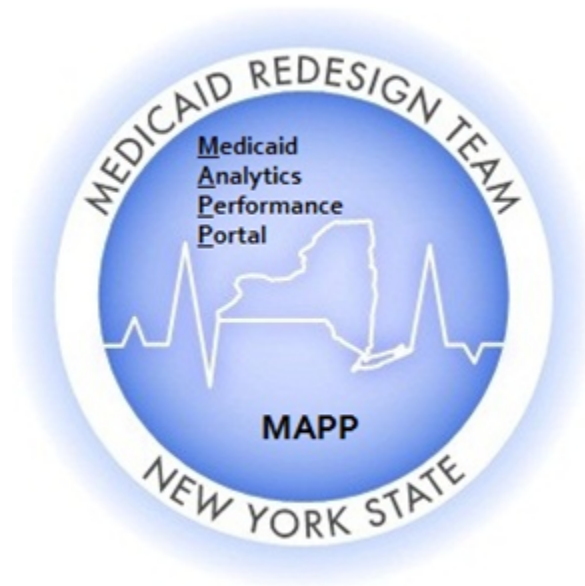


New York State Department Of Health Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



St. Barnabas Hospital (dba SBH Health System)



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

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St. Barnabas Hospital (dba SBH Health System) (PPS
ID:36)

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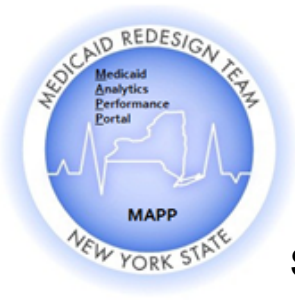
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This application is divided into 11 sections: Sections 1-3 and 5-11 of the application deal with the structural and administrative aspects of the PPS. These sections together are worth 30% of the Total PPS Application score. The table below gives you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

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

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

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

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

Currently Uploaded File: 36_SEC000_SBH 11 7 14 DSRIP_PPS_lead_financial_stability_application test_FINAL.pdf
Description of File
St. Barnabas Hospital (dba SBH Health System) Financial Viability Document
File Uploaded By: mlipson
File Uploaded On: 12/20/2014 05:23 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: mlipson
Last Updated On: 12/22/2014 12:37 PM

Certified By: lwalsh22	Unlocked By:
Certified On: 12/22/2014 12:53 PM	Unlocked On:
Lead Representative: Leonard Walsh	



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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

***Goals:**

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

#	Goal	Reason For Goal
1	Transform to an integrated delivery system (IDS) spanning the care continuum by DSRIP Year (DY) 5	The CNA confirms that the Bronx is the least healthy county in New York State. Poverty; cultural, immigration and language barriers; and the transient nature of the population have confounded the borough's best efforts for sustained population health improvement. While BPHC cannot eliminate these factors, it can fight their effects on health through an IDS with: a) Greater clinical integration among Bronx-based providers and expanded use of community-based and non-clinical care coordination resources to expand access to health services b) Eventual financial integration, beginning with expanded provider incentives for treating the whole person, moving to value-based payment arrangements c) Information-sharing infrastructure and environment giving providers more visibility into and control over performance and outcomes d) Governance that integrates services for addressing social determinants of health and enables neighborhood and Bronx-wide capacity planning to address shortages
2	Integrate social service programs and organizations into the network of IDS partners by DY5	While the Bronx is fortunate to have a deep base of community resources, more than one-third of CNA respondents do not find social services to be readily available. The concern in the Bronx is not so much the composition of resources as it is that the level of need exceeds the available community resources. DSRIP provides an opportunity to increase the reach and impact of existing resources. We will seek to mobilize key resources to help address: a) Housing issues: Over 50% of Bronx CNA respondents noted a lack of affordable housing in their community b) Food insecurity and nutrition: Over 40% of CNA respondents felt that there is a lack of access to healthy foods in their community c) Employment: Almost two-thirds of CNA respondents felt that job training was somewhat unavailable in the community d) Recidivism prevention: The Bronx's rate of jail admissions is 15% higher than NYC overall. A large percentage of state prison releasees move to the Bronx after their sentence is complete
3	Reduce avoidable hospital admissions and readmissions by 25% by DY5	The Bronx has the highest rate of potentially avoidable inpatient hospitalizations of any New York City borough. Chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes, account for the highest proportion of potentially preventable admissions. The



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#	Goal	Reason For Goal
		Bronx's rate of potentially preventable readmissions (PPRs) is 5% higher than NYC and 13% higher than NYS as a whole, and Bronx hospitals have 13% more PPRs than expected.
4	Reduce avoidable emergency department use by 25% by DY5	There are significant opportunities to reduce avoidable emergency department (ED) use in the Bronx. Almost one-quarter of beneficiaries attributed to our PPS had one or more ED visit of emergency severity level 3 (low or moderate severity), suggesting inappropriate use of the ED or lack of primary care availability. The neighborhoods identified by the Community Health Care Association of New York State as most needing community health expansion also have the highest rate of PPVs in the Bronx, reaching up to 49 PPVs/100 beneficiaries. By comparison, Bronx-wide, NYS, and NYC rates are 42/100, 36/100, and 34/100 beneficiaries, respectively.
5	Reduce excess acute care beds in the Bronx by DY5	The Bronx has 3,794 hospital beds (2.74/1,000 population, a decline from 3.14/1,000 in 2004). Since 2009, SBH has closed 81 medical and surgical beds and repurposed space for clinical programs such as hospice, sleep labs and wound care. In addition, in 2013, SBH closed a 24-bed detox unit to create an ambulatory center focused on asthma, diabetes and geriatric services and Montefiore repurposed Westchester Square Medical Center acute care units as an ED/ambulatory surgery center. In light of these reductions, BPHC does not believe there is material excess hospital bed capacity in our PPS. A 25% reduction in preventable hospitalizations will result in only a 1-1.5% reduction in demand. The Bronx has 46 nursing homes with 11,732 beds, much higher capacity than NYC and NYS rates, indicating a potential excess of nursing home beds. Beds are filled almost to capacity, suggesting that social factors prevalent in the Bronx are generating strong demand and, if addressed, may allow reductions.
6	Transition care from inpatient to community settings and improve population health management by DY5	The clinical transformation required under DSRIP, including reductions in avoidable admissions, readmissions, and ED visits, will result in major shifts in care delivery. Care will be more focused on prevention, integrated care, self-management, and population health management, increasing the demand for community-based care. DSRIP has encouraged and enabled BPHC to conceptualize integration for population health management on a large scale, as it will be managing the health and social supports of an anticipated 250,000-350,000 patients holistically.
7	Engage a robust and well-trained workforce in transformation efforts under DSRIP beginning in DY1	A robust and well-trained workforce, rooted in the diverse communities of the Bronx, and engaged in the transformative change required under DSRIP will be central to the success of BPHC. As BPHC seeks to shift care from institutional to ambulatory care settings supported by tightly coordinated care management teams, the most significant workforce impacts – and challenges – will be the need to both retrain a significant number of workers in the existing workforce and hire more healthcare professionals and care management staff to meet expanding demand. This challenge translates into an opportunity for workers – as increased demand for workers rooted in the community; new education, training and retraining opportunities; expanded and more clearly defined care roles and career ladders; and coordinated recruiting and retention supports to empower workers to transform careers and positively impact the Bronx community.
8	Achieve PCMH Level 3 (2014) recognition for all Primary Care Provider partners by the end of DY3	Working with primary care providers to achieve 2014 Level 3 PCMH recognition is a key strategy for BPHC. Within primary care sites, there is currently a lack of care management staffing to fully implement PCMH care teams, preventing PCMHs from reaching their potential. Having robust PCMH infrastructure within our PPS is critical to the success of our Health-Home At-Risk (2.a.iii), Integration of Primary Care and Behavioral Health Services (3.a.i), and Evidence-Based Strategies for Disease Management in High Risk/Affected Populations for Cardiovascular Disease and Diabetes (3.b.i and 3.c.i) projects.
9	Expand primary care capacity and access by DY5	The Bronx has a need for increased primary care capacity in targeted neighborhoods. While the Bronx's rate of primary care physicians per population (115.6/100,000) is lower than the NYC (134/100,000) and NYS



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#	Goal	Reason For Goal
		(120/100,000) rates, and access to physicians is even more limited for Medicaid and uninsured patients, especially for those living in several densely populated Bronx neighborhoods with acute primary care shortages.
10	Expand access to behavioral health services by integrating them into primary care settings by DY3	The Bronx has a need for integrated primary care and behavioral health services and improved care coordination services. Bronx residents report higher rates of serious psychological distress (7.1%) than New York City as a whole (5.5%). Community members have indicated that behavioral health issues, including anxiety, depression and substance abuse, are among the most pressing health issues facing residents. Key stakeholders point to the 'silos' among mental health and substance abuse providers as barriers to access. In addition, over half (54.4%) of Bronx adults with behavioral health issues served by NYS Office of Mental Health programs had one or more chronic medical condition. This high degree of overlap indicates that more coordination is needed between behavioral health and physical health services.
11	Increase availability of care management services beginning in DY1	The Bronx has a need to expand care management services and increase provider knowledge of existing care management resources. Care management services present a well-documented strategy for addressing chronic health issues and improving patient outcomes for high-need populations. PPS members and CNA informants identified gaps to accessing care management services at critical junctures in care. According to providers, the system is highly fragmented; there is lack of provider knowledge of and engagement in care coordination services, inadequate/inconsistent IT to conduct care management, inadequate risk stratification to identify "at-risk" populations, and limited discharge planning/referrals after hospital stays.
12	Implement new evidence-based disease management approaches for chronic conditions in DY1	Overall, the Bronx has higher prevalence of chronic disease than New York City or State as a whole; as a result, there is a need for BPHC to implement new evidence-based disease management approaches, including self-management, for chronic conditions. In its clinical projects, BPHC is specifically targeting management of cardiovascular disease, diabetes, asthma, and HIV.
13	Achieve Level 2 meaningful use (MU) and RHIO/SHIN-NY connectivity for eligible partners by DY3	Access to a complete medical record – using electronic health records, health information exchange and other health information technology – makes care coordination and population health management (PHM) feasible, scalable and sustainable. The Meaningful Use standards and incentives – along with prior investments in RHIOs and the SHIN-NY for health information exchange – represent today's de facto infrastructure for care coordination and PHM. BPHC will build PPS-wide capabilities using these tools to collect data, populate repositories and registries, and for managing performance. Features such as direct exchange, secure messaging, encounter notifications, alerts, patient record look up, referral tracking and direct messaging will help prepare patients better and enable providers to coordinate care without overburdening financial and human resources, allowing care teams to spend less time performing routine tasks and more time interacting with patients who need their assistance.
14	Transition to a transparent, inclusive Collaborative Contracting governance model in DY1	BPHC recognizes the importance of a transparent, inclusive governance process to the success of our PPS. The Collaborative Contracting Model will facilitate Partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships necessary to transition to risk-based contracting. The contractual relationships will: (i) provide accountability for DSRIP program milestones; (ii) enforce Partner obligations; and (iii) provide a basis for evaluating/tracking BPHC and Partner performance against established metrics.
15	Create a Central Services Organization (CSO) in DY1 to support the evolving IDS	BPHC's CSO will provide the backbone for supporting and overseeing our PPS's operations. The CSO will provide and/or arrange for a range of services to the PPS, including:



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#	Goal	Reason For Goal
		a) Clinical supervision services; b) Information technology services; c) Financial services, including evaluation, development of funds distribution methodologies, and sustainability and value-based payment planning; d) Training; e) Analytics; f) Back office/administrative services; and g) Care management/coordination.

***Formulation:**

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

Under SBH's leadership, BPHC has been formulated to meet community needs and address health disparities through three phases of change.

1) Phase 1, BPHC's planning process, represents an unprecedented level of community-based collaboration, supported by inclusive, transparent governance and robust stakeholder engagement to build trust, mobilize Bronx leaders to select DSRIP projects needed by the community and begin business planning. BPHC members offer a diverse network of over 160 providers, social services entities and other critical partners.

2) Phase 2 begins April 1 when BPHC will launch a new implementation governance structure. BPHC will create a Central Services Organization (CSO) to support Rapid Deployment Collaboratives charged with rolling out clinical projects; launch large-scale vendor-supported training, recruitment and redeployment; deploy new IT and care management systems; and finalize financing and incentive mechanisms.

3) New relationships will be forged with Managed Care Organizations (MCOs) to bridge BPHC to its final phase, which will increase reliance on real-time data and create clear lines of accountability between BPHC partners, vendors and the CSO.

***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.

To ensure BPHC's transformed delivery system is sustainable as we reach Phase 3 in 5 years, BPHC will have mature partnerships with MCOs that fund infrastructure and capabilities. Montefiore Medical Center (MMC) provides a critical foundation for this effort: an estimated 45-55% of BPHC's attributed population is already under MCO contract with MMC's Care Management Organization (CMO), and MMC's IPA is the county's largest clinically integrated enterprise. BPHC will build upon these capabilities in care coordination, patient stratification and patient engagement, to provide a next generation approach for BPHC partners. Through deploying evidence-based clinical standards consistently across a diverse and accountable network of providers, undergirded by IT and analytic capabilities that support rapid cycle evaluation and program improvement, and incentivized through value-based reimbursement, DSRIP will fundamentally change care to empower patients, build care coordination teams communicating in real time, and integrate physical, behavioral and social services in a manner that addresses the full range of issues that may cause overuse of our expensive inpatient healthcare system.

***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)



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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)	<ul style="list-style-type: none"> • 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 and could materially slow implementation of needed new capacity to serve the attributed population. Further, having to comply with multiple licenses would force Article 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): 3.a.i



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#	Regulatory Relief(RR)	RR Response
		<ul style="list-style-type: none"> • 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. This would prohibit Article 28 providers from allowing other providers with expertise in mental health care or substance abuse services to provide care in their facilities, thereby limiting their options at integrating care. This interpretation would prevent residential care facilities from sharing space with primary care clinics, a possible aspect of Project 2.a.i. • 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. Similarly, if residential health care facilities were unable to share space, they would have to rely on their own personnel to provide primary and urgent care services, even though an Article 28 clinic might be able to offer greater expertise and a higher level of care. • 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 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	OMH: 14 NYCRR §§ 599.5(c), 599.12(a)(6), OPWDD: 14 NYCRR § 679.99(l). OASAS: 14 NYCRR § 814.7	<ul style="list-style-type: none"> • Project(s): 3.a.i • Reason for request: The OMH regulations cited 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 as well as other behavioral health providers. The PPS's implementation plan will indicate which providers are planning to share space, and assuming DOH approves that implementation plan, DOH will approve the space sharing plans. Providers should not have to obtain a separate approval from OMH. While the OASAS regulations do not require OASAS approval of space sharing plans, they do require providers to develop such plans. Similarly, although the OPWDD regulations do not forbid Article 16 clinics from sharing space (a possible element of Project 3.a.i as providers for the developmentally disabled are also likely to participate in integration efforts), the requirement that the facility's services are provided "principally to persons with developmental disabilities" could be interpreted to discourage sharing of space. The PPS therefore requests that the relevant agencies interpret these rules to provide sufficient flexibility



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		<p>for providers to share space.</p> <ul style="list-style-type: none"> • 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, OASAS, and OPWDD 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 the relevant agency raises any concerns.
4	10 NYCRR §§ 670.1, 670.2, 670.3, 709.1, 709.2, 709.3, 710.1	<ul style="list-style-type: none"> • Project(s): 2.a.i, 2.b.iii, 3.a.i, 3.b.i, 3.c.i • Reason for request: When medical facilities seek to undertake certain projects, the certificate-of-need ("CON") regulations cited require those facilities, including acute care facilities and residential care 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 includes residential health care facilities—will fall within the scope of CON regulation; c) Projects 2.b.iii, 3.b.i, and 3.c.i will likely require the creation of new spaces to handle the increased demand for primary care, cardiovascular services, and diabetes services under DSRIP; and 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. Requiring a demonstration of public need and a separate application for these projects is unnecessary. 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. If DOH is unwilling to waive these regulations in full, DOH should at least provide a highly expedited review process to ensure that DSRIP projects are not delayed. • 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.



