealthAlliance-led PPS, including its partner organizations, into the WMC-led PPS. Planning funds will be utilized to further develop a "Medical Village" DSRIP project to expand access to needed primary care and mental health services in the region served by HealthAlliance and to develop a hub operating plan for the region that concentrates DSRIP implementation efforts around targeted population hot-spots.

3) If your PPS has elected to cease participation in the DSRIP program, please provide an explanation as to why your PPS has made this decision. *(3,000 character limit)*.

N/A

Note: If your PPS has elected to merge with another PPS or has elected to cease participation in the DSRIP program as a standalone PPS, please contact the NYS DOH for further discussion.

Award Letters Conditions

The following questions relate to award conditions stated on the August 6, 2014, if applicable to your PPSs.

1) Did your award letter include a condition which must be addressed prior to receiving the second award payment? *Please answer with either 'Yes' or 'No'. If 'Yes', please continue onto Question 2. If 'No', please move onto Question 3. (3 character limit)*

NO

2) Have you addressed your award condition? Please describe the steps taken to address the award condition. (2*,000 character limit)*

N/A

3) If you have not fully addressed your award condition, please provide an explanation as to why the condition has not yet been addressed, and plans to satisfy the condition prior to November 3, 2014. Please also reference communication you have had with NYS DOH about this condition to date. (*2,000 character limit)*

N/A

Network updates and attestation

The following questions relate to compliance regarding each PPSs DSRIP Network Tool submission and attestation and data sharing requirements.

4) **A.** Has your PPS met the October 1, 2014 deadline to update your partner organization list using the DSRIP Network Tool? *Please answer with either 'Yes' or 'No'. If 'Yes', please continue on to Question 5. If 'No', please move onto Question 4B. (3 character limit)*

   YES

   B. If you have not met the deadline, please provide an explanation as to why this deadline has not been met and what your plans are to remediate. (*2,000 character limit)*

   N/A

5) **A.** Has your PPS maintained a file of signed partnership agreements from all partner organizations, which can be made available to the State and/or CMS upon request? *If 'Yes', please continue on to Question 6. If 'No', please move onto Question 5B. (3 character limit)*

   NO

   B. If you have not completed this requirement, please provide an explanation as to why it has not been completed and provide your plan to remediate. (*2,000 character limit)*

We have signed attestations from every partner documenting their participation in the DSRIP PPS planning process on file and are in the process of collecting (prior to Nov. 15, 2014 - anticipated) signed and notarized participation agreements from every partner. Collection of the latter was delayed as we awaited State guidance regarding the use of a standard form; we did not receive confirmation from DOH until Oct. 7, 2014 that the State would not be providing a standard template for the required partner participation agreement forms.

6) **A.** Has your PPS executed a Data Exchange Application and Agreement ("DEAA") with the State for data available in the DSRIP portal, and any data sharing outside of the portal? *If 'Yes', please continue on to Question 7. If 'No', please move onto Question 6B. (3 character limit)*

   YES

   B. If you have not completed the above, please provide an explanation as to why these activities have not been completed and provide your plan to remediate. (2*,000 character limit)*

   N/A

Contract attachments

The following questions relate to contracts submitted to NYS DOH by PPSs regarding renewed grant amounts, for which PPSs were required to resubmit to NYS DOH with the updated grant amounts.

7) Has your PPS returned all contract attachments that need to be completed? If not, please provide a brief status update on your current progress and remediation steps. The required attachments are listed below for your reference. (2*,000 character limit)*

   - **APPENDIX A** - Standard Clauses as required by the Attorney General for all State contracts

- **STATE OF NEW YORK AGREEMENT**
- **APPENDIX B-3** - Award Letter
- **APPENDIX B-2** - Webinar 1 and 2
- **APPENDIX B-1** - Questions and Answers 1 and 2
- **APPENDIX C** - Proposal
- **APPENDIX E-1** - Proof of Workers' Compensation
- **APPENDIX E-2** - Proof of Disability Insurance Coverage
- **APPENDIX H** - Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement")

YES

Community Needs Assessment
The following questions address your PPSs progress in completing your Community Needs Assessment ("CNA").