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#	Regulatory Relief(RR)	RR Response
5	OMH: 14 NYCRR §§ 551.6, 551.7; OASAS: 14 NYCRR §§ 810.6, 810.7	<ul style="list-style-type: none"> • 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 §§ 702.3, 710.9, 711.2, 715-2.2, 715-2.4	<ul style="list-style-type: none"> • Project(s): 2.a.i, 2.b.iii, 3.a.i, 3.b.i, 3.c.i • Reason for request: Sections 702.3 and 711.2 set construction standards for medical facilities in general, Sections 715-2.2 and 715-2.4 set standards for freestanding ambulatory care facilities. In addition, Section 710.9 requires a preopening survey after the completion of a construction project. In order to fulfill the goals of Project 2.a.i to provide more primary care services to underserved areas, there will be an expansion of the capacity of primary care providers, which will likely require new construction and renovation. Likewise, Projects 2.b.iii, 3.b.i, and 3.c.i may require an investment in primary care infrastructure; some facilities may have to be renovated in order to provide more urgent care, more robust cardiovascular, and diabetes services, and it is also possible that new sites may need to be constructed. In addition, Project 3.a.i will require a reconfiguration of spaces of primary care providers in order to provide behavioral health care services at those sites, or for Article 31 or 32 sites to provide space for primary care services, and substantial construction is likely to occur at some facilities under these projects. The design of these new spaces under these projects may conflict with particular regulatory requirements for



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		<p>the design of clinics. Such regulatory requirements incorporate provisions of the Guidelines for the Design and Construction of Health Care Facilities, which set out detailed rules for these facilities. Having to follow all of these requirements could be particularly problematic in the context of the behavioral health integration requirement given that these standards were not written with physical and behavioral health integration in mind. Moreover, having to undergo the preopening survey process could lead to delays in the opening of the new unit, and therefore at the very least an expedited survey process is necessary.</p> <ul style="list-style-type: none"> • Potential alternatives: The PPS could follow all of these construction standards. However, doing so may result in design decisions that are suboptimal to the goals of the projects. • Patient safety: Certain provisions of the construction standards, such as parts of the Life Safety Code, are designed at ensuring patient safety. The PPS will work with DOH to ensure that all standards that directly relate to patient safety are followed.
7	10 NYCRR § 600.9(c).	<ul style="list-style-type: none"> • 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 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.
8	10 NYCRR § 405.9(f)(7)	<ul style="list-style-type: none"> • 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

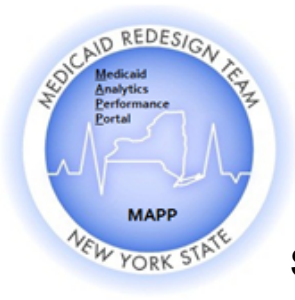


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		relationships. Hospitals will be allowed to transfer patients to the lead coalition provider and other providers within the PPS, and they will be encouraged to do so when it is in the best interest of the patient. However, these policies will emphasize that providers should never transfer a patient based on source of funding when another destination is more appropriate for the patient's care.
9	DOH: 10 NYCRR §§ 86-4.9(c)(8), 401.2(b); OMH: 14 NYCRR § 599.14; OASAS: 14 NYCRR § 822-3.1(b)	<ul style="list-style-type: none"> • Project(s): 2.a.i, 2.b.iv, 3.a.i, 3.b.i, 3.c.i, 3.d.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. Similarly, as part of the care transition project, a patient who is treated by a professional in a hospital may benefit from seeing that same professional at home (2.b.iv). Projects 3.b.i, 3.c.i and 3.d.ii aim to improve cardiovascular, diabetes and asthma care, and facility-based practitioners may seek to provide services in the home as part of that enhanced care. Social workers employed by Article 28 providers may seek to provide behavioral health services within a patient's home (3.a.i). 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. For example, the PPS plans to utilize a community-based organization and community health workers to provide care under the asthma home-based self-management program. The PPS plans to utilize these workers to the greatest extent possible. 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 to preserve continuity of care with the Medical Home care team. 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.
10	10 NYCRR § 766.4(a), (b)	<ul style="list-style-type: none"> • Project(s): 2.b.iv, 3.b.i, 3.c.i, 3.d.ii • 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. Patients often are in need of home care services back at home after staying in a hospital (2.b.iv). Patients who receive cardiovascular care (3.b.i), or diabetes care (3.c.i) under those projects also may need home care services. Likewise, on some occasions

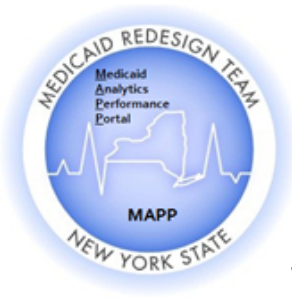


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		<p>patients with asthma symptoms may need home care to help manage their symptoms back at home (3.d.ii). Allowing PAs to order home care as part of these projects would make it easier for these providers to order such care and thus could potentially play a role in reducing inpatient admissions.</p> <ul style="list-style-type: none"> • 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.



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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

Description:

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

This section is broken into the following subsections:

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

Scoring Process:

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

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

Section 2.1 - Organizational Structure:

Description:

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

***Structure 1:**

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

The SBH Health System (SBH)-led Performing Provider System (PPS), Bronx Partners for Healthy Communities (BPHC), has established a strong organizational foundation that will enable the PPS to evolve into an integrated and high-functioning provider network. To date, BPHC has deployed a planning governance structure lead by a Steering Committee and encompassing the broadest possible Partner involvement, including more than over 54 participating organizations and stakeholders across the Bronx. Beginning on April 1, 2015, BPHC will establish a new organizational structure that preserves inclusiveness while creating the strong leadership and accountability necessary to navigate the transition to risk-based contracting. BPHC is implementing a Collaborative Contracting Model for its implementation consisting of three components:

1. Representative, Consensus-Based Governance. The implementation governance body, led by an Executive Committee (EC) and supported by at least four subcommittees (described below), will guide and oversee the deployment of the DSRIP projects and the



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evolution of BPHC into a fully integrated network. The governing body will ensure continued broad-scale participation and buy-in required for transformation, providing direct input into the PPS formation and engendering a pervasive commitment to collaboration and a strong sense of ownership by the participating BPHC health care providers (Partners) and member organizations (Members, encompassing all BPHC participants).

2. Lead Partner. As Lead Partner/fiduciary, SBH will hold ultimate legal and contractual responsibility for fulfilling the DSRIP contract terms. Given the critical importance of the BPHC Members to success, SBH will consult with the EC on key strategic and operational decisions, except in limited cases where powers have been reserved, described below. SBH is committed, qualified and prepared to fulfill the role of Lead Partner. In the unforeseen event that SBH is unable to continue in the fiduciary role, Montefiore Medical Center (MMC) agreed to assume fiduciary responsibilities. This agreement has been memorialized in a Memorandum of Understanding between SBH and MMC of which the BPHC planning Steering Committee has been advised. SBH will operate a Central Services Organization (CSO) that will manage daily DSRIP operations and provide a range of centralized services to the PPS.

3. Contractual relationships. Master DSRIP Services Agreements (MDSA) will legally bind SBH, which operates the CSO, and the Partners to operate in compliance with the PPS's governance principles. A detailed term sheet for the MDSA has been developed and approved by the planning Steering Committee, and full contracts will be in place by April 1, 2015. The MDSA will include (among other things), schedules identifying clinical protocols, IT requirements, program requirements and funding and incentives plans. Schedules will aim to foster greater Partner integration as the PPS evolves toward risk-based contracting.

The Collaborative Contracting Model is critical to BPHC's success, as it will facilitate Partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships necessary to transition to risk-based contracting. The contractual relationships will: (i) provide accountability for DSRIP program milestones; (ii) enforce Partner obligations; and (iii) provide a basis for evaluating/tracking BPHC and Partner performance against established metrics. As fiduciary, SBH will provide a single point of accountability to the State, while avoiding the creation of a new legal entity while the business functions and relationships within the PPS are still under development.

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: **36_SEC021_Section 2 - BPHC Organizational Structure.pdf**

Description of File

BPHC Governance Structure Charts

File Uploaded By: mlipson

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***Structure 2:**

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

BPHC governance is rooted in an inclusive, transparent committee structure, flowing from a participatory planning process that included representation from every willing Member organization. The implementation governance is structured to continue these principles. BPHC will be governed by an EC, which will be supported by four standing Subcommittees with defined responsibilities, and led by Member representatives with relevant expertise and diverse perspectives.

The EC will be responsible for strategic leadership, including establishing the standards for all BPHC work products and processes; approving the BPHC operating plans and budgets; reviewing and approving CSO proposals for allocating and distributing incentive funds; evaluating and approving project metrics; evaluating Partner performance; and making recommendations for corrective action or removal of Partners, as necessary.

The EC and Subcommittees will ensure representation from a broad range of Members, including Federally Qualified Health Centers, hospitals, long-term care providers, behavioral health providers, labor unions, consumer advocates, and community-based and social



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services organizations. Committee and Subcommittee members will bring expertise required to effectuate delivery system transformation, be rooted in the Bronx community, and be charged with policy development and program oversight. Committees and Subcommittees will implement a consensus-based decision-making process, which will build support and buy-in for decisions made and actions taken by the PPS.

- a) The Finance and Sustainability Subcommittee will monitor, and make recommendations for funds distribution and value based contracts and will also monitor CSO services.
- b) The Quality and Care Innovation Subcommittee will: (i) create and update clinical processes and protocols; (ii) monitor Partner performance against such processes and protocols; (iii) oversee the implementation of DSRIP clinical projects in conjunction with the CSO staff; and (iv) advise BPHC's Rapid Deployment Collaboratives (described in more detail below) on how to quickly address issues that arise during project deployment and institute continuous quality improvement processes.
- c) The IT Subcommittee will create and update processes and protocols for adoption and use of IT processes and protocols that all Partners must implement
- d) The Workforce Subcommittee is responsible for developing and implementing a comprehensive workforce strategy.
- e) A Nominating Committee will be charged with recommending members of Committees and Subcommittees.
- f) Ad-hoc committees will be established by the EC, as needed.

The work of each of the standing committees is already underway under the existing planning committees and workgroups, but will be reorganized and consolidated in the implementation governance planning body described above. BPHC also will have a Project Advisory Committee (PAC), consistent with DSRIP requirements (discussed below).

The CSO and SBH leadership will support management of BPHC's daily operations, and will leverage their resources and deep understanding of the needs of Bronx patient populations to coordinate care in the region. The CSO leadership will be comprised a Chief Executive Officer, who will supervise a Chief Medical Officer, Chief Administrative Officer, and Chief Quality and Analytics Officer. The CSO will provide and/or arrange for a range of services to the PPS, including:

- a) Clinical supervision services;
- b) Information technology services;
- c) Financial services, including evaluation, development of funds distribution methodologies, and sustainability and value-based payment planning;
- d) Training;
- e) Analytics;
- f) Back office/administrative services; and
- g) Care management/coordination.

***Structure 3:**

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

The governance structure and processes will ensure successful clinical governance at the PPS level through establishment of the Quality and Care Innovation (QCI) Subcommittee, charged with establishing quality standards and measurements, overseeing clinical care management processes, and, together with the EC, holding providers and the PPS accountable for realizing clinical outcomes. Four Rapid Deployment Collaboratives (RDCs) will report to the Subcommittees, and will be responsible for identifying best practices and challenges for designated DSRIP projects:

- a) The Disease Management RDC will support the cardiovascular and diabetes disease management (3.b.i & 3.c.i), and Health Home at-risk (2.a.iii) projects
- b) The Primary Care/Behavioral Health (PC/BH) Integration RDC will support the PC/BH integration project (3.a.i)
- c) The ED Triage/Care Transitions RDC will support the ED care triage (2.b.iii) and care transitions (2.b.iv) projects



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d) The Patient Engagement RDC will incorporate the asthma home-based self-management project (3.d.ii) and focus on patient engagement, health literacy, cultural competency and strategies to address the social determinants of health across all projects

Partners participating in each project will be contractually obligated to participate in relevant RDCs. Each RDC will each be led by an expert practitioner employed by a BPHC Partner. These leads will be members of the QCI Subcommittee to ensure accountability and dissemination of ideas across RDCs.

The QCI Subcommittee will comprise Members with clinical experience relevant to the selected projects and will report findings and recommendations to the EC. It will work closely with other Subcommittees to inform the creation of incentive payments and define workforce and IT needs. The Subcommittee and RDCs will be supported by the CSO, which will gather evidence-based protocols for review and vetting by the Subcommittee and provide day-to-day support in Partners' project deployment.

***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.

BPHC understands that the PPS governance and organizational structure must evolve as DSRIP objectives and goals move toward sustainability and value-based contracting.

BPHC's planning structure, in place for the past six months, has benefitted from robust and inclusive planning committees and work groups which have met more than 50 times and involved more than 118 participants, gaining strong Member and community buy-in. The implementation governance structure will build on this inclusiveness, while providing greater accountability to ensure successful deployment of DSRIP programs.

Beginning April 1, 2015, BPHC will transition to the implementation governance body, led by an EC and work groups, and undergirded by legally binding MDSAs and a CSO to support and oversee PPS operations. During DSRIP Years (DY) 1-2, the governance structure will focus on the process for evolving into a highly effective, sustainable integrated delivery system (IDS), including preparing a framework for oversight of Partner progress toward meeting DSRIP milestones, solidifying Member buy-in, and evaluating performance against DSRIP metrics. This structure will continue to evolve as BPHC moves toward risk-based contracting in DY 3-5 to reach sustainability by the end of the DSRIP program. The nominating process will enable leadership to evolve to meet changing demands, and MDSAs will be amended as requirements and relationships change. BPHC also will evaluate establishment of alternative governing approaches as necessary to transition to post-DSRIP self sustainability.

At the outset, SBH and the CSO will provide significant support and oversight of the PPS. However as the PPS evolves toward value-based contracting, additional entities, such as health plans and/or other investors, may be integrated into the governance structure. BPHC will evaluate its governance and organizational structure periodically during the DSRIP program, to ensure that it is meeting DSRIP goals and objectives.

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.

Membership in the implementation governing body, launching April 1, 2015, is still under development. During the planning phase, BPHC has been led by a Steering (SC) and two subcommittees with representatives from hospitals, health centers, community-based providers, long-term care systems, organized labor, community-based organizations, home care providers, and higher education. Current SC members are:

- M. Golub, Institute for Family Health
- M. Kennedy, Visiting Nurse Service of New York



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- P. Mattel, Acacia Network
- F. Oliver, Bronx United IPA
- D. Ortiz, Puerto Rican Family Institute
- T. Oruwariye, Morris Heights Health Center
- P. Rosenfeld, CenterLight Healthcare System
- S. Rosenthal, Montefiore Medical Center
- R. Shapiro, 1199
- L. Walsh, SBH (chair)
- G. Wrenick, 1199
- D. York, Union Community Health Center

The implementation governing body will draw from current BPHC leaders and add new members, including a patient representative, to broaden its perspective and strengthen its expertise. The implementation governing body will be charged with decision making and oversight of all aspects of BPHC operations, including finance, sustainability, quality of care, IT and workforce.

***Process 2:**

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

For the planning governance structure, SBH solicited nominees from key stakeholders, receiving 142 additional nominations from Bronx-based stakeholders, which were vetted and approved by the planning Steering Committee. Every organization that sought a role was included in planning governance and BPHC anticipates that many of the leaders who emerged from this process will transition to roles in the implementation governing body starting April 1, 2015.

During the DSRIP implementation stage, launching April 1, the PPS's governing body will include an EC, Nominating Committee, the four Subcommittees (Finance and Sustainability, IT, Quality and Care Innovation, and Workforce), and any ad hoc subcommittees. The EC will consist of 15 voting members, with two members from each of SBH and Montefiore. This will ensure strong, centralized leadership by the PPS fiduciary (SBH), and Montefiore, the back-up fiduciary and an organization with significant experience in population management and large-scale system reform serving the largest share of the patient population. The Executive Director of the CSO will serve as an ex officio, nonvoting member. The Chair of the EC will be an SBH representative.

The planning Steering Committee will develop of set of criteria to guide the selection process for members of the initial implementation EC, which will be designed to ensure strong leadership as well as a mix of expertise, organizational representation, and diversity of perspectives. In consultation with the planning Steering Committee and their recommended selection criteria, SBH will appoint the members of the initial EC, which will begin serving as of April 1, 2015, from Member organizations. EC members will be selected based on relevant experience, leadership roles in their communities, their understanding of how to coordinate care among diverse patient populations, and their ability to bind their organizations to participate in BPHC. The EC will include a diverse range of provider and stakeholder interests and expertise, and will engage at least one consumer representative. Half of the members of the initial EC will be appointed for one-year terms, and the other half for two-year terms, resulting in staggered terms.

In subsequent years, the members of the EC who do not serve by nature of affiliation with SBH, Montefiore or the CSO will be selected by the EC from among individuals proposed by the Nominating Committee, which will choose candidates based on the qualifications described above. Committee members will serve staggered terms of two years; there will be no term limits. While SBH anticipates considerable continuity in the EC year-to-year, it is anticipated that membership will change over time as BPHC transitions to risk-based contracting and representation of payers or other entities may be desirable.

A similar approach to that used to appoint the EC will be undertaken to appoint members of the Subcommittees. There will be at least one representative from each of SBH and Montefiore on each Subcommittee.

***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, SBH has broadly solicited participation from the providers and community organizations that will comprise the PPS. As discussed above, every member organization that submitted nominations for planning workgroup members is



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represented on a planning committee or workgroup. In addition, BPHC has held five All-PPS Member meetings, most attended by over 100 participants. Thus, the DSRIP planning process has been a highly organized, transparent, grassroots effort.

As BPHC moves toward the implementation stage, individuals who served on planning committees and workgroups will remain involved in a variety of ways, including through participation in the implementation governance body, the Rapid Deployment Collaboratives and through twice annual All-Member meetings. BPHC will continue to ensure that the diverse range of voices that informed the planning process will remain involved during the implementation stage.

***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 members comprising a range of provider, institutional and community-based organizations (CBOs) serving the Bronx have been included throughout the DSRIP planning process in the past six months, serving on the planning Steering Committee, the Clinical Delivery and Program Planning Committee, the Business Operations Committee, and multiple workgroups focused on IT and Data Analytics, Finance, and specific clinical projects. BPHC will continue to have significant coalition Member and CBO participation during the DSRIP implementation phase through the implementation governance body described above. BPHC also will be contracting with community based organizations to perform training and support program deployment. Such organizations include a.i.r. nyc, a home-based asthma self-management services provider and Health People, which will train peer educators in deploying the Stanford Chronic Disease Self-Management and LEAP amputation prevention patient engagement programs.

***Process 5:**

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

In the new implementation governance body launching April 1, 2015, BPHC will implement consensus-based decision-making in all Committees. In this context, consensus means the agreement of a supermajority (75%) of the relevant Committee. The supermajority requirement ensures that decisions have broad support of the relevant Committee, which will in turn engender Member buy-in and preserve accountable, transparent and informed participation at all levels of governance. SBH, as the fiduciary, will ensure that a consensus-based decision making process is followed, seek to build trust between Members, and if necessary, exercise the authority to make final decisions if consensus cannot be obtained. SBH does not intend to block, overturn or otherwise disrupt decisions that are consensus-based, except in cases where decisions or actions may bring BPHC out of compliance with legal or contractual obligations.

Consensus-based decision making will take the following form. Actions by the EC that are consensus-based will be final subject to the exercise of SBH fiduciary duties. Actions by Subcommittees that are consensus-based will be submitted to the EC for review, and if approved, will be final subject to the exercise of SBH fiduciary duties. The process for resolving conflicts in instances where decisions are not consensus-based is discussed below.

***Process 6:**

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

When Subcommittee actions are not consensus-based, the relevant Subcommittee will submit to the EC a summary of issues on which consensus has, and has not, been reached. The EC will work with the Subcommittee to reach consensus. If consensus cannot be reached, the EC will prepare summaries of issues of agreement and contention and a recommendation for SBH review. SBH will evaluate this proposal and work with the EC to establish consensus. In the rare case consensus cannot be reached, SBH's CEO or appointee of CEO subject to Board oversight, as fiduciary, will determine the course of action.

For EC actions that are not consensus-based, a summary of issues will be submitted to SBH, following the process described above. BPHC will adopt a Conflict of Interest (COI) Policy for key employees and Committee members, who must also complete an annual COI disclosure statement. Individuals reporting a conflict must recuse themselves from participation in decisions involving the 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.



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SBH will maintain its public-facing website (www.bronxphc.org), on which materials from all-Member meetings, updates from the Rapid Deployment Collaboratives, and other important documents will be posted. The website contains a calendar of key events for stakeholders, and a jobs page will be added to connect community members and frontline workers to DSRIP-related employment opportunities. BPHC will continue to host all-Member meetings at least twice annually, and public forums at least annually. BPHC will encourage Member and community feedback through a contact page on its website, and by creating a dedicated email address, manned by CSO staff.

In addition, the PAC, which consists of all committees and subcommittees in the implementation planning body, will communicate via email, regular meetings, newsletters and an existing PAC website. Materials and minutes from all Committee and Subcommittee meetings will be posted to the PAC website unless deemed confidential.

*Process 8:

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

The BPHC EC will have direct oversight of stakeholder engagement. BPHC has hired a Director of Collaboration with deep roots in the Bronx community, responsible for managing Member engagement and outreach to community stakeholders, under the direction of the EC. To date, he has held 43 meetings with providers, community organizations, elected officials, and business and faith leaders to educate them about DSRIP and enlist support. BPHC also employs a workforce liaison to coordinate its workforce strategy, including collaborating with the 1199 Training and Employment Fund and Members. SBH established a social media presence for BPHC, including Facebook, Twitter, and YouTube pages, to engage stakeholders and community members who may be served by the PPS. BPHC will hold annual public forums to solicit feedback from stakeholders, and establish relationships with local media to issue press releases about BPHC's activities to promote provider and community involvement in the PPS.

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.

Based on the size of its membership, SBH chose to pursue an alternative PAC structure during the planning phase instead of the model originally proposed by the State. During the planning period, the alternative structure has created efficient governance, while ensuring that all key parties within BPHC are represented and all member organizations are kept informed. The planning PAC members were selected six months ago by SBH based on their roles in their communities, their commitment to taking an active role in shaping the PPS, and relevant experience and expertise. They were selected from a diverse representation of providers across the Bronx rooted in the community, including but not limited to: primary and specialty care providers; mental health and substance abuse providers; community-based physicians; home care, long-term care and rehabilitative services; labor; and housing, social service and community-based organizations. Members of the planning PAC were nominated in June, and first convened in July.

During the DSRIP implementation phase beginning April 1, 2015, an alternative PAC structure also will be implemented, as 163 Members will be too large to effectively incorporate a representative from each into the PAC. The PAC that will be in place during the DSRIP implementation phase will be representative of the full range of Members critical to the success of the PPS, including community-based organizations and any gaps identified during the planning period.

The implementation PAC will consist of the members of the Executive and Nominating Committees, and Finance and Sustainability, IT, Quality and Care Innovation, Workforce and Ad Hoc Subcommittees. The EC will have 15 members, including at least two members from both SBH and Montefiore (MMC), and the Nominating Committee will have five to seven members, with at least one member from both SBH and MMC. The Subcommittees will have between 12 to 15 members, and both SBH and MMC will have at least one member on each Subcommittee. The PAC as a whole will have more than 70 members, and membership will increase as ad hoc subcommittees form. Each Committee and Subcommittee will meet approximately bimonthly during implementation, and the entire PAC will convene quarterly. The implementation PAC will begin meeting in April 2015, and meetings will take place at SBH, which is centrally located among Members.



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***Committee 2:**

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

The planning PAC has been responsible for developing the implementation governance structure, overseeing clinical planning efforts, and reviewing plans for deployment of central services. In the implementation phase, the PAC will oversee the deployment of DSRIP projects with regards to financing, sustainability, performance, information technology, and workforce, among other functions.

During DSRIP implementation, the PAC will meet quarterly to receive progress reports from BPHC leadership, including the CSO and the EC, and to provide feedback on BPHC operations and progress toward meeting DSRIP goals. Members of the implementation PAC will be charged with ensuring that all PPS Members have the opportunity to participate in DSRIP project development, implementation and oversight. The EC will be charged with overseeing stakeholder engagement activities conducted by the CSO. PAC members will also be engaged through their Committee and Subcommittee meetings.

***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).

Starting in March 2014, members of what became the planning PAC met regularly and discussed the framework for the DSRIP operational structure. These individuals began to analyze the DSRIP scope, discuss organizational issues, review community health and cost of care data focused on the DSRIP target areas, and select an initial suite of DSRIP projects that would be confirmed during the CNA. The PAC was given the opportunity to review drafts of the CNA and provide feedback on data interpretation and findings.

The planning PAC consisted of a Steering Committee, working with the Business Operations Committee and a Clinical Delivery/Program Planning Committee, all comprised of organizations considered key PPS Members. During the planning stage, these planning PAC Committees created the organization structure of the PPS, taking into account the perspectives and needs of their respective organizations and communities and the larger goal of population health improvement.

***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.

SBH has ensured that the PAC represents all provider sectors and a broad range of BPHC Members critical to transforming healthcare in the Bronx. The PAC includes and will continue to include primary, specialty, mental health and substance abuse providers; community-based independent physicians; home care, long-term care and rehabilitative services provider; and community-based and social service organizations. The PAC includes representatives from organizations such as Acacia Network and BronxWorks that provide support services crucial to meeting beneficiaries' social needs, such as transitional housing, children and youth programs, immigrations services, and employment assistance. Representation by these organizations ensures that the PAC continuously considers population health improvement from a holistic perspective. Labor unions represented on the PAC were chosen based on a survey of the PAC Members to identify the most represented unions.

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.

BPHC understands the importance of compliance to meeting the goals of DSRIP and to ensuring the financial and operational integrity of the initiative. SBH will recruit and hire a Compliance Officer to serve within the CSO. In the recruitment process, SBH will seek to identify an individual with experience with and deep expertise in organizational compliance policies and procedures, as well as an understanding of the local, state and federal health care landscape. The EC will review and vote on SBH's recommended candidate for the position. The PPS Compliance Officer will be an employee of the CSO (through SBH).



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***Compliance 2:**

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

The PPS Compliance Officer will leverage his considerable experience, and draw from existing SBH compliance policies and procedures, to implement a compliance plan for the PPS. He will be required to operate and monitor the PPS compliance program and report results to the EC.

The Compliance Plan will be developed with CSO staff, in collaboration with Subcommittees to ensure the appropriate scope of clinical, financial and IT compliance. The EC will approve the Compliance Plan before its implementation, and will seek input from Members as appropriate.

Among other things, the Compliance Plan will feature: written standards of conduct; policies and procedures; education/training programs for Partners and their employees, agents and contractors; the establishment of a complaint hotline and the adoption of procedures to protect anonymity and prevent whistleblower retaliation; a system to respond to allegations of improper and illegal activities; financial and operational audits and assessments for compliance monitoring; and the investigation and remediation of identified systemic problems and development of policies addressing the non-employment or retention of sanctioned individuals.

***Compliance 3:**

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

The Compliance Officer will develop Partner education and training programs drawing from existing SBH and Partner materials that will be customized for BPHC. Materials will cover topics that include, but are not limited to, compliance with HIPAA and State privacy laws; fraud, waste and abuse; and the importance of ensuring that no DSRIP projects result in withholding necessary care. Materials will be designed to help Partners identify and report compliance issues. BPHC will contract with an external vendor, NAVEX Global, that will act as an independent contact to review and catalogue complaints for follow up.

BPHC will implement a comprehensive training program during DY1 and employees will be retrained annually, and as necessary to address regulatory developments. BPHC anticipates that many Partners will need training on ensuring access to care and compliance with privacy and security rules relating to electronically stored and shared patient data. To the extent that these or other compliance materials do not currently exist, the Compliance Officer will work with Partners, governing body members and outside parties to create them and fold them into required trainings.

***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.

Members of the community served by BPHC, including Medicaid beneficiaries and uninsured community members attributed to the PPS, will be notified of how to file a compliance complaint at the point of care. Individuals with a primary care provider (PCP) will be notified of the process at a regular office visit, or through e-mail, or written or phone communication. In addition, fliers or pamphlets will be available at all Partner sites, to ensure that attributed beneficiaries who do not have PCPs will receive relevant information. Patient advocates will also educate DSRIP's target population on the complaint process.

The complaint process will include a toll-free hotline, which may be run by an external vendor, and/or dedicated e-mail address that will be easily accessible to the parties listed above. It will include translations to commonly spoken foreign languages.

In addition, if an individual (or organization) feels their rights have been violated or that the PPS is acting in conflict with its DSRIP obligations, the individual or organization may contact the Compliance Officer in writing or via phone or e-mail. This information will be posted on the BPHC website.

✔ 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.



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***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.

For BPHC to be successful, it must not only successfully integrate service delivery across providers, but it must also establish an organizational structure that supports the DSRIP goals. This structure must include the ability to implement financial and operational strategies that will ensure the financial sustainability of the PPS as a whole.

As fiduciary, SBH will be ultimately responsible for collecting and distributing DSRIP funding to Partners. SBH will ensure that decision-making, funds allocation and accounting are accomplished through an equitable and transparent process.

The CSO will be the operating hub for all business and clinical activities, and will provide financial services, including general accounting, budgeting financial planning and analysis for value based contracting, and development of funds distribution methodologies. The Finance and Sustainability Subcommittee will make recommendations for how DSRIP funds, including incentives, will be distributed to Partners.

The EC will be responsible for approving BPHC's operating plans and budget, as well as reviewing and approving CSO proposals for methodologies for allocating and distributing funds.

***Organization 2:**

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

SBH and BPHC Members view DSRIP incentive payments as essential to delivery system transformation. The transition to value-based payments will require the PPS and its partners to develop a strong governance structure and to employ sound clinical programs and information technology that improve health outcomes and manage the cost of care.

The financial structure for the PPS will involve SBH as fiduciary; the CSO, which will develop fund distribution methodologies; the Finance and Sustainability Subcommittee (FSS), which will make recommendations for funds distribution to the EC; and the EC, which must approve FSS recommendations.

BPHC will establish the following key functions within the financial organizational structure:

- The appropriate segregation of duties so that no one person can authorize, approve and disburse funds
- The review and approval of transactions by someone who did not initiate the transaction
- The implementation of a policy relating to Conflicts of Interest
- Recordkeeping and accounting
- High-level reviews of performance against PPS budgets, which will occur monthly
- Value-based payment planning and management of risk contracts

***Organization 3:**

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

BPHC plans to use both internal and external auditors to assess the PPS's internal controls. All audit processes will be overseen by the Compliance Officer, who will report to the EC, SBH and other Committees as dictated by audit findings. The Compliance Officer (CO) will present to the EC, and others as necessary, reports of internal and external audits, and will develop and implement training materials to address areas that require improvement. The CO will have a direct line to SBH through (1) its employment by the CSO, which is a division of SBH and (2) through SBH EC representation.

SBH understands that multiple audits may be necessary to assess both general and financial compliance. The PPS's compliance program will be designed to meet all requirements of New York State Social Services Law 363-d, as discussed below.

External auditors will be of particular importance in auditing DSRIP finances, and funds flow among Partners. In addition, to the extend DSRIP operations invite liability under federal and state fraud and abuse and/or privacy law, external auditors will be engaged to ensure compliance.

***Organization 4:**



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

SBH has an effective compliance program that complies with New York State Social Services Law 363-d; thus, to the extent compliance policies, procedures and processes are created from existing models, a foundation for State law compliance is already in place. BPHC's Compliance Officer, with the support of other members of the PPS, will ensure that the BPHC compliance program will meet the requirements of New York State Social Services Law 363-d.