8) Please provide a status update on your CNA's progress versus the timeline stated on your design grant application. (2*,000 character limit)*

Below is an updated timeline for our CNA process. The only date change from our original design grant application is Task 8, to make the CNA available for public comment, which was changed from October 1 to October 6.

1. 7/1/2014 (Decision)… Develop CNA methodology, vision and goals, and initiate data collection and analysis (quantitative and qualitative).

2. 8/1/2014 (Action)… Present initial CNA findings and gather input from PPS partners, target beneficiaries, consumers, caregivers and other stakeholders (beyond PPS partner organizations).

3. 8/1/2014 (Action)…. Initiate CNA community survey and focus groups targeting sub-populations relevant to selected DSRIP projects (e.g., African American males with hypertension).

4. 8/4/2014 (Action)…. Refine CNA methodology and identify areas for further data collection and analysis (quantitative and qualitative); continue conducting CNA.

5. 8/22/2014 (Action)… Present updated CNA findings review for impact on DSRIP project selection and identify gaps.

6. 8/30/2014 (Action)… Continue CNA data collection and analysis to address gaps.

7. 9/30/2014 (Milestone)… Finalize CNA for inclusion in Project Plan Application.

8. 10/6/2014 (Action)… Make CNA available on PPS public-facing website with 30 day request for public comment.

9) Please describe your stakeholder and community engagement process. (*2,000 character limit)*

We have employed a well-established process, the Community Health Assessment and Group Evaluation (CHANGE) developed by the CDC. The needs and opinions of community stakeholders across sectors are gathered in a systematic way that includes templates for data gathering and surveys that facilitate communication between community stakeholders and our PPS. The foundations of CHANGE include commitment, assessment, planning, implementation and evaluation.

We have partnered with the 7 county Departments of Health and departments of mental health to 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 are also working 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 near daily sharing of draft findings.

To engage the community directly, we conducted six focus groups with more than 50 patients and providers. The focus groups targeted patient groups in geographical “hot spots” to obtain insights regarding patient needs and challenges regarding selected projects. Focus groups also included staff from key licensed network partners and CBOs to obtain information about the needs of targeted patient groups relating to selected projects and other input to support the development of an integrated delivery system.

Finally, we have kept our PAC and PAC Executive Committee up to date on progress with monthly updates; shared findings with every DSRIP planning workgroup. We presented a preliminary version of the CNA at our Clinical Planning Summit on Oct. 9 (which will be repeated via webinar on Oct. 20) and have posted findings on our dedicated DSRIP website for public comment.

10) Please describe your needs assessment methodology, specifically regarding data collection and reporting. *(2,000 character limit)*

Our needs assessment was designed within a geographic information science (GISc) framework. GISc and spatial analyses have been used to identify particular population-based health issues. For example, access to care at clinics or hospitals, environmental exposures such as air pollution or congested roadways, and patterns of disease burden by population and region have all been assessed utilizing this framework. Detailed-level SPARCS data provided by our academic colleagues at Iona College, combined with Census information, has been mapped to identify community needs by prevalence indicators for major diagnostic categories and qualitative indicators such as PQIs. After cross-sectional analyses, we defined longitudinal records of patients’ ER visits, hospitalizations and re-admissions in zip code clusters to the extent we have been able to access relevant data; and analyzed trends over the past three years to identify negative quality indicators.

Conforming to our goal of improving population health, we have isolated “hot and cold spots” (statistical clusters of zip codes with values higher or lower than neighboring ones) and analyzed whether observable influences (e.g., local policies) in those areas are changing the rates. This approach can be expanded to include variables from a range of other sources (e.g., BRFSS, PSYCKES) related to outcomes and socio-demographic determinants (e.g., poverty, English-speaking ability, race/ethnicity,

environmental hazards, physical activity, neighborhood amenities). Indices can be created based on health outcomes as well as associated social, economic and physical determinants of health, and the zip codes, zip code clusters, or counties can be ranked in terms of risk and/or need to maximize the efficiency of proposed interventions.

Finally, we have analyzed all publicly available data sources and conducted robust patient and partner surveys and capabilities inventories using online and paper distribution tools.