If necessary, SBH will undertake a gap analysis to determine where the PPS compliance program will need to be developed in order to address the unique attributes of DSRIP participation. SBH's current auditors review its compliance program as part of the annual audit. Such a gap analysis, if deemed necessary, will be completed, and policies and procedures developed, within 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 EC, with the assistance of Subcommittees, will be responsible for oversight of PPS operations, and with ensuring that Partners comply with the terms of the MDSA. Subcommittees will provide specific oversight in their relevant areas (e.g., clinical quality, IT adoption and implementation, and adherence to requirements relating to PPS finance), informed by Rapid Cycle Deployment Collaborative and the Rapid Cycle Evaluation process, and will report up to the EC as necessary. BPHC's technical infrastructure will include a framework for evaluating performance of Partner organizations, at both a PPS and an individual level. Once the technical capabilities are established, BPHC will monitor Partner performance regularly against established metrics, including an assessment of Partners' baseline performance. The monitoring capabilities that will be implemented at the PPS will be a critical component ensuring that the PPS can respond in near-real time to performance issues at the Partner level.

***Oversight 2:**

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

BPHC will use rapid cycle evaluation to assess Partner performance. If a Partner is identified as underperforming, a written notification will be sent to the Partner at the direction of the EC describing in detail the area of underperformance

Where recommended, the underperforming Partner will develop a mutually agreed upon corrective action plan (CAP), setting forth remediation strategies, new performance metrics and timelines for reporting progress. CAPs will be submitted to the EC for approval. Once approved (as modified by the EC, if necessary), the Partner will regularly report on progress toward the CAP. The CSO will be available to provide technical assistance and facilitate access to resources and expertise within the PPS to assist the Partner in improving performance. Partners that fail to meet the performance milestones in the timeline set forth in the CAP will be required to submit detailed explanations.

Failure to comply with a CAP may lead to the suspension of DSRIP funding allocated to the Partner, temporary suspension of the Partner's participation in the PPS, or, as a last resort, removal of the Partner from the PPS.

***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.

BPHC is committed to the success of all of its Partners, which is critical to achieving the DSRIP goals and improvement in population health. If a Partner fails to comply with a CAP and/or address identified areas of poor performance after the culmination of the efforts described above, BPHC may suspend DSRIP funding allocated to that Partner, temporarily suspend the Partner's participation in the PPS, or remove the Partner from the PPS.

To determine the appropriate course of action when a Partner exhibits poor performance, the EC will convene a closed session meeting with the underperforming Partner to review and discuss the Partner's performance relative to the MDSA, and any CAP that has been



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implemented. The Partner must prepare a formal response for its failure to comply with DSRIP requirements, and/or the terms of the CAP, for presentation to the EC.

If the Partner's response is not acceptable to the EC (as determined by a vote of 75% of the members of the EC), the EC will prepare a formal recommendation to SBH's CEO or appointee of the CEO subject to Board oversight that the Partner be removed, suspended, or that allocated funding be revoked. In instances where a Partner's removal is deemed to be the appropriate plan of action, SBH will contact the State and formally request the Partner's removal.

BPHC understands that, as DSRIP spans five years and seeks to create long-term institutional change, CAPs must be reviewed with long-term goals in mind. BPHC is committed to working with Partners who are striving to function within CAPs, including at times when they fall short. A Partner's removal from BPHC will be a last resort.

Members of any Committee may be removed for cause upon the vote of 75% of the remaining members of the relevant Committee. Cause has been broadly defined to preserve Committee discretion in determining when a member must be removed. Among other things, the termination of a Committee member's affiliation with BPHC or a Partner will be considered cause for removal, if SBH or the relevant Committee 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.

BPHC will create and publicize a process for Medicaid beneficiaries, their caregivers, and advocates to provide feedback about PPS providers. This material will be translated in a variety of languages, and reading-level appropriate to ensure it can be easily read and understood by individuals from whom feedback is solicited.

BPHC will develop and distribute at all Member locations pamphlets or fliers explaining participation in the PPS, and providing information about where beneficiaries and others can go to learn more about the PPS, and where feedback may be submitted.

Feedback may be submitted through the BPHC compliance hotline, through the PPS website and/or via a dedicated e-mail address. Providers will also be trained on procedures for passing along participant feedback in a timely manner.

***Oversight 5:**

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

BPHC plans to establish a process for notifying Medicaid beneficiaries and their advocates when providers are removed from the PPS. The notifications will be translated into appropriate languages, and will be presented at an appropriate reading level.

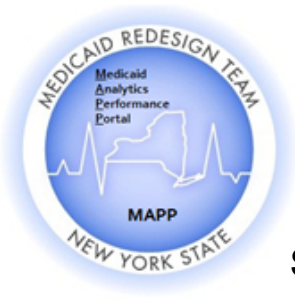
At the start, BPHC anticipates following SBH's process for notifying patients when their providers retire or otherwise cease practicing at SBH; this process will be tailored to the PPS, and will evolve over time as necessary. At the outset, beneficiaries will receive a letter from the PPS at the address on file with the relevant provider, and/or a phone call, explaining the change.

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.



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- Supporting documentation to validate and verify progress reported on governance, such as copies of PPS bylaws or other policies and procedures documenting the formal development of governance processes or other documentation requested by the Independent Assessor.



Please Check here to acknowledge the milestones information above



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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

Description:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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



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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

Description:

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

***Overview 1:**

Describe the process and methodology used to complete the CNA.

BPHC joined other Bronx PPSs in contracting with the New York Academy of Medicine (NYAM) to conduct a Bronx-wide CNA. A borough-wide Steering Committee, composed of representatives from each PPS, met biweekly from July to September 2014. The Steering Committee gave input on the development of the CNA data collection protocols and the identification of key informants, relying on CNA guidance released by DOH. In addition, the Steering Committee reviewed interim drafts of the CNA report, providing input on data interpretation and analysis. Draft versions of the CNA were also circulated to the BPHC PAC for review.

NYAM undertook primary data collection efforts to assess the Bronx healthcare landscape, including issues such as community health concerns, barriers to health promotion and disease prevention, access to care, disparities in care, and community resources. Ultimately, NYAM obtained the following primary data:

- a) Over 600 completed surveys in 10 different languages from individuals identified by CBOs or through street outreach in neighborhoods with a high proportion of Medicaid beneficiaries and uninsured residents. These neighborhoods included Hunts Point, Mott Haven, High Bridge, Tremont, Fordham Road, and Soundview
- b) 24 key informant interviews with 30 individuals with strong roots in the Bronx
- c) 22 focus groups with over 240 community members and community-based service providers

With regard to secondary data analysis, NYAM analyzed more than 70 datasets, including those posted on the DSRIP Performance Data website, to complete the CNA. NYAM also reviewed publicly available literature and reports describing Bronx healthcare needs. As noted in the CNA, prevalence and rates found in Section 3 of our application "reflect possible duplicated counts of Medicaid beneficiaries if a beneficiary's calendar year utilization was found by the NYS Department of Health to occur across multiple Episode Disease Categories...within a single Major Diagnostic Category."

***Overview 2:**

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

NYAM used a wide array of data sources to ensure that the CNA provided a comprehensive overview of the community landscape in the Bronx. In addition to the primary data sources described above, which ensured that community and stakeholder perspectives were well represented in the CNA, NYAM synthesized publicly available, de-identified data to assess health care and community resources, disease prevalence, demographic characteristics, and social determinants of health. NYAM supplemented analyses of publicly available data with a review of available literature, including reports prepared by the New York State (NYS) Department of Health, New York City (NYC) Department of Health and Mental Hygiene and Department of City Planning, academic institutions, and others. One such report was the NYU Furman Center's State of New York City's Housing and Neighborhoods in 2013.



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Datasets used included both those that include the entirety of Bronx residents and those that are specific to Medicaid beneficiaries. Key datasets included:

- a) NYS Community Health Indicator Reports
- b) BRFSS
- c) SPARCS
- d) PQI, PDI, PPV, and PPR data for Medicaid beneficiaries
- e) Aggregated Medicaid claims data on chronic conditions, inpatient admissions, and emergency room visits
- f) NYS prevention agenda tracking indicators
- g) NYC Community Health Survey
- h) Vital statistics
- i) American Community Survey
- j) NYS surveillance systems

NYAM conducted both descriptive analyses of these data and more complex analyses, such as regression, to understand the interplay between variables. Primary data were used to supplement the findings of secondary data analyses.

Finally, existing hospital and community providers' community health needs assessments (CHNAs) and community service plans were used to validate the CNA findings and understand provider-specific needs. Sources used included CHNAs by Bronx-Lebanon Hospital Center, Jacobi Medical Center, Lincoln Medical Center, Montefiore Medical Center, and SBH.

✔ 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	10	5
2	Ambulatory surgical centers	36	3
3	Urgent care centers	10	4
4	Health Homes	5	3
5	Federally qualified health centers	39	10
6	Primary care providers including private, clinics, hospital based including residency programs	1556	936
7	Specialty medical providers including private, clinics, hospital based including residency programs	2535	1775
8	Dental providers including public and private	576	110
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	73	32
10	Behavioral health resources (including future 1915i providers)	2963	2074
11	Specialty medical programs such as eating disorders program, autism spectrum early	62	14
12	diagnosis/early intervention	110	86
13	Skilled nursing homes, assisted living facilities	56	44
14	Home care services	33	23
15	Laboratory and radiology services including home care and community access	38	12



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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
16	Specialty developmental disability services	374	16
17	Specialty services providers such as vision care and DME	60	42
18	Pharmacies	73	8
19	Local Health Departments	1	1
20	Managed care organizations	12	3
21	Foster Children Agencies	49	16
22	Area Health Education Centers (AHECs)	1	1

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

***Infrastructure 2:**

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

The Bronx needs a systematic approach to modifying the composition of providers given provider shortages and residents' poor health outcomes. With a focus on high-need neighborhoods—High Bridge-Morrisania, Crotona-Tremont, and Fordham-Bronx Park—BPHC will pursue a strategy to expand, strengthen and align PPS providers.

Though CNA respondents reported availability of primary care, these services are unevenly spread across the borough and significant shortages exist in some neighborhoods. The Bronx has 18 HRSA-designated Medically Underserved Area neighborhoods and 8 HRSA-designated Health Professional Shortage Areas. To address these shortages, BPHC will request capital to build additional primary care facilities in high-need areas. SBH has also partnered with the Sophie Davis School of Biomedical Education at CUNY and will be their primary hospital campus as they become a full-fledged medical school focused on the education of primary care physicians (PCPs) to serve diverse, needy communities. To further expand the primary care base, BPHC will recruit and train midlevel providers (i.e., nurse practitioners and physician assistants). We will collaborate with all Bronx PPSs to increase the number of PCPs recruited and retrained, and we will work with community resources such as NYC REACH to support small practices in meeting NCQA and MU standards.

A key strategy to strengthen PCMHs will be implementing evidence-based disease management and care coordination. Care management (CM) staff, including peer staff, will need to be deployed to primary care practices and other providers, such as a.i.r. nyc, to bring project- specific services into the home. Bronx health providers confront significant challenges in recruiting and retaining staff. We plan to collaborate with other Bronx PPSs to standardize job titles, salaries and training, and will conduct joint recruitment, as appropriate, to improve efficiency and success. BPHC will also work with 1199 Training Fund, community colleges, community-based organizations, and NYSNA to help recruit and train a pipeline of CM staff.

BPHC plans to implement a targeted, collaborative recruitment approach to increase the number of behavioral health (BH) providers and sites. The Bronx has much lower rates of general psychiatrists and social workers than NYC as a whole. BPHC plans to add licensed clinical social workers to increase the pool of BH providers. Through the IMPACT model, BPHC will add care managers trained in BH to primary care sites. BPHC will also test telepsychiatry use in primary care, emergency departments, and the community.

Finally, BPHC will increase non-institutional sites where individuals with socially and medically complex issues can be temporarily cared for as they stabilize and return to independent living or other long-term options. For example, we plan to increase the capacity of Parachute NYC's Bronx-based crisis respite centers and mobile treatment units that offer medical supervision and temporary housing to individuals in psychiatric crisis through 2.b.i.

Note: Because the two columns in the table above draw from different data sources, their findings are often inconsistent.

✔ 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



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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.

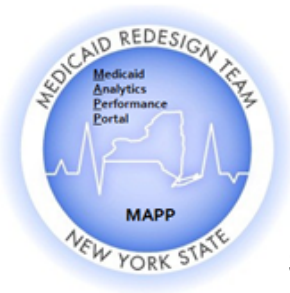
#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	299	24
2	Food banks, community gardens, farmer's markets	231	7
3	Clothing, furniture banks	128	1
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	62	10
5	Community outreach agencies	255	18
6	Transportation services	21	3
7	Religious service organizations	40	4
8	Not for profit health and welfare agencies	441	26
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	374	6
10	Peer and Family Mental Health Advocacy Organizations	13	10
11	Self-advocacy and family support organizations and programs for individuals with disabilities	38	4
12	Youth development programs	490	19
13	Libraries with open access computers	33	0
14	Community service organizations	21	5
15	Education	725	15
16	Local public health programs	7	1
17	Local governmental social service programs	43	1
18	Community based health education programs including for health professions/students	135	13
19	Family Support and training	25	6
20	NAMI	1	1
21	Individual Employment Support Services	66	8
22	Peer Supports (Recovery Coaches)	31	1
23	Alternatives to Incarceration	10	2
24	Ryan White Programs	23	7
25	HIV Prevention/Outreach and Social Service Programs	14	5

***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.

While the Bronx is fortunate to have a deep base of community resources, more than 33% of CNA respondents do not find social services to be readily available. The concern in the Bronx is not so much the composition of resources as it is that the level of need exceeds the available community resources. DSRIP provides an opportunity to increase the reach and impact of existing resources. BPHC plans to implement a culturally competent community resources strategy to facilitate connections between community members in need and help expand resources supporting them. Key areas of community resource need that BPHC plans to address include:

a) Housing conditions: Safe, affordable housing that is free of asthma triggers is a high need in the Bronx. One key informant stated,



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"Without housing you're never going to achieve [DSRIP's medical outcomes]." More than 50% of Bronx CNA respondents noted a lack of affordable housing in their community, and many Bronx neighborhoods with poor health outcomes have high rates of serious housing violations and rat sightings.

b) Food insecurity and nutrition: Food insecurity is a significant concern in the Bronx; almost two-thirds of CNA respondents noted worrying about not having enough to eat. In addition, over 40% of respondents felt that there is a lack of access to healthy foods. Notably, resources such as farmers markets and nutrition and exercise programs do not have a large presence in certain Bronx neighborhoods with high rates of obesity, such as Pelham-Throgs Neck and the Northeast Bronx.

c) Employment: Almost two-thirds of CNA respondents felt that job training was somewhat unavailable in the community, a problematic figure given that the Bronx's unemployment rate is almost 40% higher than the city as a whole.

d) Recidivism prevention: The Bronx's rate of jail admissions is 15% higher than NYC overall. A large percentage of state prison releasees move to the Bronx after their sentence is complete. This population has complex health needs; a study by the CBO Health People found that 40% of a sample of prison releasees had multiple chronic conditions and 59% said they were released without a Medicaid card.

Our PPS currently does not have any libraries, and we will continue to recruit them and other social and supportive services to join our PPS. To deploy our community resources strategy, BPHC will work with agencies with expertise in addressing the social needs listed above, e.g., a.i.r. bronx's home-based asthma program or Acacia Network's youth employment programs, to expand their outreach and help other providers build capacity. In addition, BPHC's analytics staff will share aggregate data with CBOs to help them target neighborhoods and populations most in need of resources. Finally, BPHC will optimize the extensive resources of the PPS's community resources through development of a web-based list of PPS social services providers. This list will enable real-time referrals and educate patients and caregivers about referral organizations.

Note: Because the two columns in the table above draw from different data sources, their findings are often inconsistent.

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 Bronx has a population of 1.4 million, representing 16.9% of the city's population and 7.1% of the statewide population. Slightly over half of the Bronx population is female, and according to U.S. Census data from 2008-2012, the population is slightly younger than the city and the state in general. Children in the Bronx (ages 0 to 17) represent over 25% of the total population, which is 5% higher than the proportion of children in NYC and NYS. The largest age group (ages 18 to 64) represents almost two-thirds of the Bronx population, while older adults comprise about 10% of the borough.

There are 821,339 Medicaid beneficiaries in the Bronx, accounting for approximately 59% of Bronx residents. Approximately 37% of the borough's Medicaid beneficiaries are under 18 years old. There are 93,324 Bronx residents that are dually eligible for Medicaid and Medicare, representing about 60% of the older adult population throughout the borough.

***Demographics 2:**

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

The Bronx is ethnically and racially diverse. The Bronx is approximately 43% Black/African American, 44% White, and 4% Asian. Over half of Bronx residents (54%) identify as Hispanic or Latino of any race. Historically, most Latinos in the Bronx were Puerto Rican; however, the Bronx is becoming more diverse as more immigrants arrive from the Dominican Republic and Central America, as well as South and Southeast Asia.

About one-third of the Bronx population was born outside of the United States and about a quarter speak English less than "very well," nearly double the statewide percentage. Approximately half of Bronx residents speak Spanish or Spanish Creole while 3% speak African languages. Smaller language groups have indicated experiencing difficulty with the quality of translation services, posing health literacy concerns for these populations.



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***Demographics 3:**

Income levels:

The Bronx is the poorest county in NYS. The median household income is much lower in the Bronx (\$34,300 per year) than in NYC (\$51,000) or NYS (\$57,683). Bronx residents represent 14.1% of New York's total Medicaid enrollment, as well as approximately 10% of all uninsured individuals across the state. The Bronx community has an uninsured rate of 15.7%, higher than NYC and NYS.

The low-income Bronx population faces concerns over the time and money spent on medical services. Residents who are not eligible for Medicaid find it difficult to afford plans offered on the state's health insurance marketplace, due to their low income levels and the high cost of living in NYC. As one key respondent noted, some Bronx residents might have to choose between purchasing food or buying health insurance.

***Demographics 4:**

Poverty levels:

A high proportion of Bronx residents (29%) live below the federal poverty level (FPL) compared to levels in NYC (19%) and NYS (14%). In Hunts Point-Mott Haven, nearly half of the households (46%) have incomes below the FPL, while other neighborhoods such as High Bridge-Morrisania, Crotona-Tremont and Fordham-Bronx Park have 25%-40% of households with incomes below the FPL.

Poverty impacts community health because of the proximity to unsafe environments and limited access to healthy foods. Key informants indicated that some clinics in crime-ridden neighborhoods limit extended hours in the winter due to safety concerns for the staff as it gets dark earlier in the day, thus decreasing access to care for community members. Additionally, as explained in another interview, low-income Bronx residents typically buy unhealthy foods because they last longer and feed more people than healthy foods.

***Demographics 5:**

Disability levels:

The Bronx disability rates are higher than the city and statewide rates. Nearly 3 out of every 10 households in the Bronx (29.1%) have a disabled member, which is defined as an individual with hearing, vision, cognitive, ambulatory, self-care, or independent living difficulties. Disabled populations experience multiple barriers to accessing care, including unreliable transportation services, inadequate accommodations at provider organizations, and insensitive attitudes or a lack of understanding around their disability. One key informant noted that many disabled patients often arrive late to medical or behavioral healthcare appointments because their main method of transportation, Access-A-Ride, is unreliable. Numerous providers and programs penalize patients for being late or missing appointments, thus creating a barrier to care for this at-risk population.

***Demographics 6:**

Education levels:

In addition to high levels of poverty and unemployment, Bronx residents have lower levels of educational attainment compared to the rest of NYC. A smaller percentage of Bronx community members (69%) aged 25 or older have received a high school degree compared to the city (79%) and statewide (79%) figures. Likewise, a substantially lower proportion of Bronx residents (18.0%) over age 25 have received a bachelor's degree compared to the city (34%) and statewide (32.8%) averages. The South Bronx, in particular, is known to have poor-quality schools and high dropout rates. As one key respondent described, schools there are "very ill-equipped to deal with and under-resourced to deal with all the myriad of issues that young people present in high school." CNA participants stressed that low educational attainment impacts future opportunities for individuals as well as the strength of the community overall.

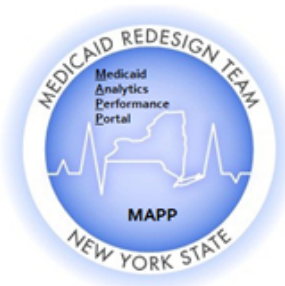
***Demographics 7:**

Employment levels:

Impoverished neighborhoods also have high levels of unemployment, with regions of Hunts Point-Mott Haven, Crotona Tremont, and High Bridge-Morrisania experiencing 17.1%-20% unemployment. The Bronx has an unemployment rate of 14.2% as a whole, which is higher than both the NYC and NYS rates, at 10.2% and 8.7%, respectively.

***Demographics 8:**

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



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In the Bronx, there are approximately 25,000 people residing in institutional settings. Although serious crime rates have been steadily declining across NYC, they are higher than the city average (13.6%) in multiple Bronx neighborhoods, with areas of the South Bronx experiencing rates between 19.1%-27.3%. Nearly 12,100 Bronx residents live in adult correctional facilities, while 450 live in juvenile facilities. Previously incarcerated populations are known to experience high levels of substance abuse, mental health problems, and HIV. A study by the community-based organization Health People found that 40% of a sample of prison releasees had multiple chronic health conditions. In addition, a large percentage of state prison releasees move to the Bronx after their sentence is complete.

File Upload (PDF or Microsoft Office only):

****As necessary, please include relevant attachments supporting the findings.***

File Name	Upload Date	Description
36_SEC034_Project Resource Needs and Other Medicaid Initiatives, Question 4b, St. Barnabas (dba SBH Health System).docx	12/22/2014 11:02:34 AM	Project Resource Needs and Other Medicaid Initiatives, Question 4b-Appendix I, St. Barnabas
36_SEC034_Bronx CNA_New York City Health Provider Partnership_Nov.2014.pdf	12/21/2014 09:22:12 AM	New York City Health Provider Partnership - Bronx Community Needs Assessment, November 2014
36_SEC034_Project 3.b.i, Question 4c, St. Barnabas Hospital (dba SBH Health System).docx	12/20/2014 08:40:25 PM	Project 3.b.i, Question 4c, St. Barnabas Hospital (dba SBH Health System).docx
36_SEC034_Health Gaps Bronx Reentry Populations.docx	12/20/2014 08:02:39 PM	Health People - Health Gaps Survey of Bronx Re-Entry Populations-2013, 2013
36_SEC034_State of NYC Housing_Part7.pdf	12/20/2014 07:41:00 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 7)
36_SEC034_State of NYC Housing_Part6.pdf	12/20/2014 07:35:25 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 6)
36_SEC034_State of NYC Housing_Part5.pdf	12/20/2014 07:33:34 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 5)
36_SEC034_State of NYC Housing_Part4.pdf	12/20/2014 07:31:53 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 4)
36_SEC034_State of NYC Housing_Part3.pdf	12/20/2014 07:29:38 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 3)
36_SEC034_State of NYC Housing_Part2.pdf	12/20/2014 07:21:29 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014 (Part 2)
36_SEC034_State of NYC Housing_Part1.pdf	12/20/2014 07:19:57 PM	NYU Furman Center - State of New York City's Housing and Neighborhoods in 2013, 2014, (Part 1)
36_SEC034_The State of NY Comptroller - The Prevalence and Cost of Asthma in NY State.pdf	12/20/2014 12:28:23 PM	The NY State Comptroller - The Prevalence and Cost of Asthma in New York State, April 2014
36_SEC034_NYS Health Workforce Planning Data Guide (2).pdf	12/20/2014 10:43:30 AM	The State University of NY CHWS - New York State Health Workforce Planning Data Guide, 2010 (Part 2)
36_SEC034_NYS Health Workforce Planning Data Guide (1).pdf	12/20/2014 10:39:23 AM	The State University of NY CHWS - New York State Health Workforce Planning Data Guide, 2010 (Part 1)
36_SEC034_ICPH_PolicyReprot_OnTheBrink_HomelessnessARealityInTheSouthBronx.pdf	12/19/2014 04:31:37 PM	ICPH - On the Brink: Homelessness a Reality in the South Bronx, July 2011
36_SEC034_Health People _ A&U Magazine.pdf	12/19/2014 04:31:04 PM	A&U Magazine - Health People: People Who Heal People, November 2014
36_SEC034_Commission Final Report - A Plan to Stabilize and Strengthen NY's Health Care System.pdf	12/19/2014 04:29:12 PM	Commission on Health Care Facilities in the 21st Century - Final Report, 2006
36_SEC034_CNA - Maternal and Infant Health in the Bronx 2013.pdf	12/19/2014 04:28:12 PM	Bronx Health Link - Community Needs Assessment of Maternal and Infant Health In the Bronx - 2013
36_SEC034_NYC DOHMH Epi Data Brief - Unintentional Opioid Analgesic Poisoning in NYC.pdf	12/19/2014 04:25:19 PM	NYCDOHMH Epi Data Brief: Unintentional Opioid Analgesic Poisoning (Overdose) Deaths in New York City
36_SEC034_CHCANYS_ExpanSustain_April2013 (5).pdf	12/19/2014 04:18:25 PM	CHCANYS - A Plan for Expanding Sustainable Community (Part 5)
36_SEC034_CHCANYS_ExpanSustain_April2013 (4).pdf	12/19/2014 04:15:48 PM	CHCANYS - A Plan for Expanding Sustainable Community (Part 4)



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File Name	Upload Date	Description
36_SEC034_CHCANYS_ExpanSustain_April2013 (3).pdf	12/19/2014 02:53:12 PM	CHCANYS - A Plan for Expanding Sustainable Community (Part 3)
36_SEC034_CHCANYS_ExpanSustain_April2013 (2).pdf	12/19/2014 02:39:44 PM	CHCANYS - A Plan for Expanding Sustainable Community (Part 2)
36_SEC034_CHCANYS_ExpanSustain_April2013 (1).pdf	12/19/2014 02:32:07 PM	CHCANYS - A Plan for Expanding Sustainable Community (Part 1)

✔ 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:

Leading causes of death and premature death in the Bronx align closely with city and statewide trends. The leading cause of death is heart disease for Black, Hispanic and White populations in the borough, with a death rate of 200.7/100,000 people, followed by cancer, influenza and pneumonia, diabetes, chronic lower respiratory disease, stroke, accidents, hypertension and renal diseases, mental and behavioral disorders, and Alzheimer's disease. The top five causes of premature death in the Bronx, in order, are cancer, heart disease, unintentional injury, AIDS and diabetes. The borough's premature death rate of 33.9% in 2012 was the highest in the state and substantially higher than the statewide premature death rate of 23.9%. In addition, the percentage of premature deaths in the borough is approximately 2.7 times higher among Black non-Hispanic and Hispanic populations as compared to White non-Hispanics. These statistics make heart disease, HIV, diabetes and behavioral health critical focal points in BPHC's clinical project planning.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The Bronx ranks highest among all NYC boroughs in the rate of potentially preventable Medicaid hospitalizations (PQIs for adults or PDIs for children). Conditions with notably high PQIs/PDIs include pediatric asthma, which caused 1,865 PQI admissions in 2012, at an observed/expected (O/E) ratio of 1.80 as well as adult hypertension (HTN) with 969 PQI admissions at a ratio of 1.51. Other conditions with high O/E ratios of PQI admissions include lower extremity amputation for diabetes (1.38) and COPD and asthma in older adults (1.38). There are racial and ethnic disparities in PQI admissions in the Bronx. Across all payers, the percentage of HTN PQI admissions for African-Americans was 429% higher than expected in 2008-09, while for Whites, it was 77% of the expected number. Similarly, for asthma during that time period, PQI admissions among adults were 366% higher than expected for Hispanics compared to 121% of that expected for Whites. In 2013, the leading cause of Bronx hospitalizations across all payers besides pregnancy-related admissions was respiratory disease, accounting for 10% of all hospitalizations in the Bronx, followed by digestive problems (8%) and heart disease (7%).

***Challenges 3:**

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

The Bronx has high rates of ambulatory care sensitive conditions. The rate of Bronx Medicaid beneficiaries with diabetes-related utilization is 11 per every 100 beneficiaries, more than 15% higher than the NYS rate. About 26% of Bronx Medicaid beneficiaries have cardiovascular disease (CVD)-related utilization. Risk factors for diabetes and CVD include smoking, obesity, and lack of exercise. In the Bronx, 16% of the population smokes, similar to NYC and NYS figures. Thirty-two percent of the population is obese, higher than in NYC and NYS (both 24%). Finally, approximately 30% of the population has not participated in a leisure-time activity in the past 30 days, a larger proportion than NYC (28%) and NYS (24%).

Among Bronx Medicaid beneficiaries who are children, the asthma rate of 701 per 100,000 is much higher than the NYC and NYS rates of 427 per 100,000 and 210 per 100,000, respectively. Asthma is linked to environmental health risk factors such as indoor air quality. In 2011, 6.7% of Bronx adults reported secondhand smoke in their homes compared to 4.9% in NYC overall, and higher rates of Bronx adults reported mold in their home (12.9%) than in the city (9.5%) as a whole.

***Challenges 4:**



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

The disease prevalence for chronic conditions in the Bronx is either at or above NYC and NYS levels. More than half (54%) of CNA survey respondents named diabetes as one of their greatest health concerns. Prevalence of diabetes among Medicaid beneficiaries in the Bronx is 11.1%, slightly higher than the statewide and the same as NYC's prevalence. Asthma presents another significant health challenge, as 39% of CNA survey respondents listed asthma as a health concern. Among Bronx children who are Medicaid beneficiaries, the asthma rate of 701 per 100,000 is substantially higher than the NYC rate (426.7 per 100,000) and NYS (210 per 100,000). For all Bronx Medicaid beneficiaries, the rate of asthma is 130 per 1,000, while the NYC and NYS rates are both 99 per 1,000. The percent of beneficiaries with asthma-related utilization is also slightly higher in the Bronx than NYC and NYS overall. The prevalence of Medicaid beneficiaries with cardiovascular diagnoses is equal to that of NYS (26.4%), but lower than NYC (30.2%). With 22% of survey respondents listing heart disease as a health concern, heart disease remains a major health challenge within the borough as it represents a leading cause of death and preventable admissions.

Among CNA survey respondents, 19.5% indicated that mental health issues are a key area of concern and 21.5% reported that they have faced depression or anxiety. The prevalence of Medicaid beneficiaries with behavioral health diagnoses (22.9%) is about equal to that of NYS (22.8%), but slightly higher than NYC (19.6%). In addition, the prevalence of serious psychological distress is also higher in the Bronx (7.1%) than NYC (5.5%). Suicide rates in the Bronx (5.4%) are similar to NYC (5.7%) and lower than NYS (7.8%) rates. Similarly, the proportion of Medicaid beneficiaries who binge-drank within the last month in the Bronx is 18.5%, which is comparable to the percentages in NYC (19.6%) and NYS (17.7%). Additionally, with almost half (47%) of Bronx survey respondents listing it, drug-and-alcohol abuse was the second most frequently cited health concern. Across the state, comorbidity levels are high; over half (54.4%) of behavioral health patients report having one other chronic medical condition or more. High prevalence of behavioral health, diabetes, asthma and cardiovascular disease led to BPHC's selection of these conditions for Domain 3 disease management projects.

The HIV/AIDS prevalence rate for the Medicaid beneficiaries in the Bronx (approximately 1,660 per 100,000) is higher than the NYC rate (1,370 per 100,000), and about a quarter of survey respondents reported HIV as a physical health concern for their community. In addition, the rate of new HIV diagnoses in 2011 among African Americans living in the Bronx was almost four times higher than that of Whites living in the borough, and the rate for Latinos was twice the rate for White residents. The Bronx has high rates for other sexually transmitted diseases: chlamydia rates were nearly double in the Bronx (1,238.8 per 100,000) than NYC overall (697.7 per 100,000) in 2009.

***Challenges 5:**

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

The percentage of pregnant women who receive late or no prenatal care in the Bronx is almost double (10.2%) that of the state overall (5.4%). The infant mortality rate (5.3 per 1,000 live births) in the Bronx is higher than in NYC (4.4 per 100,000), and is highest among Black and Puerto Rican populations, and in the poorest Bronx neighborhoods, such as High Bridge-Morrisania. In 2011, birth defects caused 20% of infant deaths in the Bronx. Babies are born at low birth weights more frequently in the Bronx (9.5%) than in NYC (8.5%) or NYS (8.1%). The percentage of preterm births, at 12.2%, is higher than the 10.8% in both NYC and NYS. Furthermore, there are racial disparities in preterm births throughout the Bronx; there are 40% and 20% more preterm births among black families and Hispanic families, respectively, than among non-Hispanic white families. The Bronx also has a higher maternal mortality rate (31/100,000 births) than NYC as a whole (27/100,000 births), a higher rate of teen pregnancies (95.9/1,000 females in the Bronx vs. 69.2/1,000 in NYC), and a higher percentage of pre-pregnancy obesity (25% in the Bronx vs. 17% in NYC), which pose health risks.