11) Please describe any challenges and/or significant deviations encountered during the completion process of your CNA. (*2,000 character limit)*

The only minor deviation to our original project plan was a five day postponement from October 1 to October 6 to make our CNA available on a PPS public-facing website with 30 day request for public comment.

During the data collection process, we encountered challenges accessing certain data sets and, in some cases, obtaining sufficient level of detail. The lack of certain data (e.g., safety net lists and detailed patient-level data described below) has affected both our near-term needs to inform project planning and our longer-term needs to support project implementation and monitoring.

One data issue that proved challenging was the requirement to reconcile our PPS network lists with DOH's list of safety net providers. Based on information that is currently provided, we are unable to do reconcile the two lists. Minor updates to the dashboard to include NPI/MMIS numbers would be extremely helpful in matching lists to safety net provider lists and HCS/MAPP network lists. Claims data will also help in expanding access and capacity for segmentation.

In addition, the lack of detailed data about attributed patients (including provider-level attribution, patient demographics, chronic condition diagnoses, enrollment history, utilization/claims history, baseline quality scores by zip code for all measures, etc.) has affected our ability to complete our planning efforts.

To address our data challenges, we have established weekly conference calls with KPMG to discuss our needs and identify potential solutions.

Cultural Competence and Health Literacy

The following questions address your PPSs progress achieving cultural competence and improve health literacy.

12) Please provide a status update on your process to identify cultural competence challenges and achieve a culturally competent organization that targets the needs of your community. (*2,000 character limit)*

Our PPS recognizes the importance of achieving cultural competence to realize DSRIP goals and improve the health status of residents in the Hudson Valley. As such, the PPS is taking proactive steps to identify cultural competence and challenges, as well as successes that we may build upon during the implementation phase.

As part of the CNA, the PPS is conducting a survey of Hudson Valley 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 six languages prevalent in the Hudson Valley: English, Spanish, Portuguese, French Creole, and Yiddish. As of October 9, 2014, the survey had received over 1,850 responses. The survey will remain open through the end of 2014 and responses will be formally analyzed in January 2015. This survey, as well as the broader CNA, are being completed in collaboration with the other PPSs in the Hudson Valley. Together, the PPSs are taking action to ensure the survey reaches and garners responses from Medicaid and uninsured patients across the eight target counties. For example, PPS partners will be placing surveys in local grocery stores, pharmacies, and clinics.

In addition to the resident survey, cultural competence is an important dimension of the planning process. Our PAC and clinical Committees routinely discuss strategies to engage patients, identify barriers to cultural competence, and develop effective implementation strategies. During our October 9 Clinical summit, participants responded to a survey that included questions regarding cultural competence. We will also add a patient to the Executive Committee at the start of implementation to ensure this perspective is well represented. During the planning phase, the PPS is documenting local and organizational challenges, as well as best practices.

13) Please provide a status update on your approach to improving the health literacy of patients who will be served by your PPS. (*2,000 character limit)*

During our October 9 Clinical summit, participants responded to a survey that included questions regarding health literacy including information on (1) any health literacy challenges that the PPS will need to address to ensure success; (2) any solutions ; and (3) any approaches that could address the challenge.

Our PPS's approach to improving the health literacy of patients will rely on patient engagement in the selected care models. Patient engagement, as well as the engagement of their families, caregivers, and members of the broader community, will be critical to realizing progress toward self-management, shared decision-making, and ultimately improved health outcomes for residents of the Hudson Valley. Toward this end, the PPS is identifying and evaluating models of care that support patients through the use of peers, coaches, care navigators, and care managers. While this support may come in many forms, the PPS recognizes it is critical that patients feel supported and not intimidated or unwelcome when seeking and receiving care. Some PPS partner organizations have successfully implemented peer or care management models in their communities, and the PPS will extend best practices and replicate or expand programs where appropriate. The use and empowerment of peers - individuals with similar conditions who have recovered or are successfully managing their conditions - is one particular model of interest to the PPS.

To improve and promote health literacy among patients served by the PPS, the PPS and its partner organizations will adopt a set of common organizational values that places the patient

at the center of the care model and addresses the full range of health literacy issues, including social determinants of health (e.g., housing, access to healthy food, education, income).

Project Advisory Committee

The following questions relate to your activities in forming your Project Advisory Committee ("PAC"), structure of your PAC, activities undertaken, and future plans.