***Challenges 6:**

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

The Bronx has the highest percentage of obesity among all NYC boroughs, as 32% of adults are obese compared to 24.2% in the city overall. It was described as a "healthy food desert" by a key informant, and cultural preferences for fried and high-caloric foods contribute to obesity rates. The proportion of adults that report partaking in a leisure-time physical activity (70%) in the last 30 days is slightly lower than NYC (72%) and NYS (76%) rates. In addition, only 6% of Bronx adults indicate that they eat five or more fruits or vegetables per day, as compared to 9% in NYC and 26% in NYS. The link between obesity and other conditions, such as heart disease and diabetes, mark obesity as a significant health risk factor for BPHC.

Other health risk factors in the Bronx relate to substance use. In 2012, cigarette smoking rates (15.8%) were similar to NYC and NYS



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percentages, and 18.5% of the population reported binge-drinking in the past month. Accidental narcotics overdose is the eighth leading cause of death in the borough, at 9.2/100,000, and the mortality rate for opioid overdose, 3.7/100,000, has risen since 2005.

***Challenges 7:**

Any other challenges:

Immigrant communities face particularly pronounced challenges in the Bronx. Approximately 18.6% of Bronx residents are not US citizens, which is higher than the 10.5% of NYS residents, but similar to the NYC rate overall. The number of non-citizen individuals is considered an underestimation. During a key informant interview for the CNA, one provider reported that undocumented individuals "want to avoid providing information about themselves, and avoid 'the system' to the greatest extent possible," hindering their access to and appropriate use of healthcare services. One specific issue highlighted in the CNA for immigrant communities was domestic violence. Domestic violence poses additional challenges for immigrant families as they encounter stigma, lack of linguistically and culturally appropriate resources, and fear of deportation. Among CNA survey respondents, 31% reported that education programs about domestic violence are needed in their communities. Furthermore, key respondents linked domestic violence to the stresses of poverty and drug use, demonstrating the interconnectivity of social issues and community health.

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.**

While the Bronx's rate of primary care physicians per population (115.6/100,000 population) is lower than the NYC (134/100,000) and NYS (120/100,000) rates, the numbers do not fully reflect the limited access to physicians by Medicaid and uninsured patients, nor the acute primary care shortage in several densely populated Bronx neighborhoods with high prevalence of chronic illness. Four Bronx neighborhoods are designated in the New York State Health Foundation-funded Community Health Care Association of New York State study as having the highest need for community health center (CHC) expansion (Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania and Hunts Point-Mott Haven), three of which have the top need for CHC expansion in NYS. Almost one-third of Bronx residents live in Health Professional Shortage Areas and 46% of CNA respondents had visited an ED in the past year, suggesting inappropriate use of the ED or lack of primary care availability. Accordingly, the neighborhoods identified by CHCANYS as needing CHC expansion also have the highest rate of PPVs in the Bronx, reaching up to 49.4 PPVs/100 beneficiaries. By comparison Bronx-wide, NYS and NYC rates are 42/100, 36/100 and 34/100 beneficiaries, respectively.

The Bronx is also underserved by behavioral health (BH) providers. Only 53% felt that mental health services were available. There are 391 psychiatrists in the Bronx, 28.1/100,000, low compared to NYC (49/100,000) and NYS (36/100,000), and not all of these practitioners are not safety net providers. Similarly, the rate of social workers in the Bronx is 135.5/100,000, as compared to a rate of 231/100,000 in NYC and 234/100,000 in NYS. This shortage is problematic given that the prevalence of BH conditions in the Bronx is on par with city and state rates.

The Bronx currently has 3,794 hospital beds, or approximately 2.74/1,000 population, a decline from 3.14/1,000 in 2004. In 2013, SBH closed a 24-bed detox unit to create an ambulatory center focused on asthma, diabetes and geriatric services, and Westchester Square Medical Center acute care units have been repurposed as a Montefiore ED and ambulatory surgery center. Using SDOH data, it is estimated that a 25% reduction in preventable hospitalizations will result in a one-to-1.5 percent reduction in hospital beds in our PPS. In light of the recent bed reductions noted, we do not believe that there is material excess hospital-bed capacity in our PPS.

Finally, the Bronx has 46 nursing homes with 11,732 beds, or 843.7 beds/100,000 population, much higher than NYC and NYS rates, indicating that the Bronx may have excess nursing-home beds. The beds are filled almost to capacity, suggesting that social factors prevalent in the Bronx and noted in the CNA—severe poverty, disability rates and inadequate housing—are generating strong demand for skilled nursing facility beds.



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***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.

During the DSRIP planning process, clinicians and healthcare administrators cited challenges in recruitment as the primary rationale for the Bronx's shortage of primary care and behavioral health providers. The Bronx is the least healthy county in NYS and ranks worst in social and economic factors. These factors make Bronx residents an especially challenging population to treat, hindering recruitment efforts. In addition, compensation for Bronx health providers is reported to be less than surrounding counties in New York and New Jersey, so that qualified candidates are lost to other locales.

Because of gaps in capacity, Bronx residents may use EDs in situations where primary care would be more appropriate. In the CNA, key informants noted that affordability may drive unnecessary ED visits, as costs of healthcare services prevent many Bronx residents from obtaining preventive care and properly managing chronic conditions. Accessibility to care is affected by the lack of affordable transportation resources. Access-A-Ride, a transportation service for the elderly and disabled, is considered unreliable. Subway lines do not reach large portions of the Bronx. Services may not always be available when residents need them, as less than half (41.6%) of clinics serving Medicaid patients list weekend hours, representing a potential access barrier for those who work long hours, multiple jobs, or lack childcare. In addition, the Bronx has a high percentage of undocumented residents who because of immigration status use EDs when primary care would be appropriate. In neighborhoods Fordham-Bronx Park, High Bridge-Morrisania and Crotona-Tremont, 25-35% of the population speaks English less than "very well," making counseling about appropriate service use challenging. Finally, the high degree of poverty (29% of the population lives below the FPL) in the Bronx strains the behavioral health system. CNA participants emphasized the relationship between poverty, chronic conditions and depression. CNA participants also noted that behavioral health issues are particularly stigmatized by cultural groups living within BPHC's service area, making individuals in need of assistance less likely to seek care. Furthermore, only 52% and 53% of respondents reported that substance abuse services and mental health services, respectively, were available or very available.

***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.

BPHC's strategy to address the gaps described is primarily based on five tactics: expand primary care sites' hours of operation and build new primary care capacity in key neighborhoods; ensure that primary care sites in BPHC's network provide team-based care and achieve 2014 Level 3 PCMH status; recruit and train a larger workforce that is community based, culturally competent and able to provide care management and health education services; integrate knowledge of social determinants and behavioral services into primary care practices; provide technology that will enable coordination of care and information-sharing among providers within the BPHC and across Bronx PPSs.

BPHC will request capital funds under DSRIP to build new or expand existing primary care and BH facilities in underserved neighborhoods, including Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania and Hunts Point-Mott Haven. BPHC will also work with other Bronx PPSs to institute a recruitment campaign to attract PCPs and BH providers to underserved areas of the Bronx. BPHC will make use of state incentive programs, including Doctors Across New York, Physician Loan Repayment and Primary Care Service Corps, to increase capacity in the Bronx.

BPHC will pursue the Primary Care/Behavioral Health Integration Project (3.a.i) with the goal of extending BH services to sites that destigmatize such services, thus increasing accessibility. The project will provide funds to deploy psychiatrists as consultants and depression care managers in primary care practices, and add primary care providers to mental and behavioral care sites. This project will be particularly impactful for the 54% of beneficiaries with a BH condition who have a co-occurring chronic health condition.

Finally, BPHC has begun the process of procuring a care coordination management system that all providers, including those without electronic health records, will use to access shared data.

Section 3.7 - Stakeholder & Community Engagement:



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Description:

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

*Community 1:

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

The four Bronx PPSs that collaborated on the Bronx CNA, Bronx Partners for Healthy Communities, HHC, Advocate and Bronx-Lebanon, along with NYAM, undertook an extensive stakeholder and community engagement process in developing the CNA. NYAM formed an advisory committee of the PPSs to guide selection of key community leaders, identify ethnic enclaves and community-based organizations (CBOs) whose voices needed to be heard, and provide feedback as primary and secondary data were assembled and analyzed. NYAM worked with CBOs to administer and recruit representative individuals for surveys and focus groups. NYAM staff also trained community partners in the primary data-collection research protocols, the voluntary nature of research and confidentiality. As outlined in the CNA report, the goal of the stakeholder and community engagement process was to understand: the impact of community and environmental conditions on health promotion and disease prevention; primary health concerns and needs of residents by neighborhood and socio-demographics; and the health-related services available to residents, organizations providing the services, and service gaps. Other issues explored included mechanisms for addressing health promotion and care needs in the community, including for distinct populations.

Participants appreciated the DSRIP goals and the opportunity to have their opinions heard. Community members and stakeholders were very responsive to requests for participation in the CNA. Approximately 600 Bronx community members completed surveys. While the majority of survey respondents were recruited through the collaborative methods outlined above, NYAM also engaged residents through direct street outreach, ensuring that community members from all Bronx neighborhoods were surveyed. Throughout the data-collection process, NYAM aimed to understand the perspectives of Medicaid and other low-income populations. NYAM also conducted 24 interviews with 30 key informants across the borough. Informants were selected with the input of participating Bronx PPSs, based upon their experience with certain populations or specific health or social problems. NYAM staff conducted all interviews and asked follow-up questions on an ad-hoc basis.

*Community 2:

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

NYAM facilitated 22 focus groups, including 240 community members from diverse backgrounds for the Bronx CNA. Participants included residents from low-income neighborhoods with unique health and service needs, including "individuals with behavioral health issues, older adults, LGBTQ, and immigrants and other limited English proficient (LEP) individuals." The focus group population was 62.8% female, 46.1% Black/African American, 39.2% Latino and 57.6% Medicaid beneficiaries. The mean age of participants was 49.6. Focus groups were conducted in English, Spanish, French and other languages as needed. NYAM also completed a small number of focus groups with community leaders, medical and behavioral providers, and care coordinators. Topics for these focus groups included access to medical and behavioral health services, resources that promote health and social determinants of health. Focus groups also solicited recommendations for change, such as strategies for increasing community attendance at health-related events. Given the diversity of the participants and the range of topics explored, focus group responses added valuable insights to supplement data discussed in the CNA.

*Community 3:

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

Bronx stakeholders and residents highlighted key areas of concern, gaps and suggestions for improving access to and quality of healthcare services across the borough. Stakeholders described gaps in mental health services affecting population health. Providers reported difficulties in care coordination due to regulatory barriers and hiring problems due to limited funding for coordination services. Respondents were concerned about the prevalence of diabetes, obesity, cancer, cardiovascular disease, asthma, domestic violence, and substance abuse in their community. In addition, they discussed the effects of stress and depression on medical and emotional well-being, which are considered byproducts of high poverty levels. Furthermore, concerns about the cost of care and health insurance prevent residents from receiving appropriate care. Finally, respondents were enthusiastic about creating new partnerships between healthcare providers and CBOs, as well as the potential to improve the quality of care provided and health outcomes overall.

In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations



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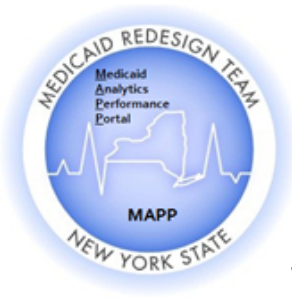
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engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.

[St. Barnabas Hospital (dba SBH Health System)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	African Diaspora and Festival Parade	Unites thousands of Bronx residents of African descent to promote the economic development, traditions and arts of the African continent	This event helps the PPS engage with African-American residents to better understand their culture, and ultimately provide culturally sensitive health and supportive services. Cultural competency across all PPS services is a critical part of BPHC's strategy. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
2	BOOM! Health	Provides medical and behavioral health services, including healthcare centers and coordination for diverse Bronx populations, particularly homeless people and those suffering substance abuse problems. The organization also offers advocacy, housing, legal assistance, sterile syringe access and general wellness services.	Community members indicated that the need for multiple visits and separate care services creates frustration and barriers to care coordination. Providing social and healthcare services through the same organization can demonstrate the benefits of colocated services and improved care coordination, two key focus areas within BPHC's strategy. This organization also offers important resources to some of BPHC's most significant at-risk populations, increasing the potential to reduce rates of avoidable ED visits and admissions. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
3	BronxWorks	Offers services for benefit assistance, senior citizens, children and youth, immigration, homeless persons, eviction prevention, chronic illness and workforce development.	This organization provides numerous support and social services needed by substantial portions of the PPS's attributed population. As reported in the CNA, housing concerns, homelessness, chronic illnesses and lack of healthcare coverage act as barriers to care and causes of severe psychological stress. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
4	Center for Independence of the Disabled, New York	Provides a variety of resources and assistance to disabled New Yorkers for housing, transportation, health insurance, emergency preparedness, Social and Security Disability Insurance needs.	The CNA report outlines the unique challenges and barriers to care faced by beneficiaries with disabilities. The resources and information provided by this organization will be critical to BPHC's strategy to care for this population. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
5	Friends of Saint Mary's Park	Promotes community engagement for the largest	Community parks can provide



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[St. Barnabas Hospital (dba SBH Health System)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		park located in the South Bronx, such as free concerts, park-cleaning and cultivation of green space among residents of all ages, races and ethnicities.	healthy, clean and safe environments for Bronx residents, as well as facilitate exercise and other healthy behaviors that are vital to the success of many of BPHC's clinical projects. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
6	Health People	Health People is the Bronx's only entirely peer education-based health promotion and disease prevention organization, providing outreach, prevention, self-care classes, mentoring and support by training low-income people impacted by chronic disease and AIDS to implement evidence-based practices to reduce sickness and hospitalization from chronic illnesses, including HIV/AIDS, hepatitis C, diabetes, heart disease and asthma.	Health People's well-evaluated, in-depth experience in implementing peer programs for a range of disease offers important models for increasing health literacy across the PPS's attributed members, an important focus across all BPHC projects. Peer educators will play a significant role in BPHC's Domain 4 projects, and this organization can be leveraged and provide insight to ensure that BPHC's peer education programs are as effective as possible. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
7	Highbridge Gardens Houses	A housing development that provides 699 apartments across 12.63 acres of land to low-income Bronx residents.	As many Bronx residents struggle with poverty, affordable housing will be pivotal to the PPS's overall strategy. Housing solutions have the potential to decrease stress levels and improve living conditions for poor Bronx populations. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
8	Local Initiatives Support Corporation	Focuses on building sustainable communities by connecting corporate, government and philanthropic support to local community development organizations to provide loans, grants and investments, policy support and management assistance.	This organization can help ensure financial sustainability for important community-based organizations that provide critical services and support to our PPS's attributed members. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
9	Mekong	Empowers the Southeast Asian Community in the Bronx by sponsoring events where topics such as healthy living and leadership-building are discussed.	As immigration from Southeast Asia is growing in the Bronx, it is becoming more important for the PPS to understand this subgroup's unique needs and challenges to ensure that it provides culturally sensitive services. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
10	Morris Heights Health Center	Provides primary care, urgent care, counseling, school-based health, family planning services and linkages to health insurance enrollment assistance,	In an effort to create a truly integrated delivery system, the PPS views community-based primary care



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[St. Barnabas Hospital (dba SBH Health System)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		WIC distribution centers and other supportive services, such as home visits to new parents and mobile health outreach programs.	providers as critical to addressing the full spectrum of diverse patient health and social needs. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
11	Regional Aid for Interim Needs (RAIN)	Offers home-delivered meals, senior housing, neighborhood senior centers, transportation services, assistance with benefits and entitlements, case management and elder abuse services, and community-based mobile meals for homeless and hungry residents.	This organization provides numerous support and social services needed by a significant portion of the Bronx community. As noted in the CNA, food security, transportation challenges and housing concerns act as major health challenges, barriers to care and causes of severe psychological stress. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
12	Services and Advocacy for LGBT Elders (SAGE)	Offers services and linkages to programs for older LGBT Bronx residents, including different support groups, case management, benefits a	The PPS aims to provide culturally competent care and work with community resources to understand the unique needs of sub-groups, such as older LGBT adults. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
13	Soundview Houses	A housing development that provides 1,255 apartments across a 26.29-acre complex for low income Bronx residents.	Many of the PPS's attributed members struggle with poverty, indicating that affordable housing will be crucial to the PPS's strategy. Housing solutions have the potential to improve living conditions and decrease stress levels for poor Bronx populations. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
14	Violence Intervention Program	Focuses on preventing violence through community outreach and education programs, hotlines, counseling, economic empowerment programs, and residential programs for women and children victims of violence.	Bronx CNA survey respondents indicated that domestic violence has not received enough attention as a community health problem, and 31% reported that health education and programs on the topic are needed within their communities. The PPS can work with this organization to ensure that the problem is addressed in a comprehensive manner as part of the PPS strategy, thereby improving population health and wellness across the PPS. This organization collaborated with the PPS's on primary data collection for the Bronx CNA.
15	a.i.r. nyc	Focuses on asthma management for children by providing home visits from community health workers, linkages to legal support and environmental mitigation and establishing partnerships with school-	The CNA has indicated that asthma rates in the Bronx are particularly high (the second highest among all NYS counties) and increasing. BPHC



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[St. Barnabas Hospital (dba SBH Health System)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		based programs.	will contract with a.i.r. nyc for the implementation of its asthma management model as part of project 3.d.ii.

✔ Section 3.8 - Summary of CNA Findings:

Description:

In the chart below, please complete the summary of community needs identified, summarizing at a high level the unique needs of the community. Each need will be designated with a unique community need identification number, which will be used when defining the needs served by DSRIP projects.

***Community Needs:**

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

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

[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need to reduce fragmentation in care delivery and integrate services	Bronx providers feel that the service delivery system is fragmented, with a need to create integration between different care providers. This fragmentation compounds the challenges faced by the Bronx population when interacting with sources of care. The relative lack of services, patient lack of experience or knowledge of the health system, immigration status, long wait times for visits and other inconveniences associated with accessing care discourage timely attention to health, wellness and prevention, and make the emergency room a rational "one stop shop" for many. This need will be addressed by all projects, but specifically addressed and focused on in 2.a.i – Create an Integrated Delivery System 2.a.iii – Health Home At-Risk Intervention, and 3.a.i-Integration of Primary Care and Behavioral Health Services	NYAM focus groups
2	Need for increased primary care capacity in targeted neighborhoods	The Bronx has a need for increased primary care capacity in targeted neighborhoods. While the Bronx's rate of primary care physicians per population (115.6/100,000) is lower than the NYC (134/100,000) and NYS (120/100,000) rates, the numbers do not reflect the limited access to physicians by Medicaid and uninsured patients nor the acute primary care shortage in several densely populated Bronx neighborhoods with high	Center for Health Workforce Studies, NYS Health Workforce Planning Data Guide Community Health Care Association of New York, A Plan for Expanding Sustainable



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[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>prevalence of chronic illness. Four Bronx neighborhoods are designated in a New York State Health Foundation/Community Health Care Association of New York (CHCANYS) study as having the highest need for community health center (CHC) expansion (Fordham-Bronx Park, Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven), three of which have the top need for CHC expansion in NYS. Almost one-third of Bronx residents live in Health Professional Shortage Areas and 46% of CNA respondents had visited an emergency department in the past year, suggesting inappropriate use of the ED or lack of primary care availability. Accordingly, the neighborhoods identified by CHCANYS as needing CHC expansion also have the highest rate of PPVs in the Bronx, reaching up to 49.4 PPVs/100 beneficiaries. This need will be addressed in projects 2.a.i – Create an Integrated Delivery System, 2.a.iii – Health Home At-Risk Intervention, 3.a.i – Integration of Primary Care and Behavioral Health Services.</p>	<p>Community Health Centers in New York, April 2013</p> <p>HRSA data on Health Professional Shortage Areas</p> <p>2011-2012 Medicaid PPV by Patient Zip Code</p>
3	Need for increased behavioral health capacity across the borough	<p>There is a need for increased behavioral health capacity across the Bronx. Only 53% of CNA respondents felt that mental health services were readily available. There are 391 psychiatrists in the Bronx, 28.1/100,000, low compared to NYC (49/100,000) and NYS (36/100,000). Similarly, the rate of social workers in the Bronx is 135.5/100,000, as compared to a rate of 231/100,000 in NYC and 234/100,000 in NYS. This shortage is problematic given that the prevalence of behavioral health conditions in the Bronx is on par with city and state rates. This need will be addressed in Project 2.a.i – Create an Integrated Delivery System, Project 3.a.i – Integration of Primary Care and Behavioral Health Services, and Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure Across Systems.</p>	<p>NYAM survey of Bronx residents</p> <p>Center for Health Workforce Studies, New York State Health Workforce Planning Data Guide</p>
4	Need for integrated primary care and behavioral health services	<p>The Bronx has a need for integrated primary care and behavioral health services and improved care coordination services. Bronx residents report higher rates of serious psychological distress (7.1%) than New York City as a whole (5.5%). Community members have indicated that behavioral health issues, including anxiety, depression and substance abuse, are among the most pressing health issues facing residents. Key stakeholders pointed to the 'silos' among mental health and substance abuse providers as barriers to access. In addition, over half (54.4%) of Bronx adults with behavioral health issues served by NYS Office of Mental Health programs had one or more chronic medical condition. This high degree of overlap indicates that</p>	<p>New York City Department of Health and Mental Hygiene, Community Health Survey 2012 data</p> <p>NYS OMH, Patient Characteristic Survey (PCS), 2013</p> <p>NYAM interviews with key informants</p>



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[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		more coordination is needed between behavioral health and physical health services. This need will be addressed in Project 3.a.i. – Integration of Primary Care and Behavioral Health Services and Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure Across Systems.	
5	Need to expand care management services and increase provider knowledge of related existing resources	<p>The Bronx has a need to expand care management services and increase provider knowledge of existing care management resources. The borough has the highest rate of potentially avoidable inpatient hospitalizations and the second highest rate of preventable emergency department (ED) visits (PPV) of any New York City borough. Chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes, account for the highest proportion of potentially preventable admissions.</p> <p>In addition, CNA informants noted that lack of provider knowledge of and engagement in care coordination services, inadequate/inconsistent IT to conduct care management, and limited discharge planning/referrals after ED stays create barriers to accessing care management services at critical junctures in care. This need will be addressed by all projects, but specifically addressed and focused on in Project 2.a.iii- Health Home At-Risk Program.</p>	<p>2011-2012 Medicaid PQIs</p> <p>New York State Department of Health, Office of Quality and Patient Safety, 2014, as reported by the Office of Health Systems Management</p> <p>2011-2012 Medicaid Potentially Preventable Emergency Visits (PPV) by Patient Zip Code</p> <p>NYAM interviews with key informants</p>
6	Need to connect patients to resources addressing the social determinants of health	The CNA confirms what knowledgeable residents, healthcare professionals and policymakers already know about the Bronx – poor health conditions in the Bronx result from social determinants of health, including conditions of poverty. A higher proportion of Bronx households (29%) live below the federal poverty level than in NYC (19%) or NYS (14%) as a whole, with rates as high as 40% in some neighborhoods. Nearly 60% of the borough's population is covered by Medicaid (with rates as high as 84.2% in some ZIP Codes), representing 14.1% of the state's Medicaid population. The Bronx is the least healthy county in New York State. More than half of the population are non-native English speakers and one in five are non-residents, presenting cultural and regulatory barriers to access. While the Bronx is fortunate to have a deep base of community resources, more than one-third of CNA respondents do not find social services to be readily available, indicating that there is need for providers to increase efforts to connect patients to needed services. This need will be addressed across all projects.	<p>US Census, American Community Survey, 5 year data, 2008-2012</p> <p>New York State Department of Health, 2012 data</p>
7	Need for comprehensive discharge planning and follow-up after ED visits and inpatient stays	In the Bronx, there is a need for comprehensive discharge planning and follow-up processes after ED visits and inpatient stays to prevent 30-day readmissions. The Bronx's rate of potentially	New York State Department of Health, Office of Quality and Patient Safety, Bureau of



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[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>preventable readmissions (PPRs) is 5% higher than NYC and 13% higher than NYS as a whole. In addition, Bronx hospitals have 13% more PPRs than expected. There is strong evidence that addressing social needs through care management and comprehensive pre- and post-discharge care transitions can reduce avoidable readmissions. However, in the Bronx, gaps currently exist in discharge planning and follow-up processes after ED visits and inpatient stays, reducing the likelihood that patients receive appropriate referrals and follow-up care and increasing the likelihood of 30-day readmissions. This need will be addressed by Project 2.b.iv – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions.</p>	<p>Health Informatics Medicaid Claims Extract, 2012</p>
8	<p>Need for ED triage programs to identify and connect non-urgent patients to PCPs</p>	<p>The Bronx has a need for ED programs dedicated to identifying and connecting non-urgent patients to PCPs and Health Homes. Residents rely heavily on the ED as a source of care. Nearly 46% of CNA respondents reported using an ED in the last year because of reasons such as a lack of insurance, cost of co-pays, and inability to "get an appointment soon or at the right time." The Bronx has the second highest rate of preventable ED visits (PPV) of all New York City boroughs.</p> <p>In addition, numerous neighborhoods in the Bronx are HRSA-designated Health Professional Shortage Areas and/or medically underserved areas, and four Bronx neighborhoods, Fordham/Bronx Park, Crotona/Tremont, High Bridge/Morrisania, and Hunts Point/Mott Haven, fall in the CHCANYS-designated category of having the highest need for community health center expansion. Together, these factors increase reliance on the ED for on-demand care and contribute to high rates of potentially avoidable ED visits and readmissions in the borough. This need will be addressed by Project 2.a.i – Create an Integrated Delivery System and Project 2.b.iii – ED Care Triage.</p>	<p>NYAM survey of Bronx residents</p> <p>HRSA data on Health Professional Shortage Areas</p> <p>Community Health Care Association of New York, A Plan for Expanding Sustainable Community Health Centers in New York, April 2013</p>
9	<p>Need for asthma home-based self-management services</p>	<p>There is a need in the Bronx to expand availability of asthma home-based self-management services. As of 2013, 130 of every 1,000 Bronx Medicaid beneficiaries had asthma, the second highest rate of any county in the state and an increase of almost 10% since 2009. The rate of asthma among Bronx children covered through Medicaid is particularly poor; 701 per 100,000 Bronx children who are Medicaid beneficiaries had asthma in 2012, 64% higher than the citywide rate and 333% higher than the statewide rate. Accordingly, there is a high level of utilization associated with asthma in the Bronx, a</p>	<p>New York State Comptroller, The Prevalence and Cost of Asthma in New York State, April 2014</p> <p>New York State Department of Health, 2012</p> <p>Medicaid PQIs, 2012.</p>



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[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		substantial amount of which is preventable. The high prevalence and utilization associated with asthma are linked to poor environmental conditions in the Bronx, such as housing issues and pollution. This need will be addressed in Project 3.d.ii – Expansion of Asthma Home-Based Self-Management program.	
10	Need for PCMHs to implement a robust, evidence-based disease management approach for CVD	<p>We have identified a need for PCMHs to implement a robust, evidence-based disease management approach for cardiovascular disease (CVD). More than one-quarter of Bronx Medicaid beneficiaries have utilized services in the past year for CVD. CVD is the leading cause of mortality in the borough among white, black, and Hispanic residents, and the Bronx age-adjusted mortality rate for diseases of the heart (225.8/100,000 residents) surpasses city (212.2/100,000) and state (198.6/100,000) rates. Community members have indicated that addressing CVD is a community need; over 40% of CNA respondents indicated that hypertension is a particularly high area of concern.</p> <p>Accordingly, there is substantial utilization associated with CVD in the Bronx; the hospitalization rate for CVD is 210.8 per 10,000 residents as compared to 173.6 and 159.9 per 10,000 for the city and state, respectively. A high number of these CVD hospitalizations are preventable. As BPHC's primary care providers attain 2014 Level 3 PCMH recognition, there will be opportunities to integrate evidence-based CVD disease management strategies into practice to improve the quality of care for impacted individuals. This need will be addressed in Project 3.b.i – Evidence-Based Strategies for Disease Management in High Risk/Affected Populations for Cardiovascular Disease.</p>	<p>New York City Vital Statistics, Top Ten Leading Causes of Mortality, 2012</p> <p>2009-2011 data reported on the NYS Dept of Health Website County Health Assessment Indicators</p> <p>NYAM survey of Bronx residents</p> <p>PQI data from New York State Department of Health, 2012</p>
11	Need for PCMHs to implement a robust, evidence-based disease management approach for diabetes	<p>There is a need in the Bronx for PCMHs to implement a robust, evidence-based disease management approach for diabetes. 54% of CNA survey respondents indicated that diabetes is a top health concern in the community. In addition, diabetes PQI admissions among Medicaid beneficiaries in the borough are almost 25% higher than expected, and the rate of hospitalizations for short-term diabetes complications for this population is substantially higher than in NYC or NYS. As BPHC's primary care providers attain 2014 Level 3 PCMH recognition, there will be opportunities to integrate evidence-based diabetes disease management strategies into practice to improve the quality of care for impacted individuals. This need will be addressed in Project 3.c.i – Evidence-Based Strategies for Disease Management in High</p>	<p>NYAM survey of Bronx residents</p> <p>PQI data from New York State Department of Health, 2012</p>



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[St. Barnabas Hospital (dba SBH Health System)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		Risk/Affected Populations for Cardiovascular Disease for Diabetes. Depression is often a co-occurring disorder with diabetes. Project 3.a.i will address this through implementation of the Collaborative Care Model.	
12	Need to strengthen mental health and substance use infrastructure	The Bronx has a strong need to improve the mental health and substance use infrastructure. While the Bronx has high mental health and substance abuse utilization, only 53.3% of CNA survey respondents reported that mental health services are "available" or "very available" in their community. Accordingly, the Bronx has substantially lower rates of general psychiatrists (28.1 per 100,000) than the NYC rate of 49 per 100,000. Gaps in care are compounded by provider shortages, insufficient provider training, and insufficient coordination of services. Of particular concern are the lack of attention to prevention and early intervention services for adolescents; and the need for knowledge-sharing about best practices. This need will be addressed in Project 3.a.i – Integration of Primary Care and Behavioral Health Services and Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure Across Systems.	NYAM survey of Bronx residents Center for Health Workforce Studies, New York State Health Workforce Planning Data Guide
13	Need to increase early access to and retention in HIV care in targeted populations and neighborhoods	There is a need in the Bronx to increase early access to and retention in HIV care, particularly among targeted populations and neighborhoods. Although transmissions have decreased overall in recent years, the Bronx still experiences a substantially higher rate of new HIV diagnoses at 43.1 per 100,000 people as compared to the citywide rate of 33.5 per 100,000 people. In addition, the Bronx's age-adjusted mortality rate for AIDS (20 deaths/100,000) is double the citywide rate (9.4/100,000) and four times the statewide rate (4.7/100,000). There are significant disparities in HIV in the rate of new HIV diagnoses in the borough; the rate among black/African American people living in the Bronx is approximately four times the rate among whites throughout the borough, while the rate of new HIV diagnoses among Latinos living in the Bronx is over double that of whites. In addition, some neighborhoods in the Bronx have double the rate of infection as the city as a whole. This need will be addressed in Project 4.c.ii – Increase Early Access to and Retention in HIV Care.	NYC DOHMH 2011 NYS Dept of Health County Health Assessment Indicators, 2009-2011 NYC DOHMH, HIV/AIDS Surveillance Data, 2009