14) Please provide a status update of PAC activities to date. For example, please address PAC projects and activities undertaken, as well as frequency of PAC meetings. (*2,000 character limit)*

The Project Advisory Committee (PAC) consists of one member from each PPS partner organization. The PAC first convened in-person in June, prior to the submission of the Design Grant Application, and has since met via webinar in mid-August and early October to receive and provide feedback on the DSRIP planning process and respective progress. The PAC is scheduled to meet next on October 27th, followed by meetings in mid-November and December following the submission of the Project Plan Application.

As of October 3, 2014, the PAC includes 167 unique partner organizations representing over 1,600 physicians and participants from behavioral health, children's care/pediatrics, dental care, local departments of health, eldercare, family and community services, health centers, home care, hospice, hospitals and health systems, labor unions, mental health associations, public health, social services agencies, and specialty care. In addition to participating in PAC meetings and webinars, PAC members constitute the Executive Committee (described below), Clinical and Program Planning Sub-Committee, Business, Operations and Finance Sub-Committee, and their respective workgroups. The Sub-Committees have played a key advisory role with respect to project and IDS development.

An Executive Committee of the PAC was established to provide oversight of the planning process and began meeting in mid-August. The PAC meets in-person every three weeks and is charged with strategic leadership, development and oversight of PPS deliverables, development of PPS governance, and leading the development of the integrated delivery system (IDS) to improve the health status of Hudson Valley residents. The Executive Committee is representative of the PPS and includes hospital/health system, physician, health home, FQHC, physician groups, behavioral health, mental health, local county departments of health, health plans, labor, and RHIO stakeholders.

Governance Structure

The DSRIP FAQs contain specific guidance such as ensuring the Governing Committee is regionally representative, includes subject-matter experts, and includes union and worker representation, among other recommendations. Please ensure that you address each of the suggestions in the FAQs. The following questions relate to the structure of your Governing Committee.

15) The DSRIP FAQs and the design grant application provide direction on how to form PACs using an alternate structure. Specifically, PPSs are encouraged to form a smaller Governing Committee of no more than 25 members, which is then supported by subcommittees. How many representatives comprise your PPSs Governing Committee? (*10 character limit)*

16) Please list all of the subcommittees that fall under your Governing Committee, and briefly explain how the Governing Committee and sub-committees currently collaborate within your PAC structure. *Please list your subcommittees in the table below and provide your collaboration explanation in the text field below the table.* (*2,000 character limit)*

#	Subcommittee
1	Clinical and Program Planning Sub-Committee
2	Business, Operations and Finance Sub-Committee
3	Behavioral Health Workgroup
4	Care Management Workgroup
5	Perinatal and Early Childhood Workgroup
6	Workforce Workgroup
7	Sustainability Taskforce
8	
9	
10	
11	
12	
13	
14	
15	

The Executive Committee serves as the PPS governing body and regularly collaborates with the Clinical and Program Planning and Business, Operations and Finance Sub-Committees. This collaboraiton is facilitated through cross-Committee membership, meaning that Executive Committee members or other representatives of their organizations also serve on the Sub-Committees, as well as regular reports on Sub-Committee progress during Executive Committee meetings.

The existing Sub-Committees are comprised of diverse stakeholder membership representing the entire PAC and PPS. The Clinical Sub-Committee in particular has seen tremendous participation from over 100 stakeholders across its Workgroups. The Sub-Committees and their respective Workgroups, with support from Center for Regional Healthcare Innovation (CRHI) staff, are advising the development of DSRIP projects and the integrated delivery system (IDS) (e.g., operational structure). Their work and progress is communicated to the Executive Committee and larger PPS through in-person meetings, webinars, email newsletters, and the CRHI website - http://www.crhi-ny.org. Sub-Committee co-chairs as well as CRHI staff play an important role in shepherding content and information between the Executive Committee, Sub-Committee, and Workgroups.

Design Grant Funding Spend

The following questions address how your PPS has spent the first payment of design grant funds and plans for the second payment. NYS DOH is interested in determining whether your PPS has spent the

funds in accordance to what was submitted in the design grant application, and ensure PPSs are on track to finalize their Project Application. You are not expected to provide a detailed list of funds spent.

17) Please provide an overview of how the first grant payment was used to assist your PPS during the design phase in preparing for your Project Application. Please ensure your response addresses the budget and narratives submitted in your design grant application. (*2,000 character limit)*

Our Project Design Grant Application forecasted costs across five categories (Community Needs Assessment, Stakeholder Engagement, Project/Program Development, Subject Matter Expertise, and Application Development) totaling $3,570,337.

We have used the first payment of our design grant funds to: (1) hire staff to support project planning, CNA development (and the full cost of leadership, staffing and development of a Hudson Valley-wide CNA, supporting all four emerging PPSs in the region), and cross PPS coordination; (2) retain subject matter experts to support the selection and prioritization of projects and to facilitate the development of detailed clinical and health IT plans, governance approaches, and financing considerations; and (3) acquire resources and materials to field surveys, convene stakeholders, develop communication materials, and conduct focus groups.

To date, Westchester Medical Center has used all of our Project Design Grant Application and supplemented planning with our own funds to support the activities noted above.

18) Please provide a percentage estimate of how much of the design grant award first payment has been spent to date. (4 *character limit)*

100%

19) Please describe any challenges and/or significant deviations encountered since you submitted your design grant application, as well as how they were addressed. (*2,000 character limit)*

As noted in the response to question 11, our most significant obstacle has been the availability of sufficient detailed data to inform our planning design process. To address our data challenges, we have established weekly conference calls with KPMG to discuss our needs and identify potential solutions.

Early in the project planning process, we recognized the value of facilitating our Community Needs Assessment and project development efforts with the three other PPS's in our region: Health Alliance of the Hudson Valley, Montefiore Medical Center, and Refuah Health Center. Cross-PPS cooperation has emerged as a hallmark of our planning efforts, and we have allocated additional funds in order to support cross-PPS coordination responsibilities. .

20) What projects and activities will the second award payment be used for, if applicable? (*2,000 character limit)*

Continuation of the above activities, planning and drafting of written application, onboarding on dedicated-DSRIP staff and development of the"detailed implementation plans" as outlined in

the Draft PPS Organizational and Project Plan Application. We anticipate this will require additional work on project plan design, governance approach, workforce strategies, IT infrastructure planning and financial sustainability plans following the submission of our applications on December 16, 2014.

21) Please list all DSRIP projects that are either confirmed or currently still being considered for implementation by your PPS. Indicate the statuses of each by selecting either "Confirmed" or "Considered" from the drop-down list under the Status column. (*Minimum five projects, maximum fifteen in cases where multiple proposals are still being considered.)*

#	DSRIP Project	Status
1	2.a.i Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management	Confirmed
2	2.a.iv Create a Medical Village Using Existing Hospital Infrastructure	Confirmed
3	2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions	Confirmed
4	2.b.vi Transitional Supportive Housing Services	Confirmed
5	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	Confirmed
6	3.a.i Integration of Primary Care and Behavioral Health Services	Confirmed
7	3.a.ii Behavioral Health Community Crisis Stabilization Services	Confirmed
8	3.b.ii Implementation of Evidence-Based Strategies in the Community to Address Chronic Dieases - Primary and Secondary Prevention Projects (adults only)	Confirmed
9	3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)	Confirmed
10	4.b.i Promote Tobacco Cessation, Especially Among Low SES Populations and Those with Poor Health	Considered
11	4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings	Confirmed
12	4.c.ii Increase Early Access To, and Retention In, HIV Care	Considered
13		Select One
14		Select One
15		Select One

Completion

Please select "Yes" or "No" from the check box provided and in the space provided, input the name of and title of the person making this certification. As stated in the introduction of this questionnaire, the individual certifying this questionnaire should be the CEO, CFO or comparable level personnel. An electronic signature below is sufficient; a signed and dated copy is not required.

I hereby certify that the information and data on this form is accurate and correct to the best of my knowledge. I understand that this information may be subject to audit and I may be asked to provide documentation in support of my responses.

Name: June Keenan

Title: June Keenan, Senior Vice President, Delivery System Transformation

Check box with yes or no: Yes: ☒ | No ☐