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.*

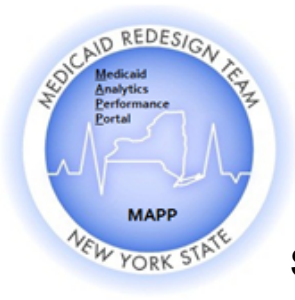


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File Name	Upload Date	Description
36_SEC038_Appendix C - Bronx Key Informant List.pdf	12/21/2014 12:45:10 PM	NYAM Bronx CNA - Appendix C. Bronx Key Informant List
36_SEC038_Appendix D.2. Organizations Collaborating on Bronx CNA.pdf	12/21/2014 10:15:01 AM	NYAM Bronx CNA - Appendix D. Organizations Collaborating on Bronx CNA
36_SEC038_NYAM CNA - Appendix D. Bronx Primary Data Findings Narrative.pdf	12/18/2014 10:51:41 PM	NYAM Bronx CNA - Appendix D. Bronx Primary Data Findings Narrative
36_SEC038_Appendix C - CNA focus group guide_final.pdf	12/18/2014 10:50:29 PM	NYAM Bronx CNA - Appendix C. Focus Group Guide
36_SEC038_Appendix C - CNA focus group brief survey_final.pdf	12/18/2014 10:46:55 PM	NYAM Bronx CNA - Appendix C. Focus Group Brief Survey
36_SEC038_Appendix C-CNA KI interview guide_final_.pdf	12/18/2014 10:44:18 PM	NYAM Bronx CNA - Appendix C. Key Informant Interview Guide
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36_SEC038_Appendix C - CNA_Survey_final_.pdf	12/18/2014 10:40:02 PM	NYAM Bronx CNA - Appendix C. Community Survey
36_SEC038_NYAM Bronx CNA -Appendix B Bronx Tables and Charts.pdf	12/18/2014 10:34:34 PM	NYAM Bronx CNA -Appendix B. Bronx Tables and Charts
36_SEC038_Appendix A- Maps of Bronx (6).pdf	12/18/2014 10:31:23 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 6)
36_SEC038_Appendix A- Maps of Bronx (5).pdf	12/18/2014 10:27:28 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 5)
36_SEC038_Appendix A- Maps of Bronx (4).pdf	12/18/2014 10:25:09 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 4)
36_SEC038_Appendix A- Maps of Bronx (3).pdf	12/18/2014 10:21:52 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 3)
36_SEC038_Appendix A- Maps of Bronx (2).pdf	12/18/2014 10:19:23 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 2)
36_SEC038_Appendix A- Maps of Bronx (1).pdf	12/18/2014 10:17:21 PM	NYAM Bronx CNA - Appendix A. Maps of the Bronx (Part 1)
36_SEC038_NYAM Bronx CNA Report_Final.pdf	12/18/2014 09:45:02 PM	New York Academy of Medicine (NYAM) Bronx Community Needs Assessment, October 2014



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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

Description:

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

Scoring Process:

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: St Barnabas_Section4_Text_St. Barnabas (dba SBH Health System) Project Plan Application.docx
Description of File
<input type="text" value="St. Barnabas (dba SBH Health System) Project Plan Application"/>
File Uploaded By: mlipson
File Uploaded On: 12/22/2014 11:49 AM

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

Currently Uploaded File: St Barnabas_Section4_ScopeAndScale_St Barnabas_Section4_ScopeAndScale_SBH Health System - DSRIP Project Plan Applications _ Scale Speed only _ 20141203_12-21-2014.xlsx
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File Uploaded On: 12/22/2014 09:47 AM



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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

Description:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

Description:

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

***Strategy 1:**

In the response, please include

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

A robust and well-trained workforce, rooted in the diverse communities of the Bronx, and engaged in the transformative change required under DSRIP will be central to the success of BPHC. As BPHC seeks to shift care from institutional to ambulatory care settings supported by tightly coordinated care management teams, workers will be impacted in three ways. First, we believe that job loss for the roughly 35,000 existing workers in the BPHC workforce will be minimal. Assuming a 25% reduction in unnecessary hospitalizations, we anticipate a reduction of 18-20 hospital beds across our two hospital PPS members, which, combined with some marginal shifts in ambulatory settings, will result in the redeployment of approximately 150 workers. Most of these workers will be redeployed through natural attrition. Consistent with BPHC commitment to the workforce, we anticipate that all remaining workers will be redeployed with the support of case



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management and career services provided by the 1199 Training and Education Fund (TEF) in conjunction with BPHC Members and potentially other vendors. Second, we anticipate intensive retraining needs of our existing workforce, particularly those in primary care and BH settings. Approximately 10,000 staff will need retraining to implement the BPHC clinical projects. Finally, we anticipate 750 new jobs will be created within the PPS. Most of these positions will be for primary care physicians (PCPs), nurses, and an anticipated four tiers of care management positions supporting the PCMH, HHs, BH settings, and, to a lesser degree, hospital EDs. We also anticipate a limited number of new staff positions for those engaged in data analytics, HR, and within BPHC's Central Services Organization (CSO). Recruitment to address the Bronx's dearth of psychiatrists, which can be only partially addressed through DSRIP, will also contribute to job growth. In addition to changes stemming from DSRIP, we anticipate an approximately 15% turnover rate attributable to normal operations. These expectations are consistent with industry trends, where 14% job growth in healthcare is expected in the next five years, mostly among middle-skill health occupations paying family-sustaining wages.

Thus, the most significant workforce impacts – and challenges – will be the need to both retrain a significant number of workers in the existing workforce and hire more healthcare professionals and care management staff to meet expanding demand. This challenge translates into an opportunity for workers – as increased demand for workers rooted in the community; new education, training and retraining opportunities; expanded and more clearly defined care roles and career ladders; and coordinated recruiting and retention supports to empower workers to transform careers and positively impact the Bronx community. BPHC is committed to working closely with our partners in labor and Members to ensure our existing workers are prepared to take full advantage of this opportunity.

The clinical transformation required under DSRIP will result in major shifts in the current nature of work involved in care delivery. Care will be more focused on prevention, integrated care and self-management. There will be increases in PCPs, increased titles in ambulatory care and greater use of home and community based care. We anticipate that specific workforce categories of existing staff will be impacted in the following ways (N=new hires, RT=retraining, and RD=redeployment):

- PCPs: N, RT
- Nursing professionals staff (medical assistants, LPNs, RNs): N, RT, RD
- Social workers/Care managers/navigators: N, RT, RD
- Patient educators including certified patient educators for diabetes: N, RT
- Peer services (community health workers, outreach workers, patient advocates): N, RT
- Psychiatrists/psychologists: N, RT
- BH specialists: N, RT
- Business and administrative support: N, RT

***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 minimize negative impacts on individual workers and meet the workforce needs of a re-configured healthcare delivery system over the five years, BPHC has identified a four-part workforce strategy:

(1) Redeployment. To rapidly respond to the shifting staffing needs and ensure any displaced workers are connected to new employment opportunities, BPHC will contract with TEF to provide case management, counseling, job search assistance and employment workshops, and tracking systems for impacted workers. BPHC will work with TEF to conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS. These efforts will be coordinated with the recruiting efforts, described below, to ensure that redeployed workers are connected to new employment opportunities.

(2) Training and Education. To address the needs for both retraining of existing staff and onboarding those newly hired under DSRIP, BPHC will undertake a large-scale training initiative addressing care coordination, patient engagement, motivational interviewing, cultural competence, inter-disciplinary team care planning, chronic disease management, virtual and cross-sector communications and use of health information technology, as well as protocols associated with specific project interventions. Some training will result in certification/licensing for existing employees.



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(3) Recruitment. To attract new workers, BPHC will develop common templates for job descriptions and postings for use by Partners; create a "jobs board" on the BPHC website; provide TA to Partners on recruiting, onboarding and retention strategies; and partner with local colleges, CBOs such as Phipps Neighborhood and BWAHEC, local high schools, and TEF to develop new and sustainable workforce talent pools. The largest volume of new hires will be care management workers. BPHC will create a common lexicon for care management roles with defined qualifications that will provide structure to the recruitment process and provide common minimum standards for care management teams.

(4) Engagement. BPHC will continue to ensure robust representation from labor in our governing body, and will expand upon our current outreach initiative to engage frontline staff about DSRIP. The workforce strategy will be overseen by a Workforce Subcommittee of the BPHC governing body and supported by a Workforce Liaison employed by the CSO with 25 years' experience working with the healthcare workforce and unions, as well as vendors with a proven track record in worker training, career development and job placement support, and change management.

PPS members report enormous barriers recruiting and retaining staff in the Bronx. BPHC conducted two workforce surveys: one focused on member capabilities in care management, cultural competency and health literacy; and a second to estimate workforce capacity. BPHC partners reported overwhelmingly that recruiting and retaining bilingual, culturally competent staff with the training and skills required to perform the increasingly complex tasks required in care settings is a principal challenge, and care settings are often under-resourced as a result. The CNA, discussions with CBOs and focus groups confirmed this finding, as did clinical leaders and front line staff participating in our Clinical workgroups. Shortages of primary care physicians in the Bronx has been well documented. Partners and the CNA reveal that these shortages extend to psychiatrists, behavioral health specialists and care management workers generally. BPHC's workforce strategy will be designed to combat these shortages through the efforts described above and others including preparing talent pools of Bronx residents for training opportunities within the PPS.

***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	1%
Retrain	30%
New Hire	1.5%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

The transformative nature of DSRIP will require workers in existing positions to perform functions in different ways; a robust retraining effort will be critical to preparing workers to fulfill these newly configured roles. The process by which BPHC will retrain the workforce will consist of identifying targeted staff for retraining, developing training curricula, and deploying training to workers at PPS Partners. BPHC defines the term "retrain" to apply to workers who will be trained in news methods, approaches, or technology and estimates 10,000 workers will be retrained in some form. These efforts will have significant overlap with training new hires.

1) Targeting Staff for Retraining. Working through the Workforce and Quality and Care Innovation Subcommittees and workforce vendors,



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BPHC will create an inventory of necessary training modules and the criteria for staff that require training. The retraining impact will be most profound among care managers. Employees will be strongly encouraged to participate in targeted training programs as necessary to equip them to support DSRIP goals and project implementation. BPHC also will procure assistance from vendors in tracking training participants to ensure targeted staff are reached and to measure and report the impact of training.

2) Developing Training Curricula. Training will be conducted by technical assistance providers with experience deploying specific evidence based protocols and interventions. For example, BPHC intends to partner with the Institute for Family Health to provide training for the IMPACT intervention and with Montefiore's CMO Center for Learning and Innovation to provide training for the Montefiore CMO Clinical Navigator Program and the Bronx Collaborative. BPHC will also utilize training curricula offered by Parachute NYC including the Intentional Peer Support and Peer Health Navigation programs. Other trainings, such as care management, cultural competence and patient engagement, will have broad applicability across Members, and will be developed by vendors, such as TEF, with experience developing large-scale training programs. This will require new training integrated curricula with modules targeted to specific positions and care settings, as well as core competency training that will cross over multiple positions. Some training will result in certification/licensing for existing employees. BPHC will work closely with the CUNY schools in the Bronx, Hostos, Bronx Community and Lehman Colleges as well as the New York State Area Health Education Center (AHEC) at Lehman College and the regional office of AHEC at our partner organization, Institute for Family Health, to ensure access to educational supports and develop a pipeline to ensure the sustainability of the new workforce over the life of DSRIP and beyond.

(3) Deploying Training. To address the needs for both retraining of existing staff and onboarding those newly hired to fulfill new and expanded job functions under DSRIP, BPHC will undertake a large scale training initiative. BPHC will retain highly skilled and experienced vendors, including TEF, to develop and deploy this training across its Members. Training will be conducted by expert clinical staff, experienced educators in adult learning theory and organizational development experts. In addition to TEF, BPHC will work with CUNY schools in the Bronx wherever possible to deliver training programs that offer college credit or high quality workforce and certificate programs that meet industry needs. Other retraining will be conducted in existing inservice, staff education and orientation sessions.

BPHC is committed to partnering with Bronx-centric vendors where possible and appropriate, as we believe their knowledge and experience with the Bronx community will directly impact the success of BPHC's retraining campaign.

***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.

BPHC is committed to providing employees opportunities to progress to positions of higher skill and salary and to helping to develop a Bronx healthcare workforce prepared for the challenges ahead. DSRIP will increase the demand for skills such as care coordination while decreasing the necessity of others. However, BPHC's preliminary analysis indicates DSRIP provides an opportunity for growth and upward mobility for Bronx workers, and estimates 95% of retrained workers will experience full placement. If retraining results in a certification award, a salary increase is likely to be appropriate. While compensation terms are dictated by contractual terms between Partners and their employees, BPHC will offer technical assistance with Partner human resources representatives on developing appropriate compensation levels for remodeled positions. BPHC will encourage Partners to provide workers with the time and funding to complete necessary retraining programs.

***Retraining 3:**

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

Affected employees will be given advance notice of any required retraining. In cases where retraining may be necessary for only select individuals, BPHC will rely on Partner organizations to identify employees most receptive to change. BPHC is committed to securing a position for each staff member who wishes to be part of the BPHC team. Employees who do not wish to follow their assignment will be included in the redeployment pool and given the option to search for a new position. Employee who continue to refuse redeployment will be referred to employment counseling through TEF or other PPS entities.

***Retraining 4:**

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



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BPHC recognizes the importance of consulting with labor representatives – both for their specialized expertise in workforce development and the critical importance of their members in deploying the DSRIP projects. During the planning phase, labor representatives served on the Workforce Development Workgroup, where the workforce strategy was primarily developed; the Steering Committee, where the strategy was reviewed and ultimately approved; and the Clinical Delivery/Program Planning Committee, which recommended clinical projects for BPHC to pursue. The Workforce Development Workgroup convened for two, two-hour working sessions where members developed recommendations on the training approach and care management models. During these meetings, BPHC engaged representatives in developing the appropriate process for retraining employees and identifying industry best practices. The Workgroup will reconvene in 2015 to continue its work. In the implementation governing body beginning April 1, 2015, workforce strategy development and implementation will fall under the newly elevated Workforce Subcommittee, which will be part of the PAC and report directly to the Executive Committee.

***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	95%
Partial Placement	5%

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.

BPHC defines the term "redeploy" to apply to workers who are trained in new skills resulting in a change in position within an organization. As skills and tasks are redefined for existing positions and a limited number of jobs are lost due to the shift from institutional to ambulatory care, our goal is to align the skills of our workers with the needs of BPHC Members, without job loss or other negative impacts on workers.

BPHC has conducted an analysis of the potential impact of job loss for the roughly 35,000 existing workers in the BPHC Partner workforce, and anticipated that job displacement will be minimal. Based on financial analyses of the reduced admissions and revenue assuming a 25% reduction in unnecessary hospitalizations, we anticipate the need for the reduction of 18-20 hospital beds across the two hospital members of our PPS, SBH and Montefiore, displacing approximately 100 workers (5-7 workers per bed). Combined with some marginal shifts in ambulatory setting, this will result in the redeployment of approximately 150 workers. Most of these workers (about 95%) will be redeployed through natural attrition. Consistent with BPHC core values, respect and commitment to the workforce, we anticipate that all remaining workers will be redeployed with the support of case management and career services provided by the 1199SEIU League Job Security Fund (JSF) and 1199SEIU Employment Center (EC) in conjunction with BPHC Partners and potentially other vendors, as described further below.

To ensure the small number of displaced workers are connected to new employment opportunities, BPHC will contract with JSF/EC to provide case management for workers. The JSF/EC share staff and resources and have a proven track record of assessing, counseling, training and placing laid-off, at-risk workers and/or members of the general public in jobs in the health industry, ranging from entry level workers through professional and technical staff. Case management services will include counseling to deal with the stress, anger, fear and often denial of the dislocation, as well as preparation in resume and interviewing skills training, job search assistance and employment workshops. The redeployment strategy will include a process to identify workers least likely to obtain jobs without retraining and individual assessment to provide appropriate services. Tracking systems will be deployed to measure the impact on affected workers. BPHC also will work with JSF/EC to conduct a job analysis of at-risk positions and a skill transferability analysis to create job transition maps and career ladders within the PPS. These efforts will be linked to and coordinated with the retraining and recruiting efforts, described above and below, to ensure that redeployed workers are connected to new employment opportunities within the PPS.



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It is anticipated that the small number of redeployed workers will include nurses and patient care technicians moving from inpatient to ambulatory care settings, as well as entry level workers, such as food service, transport, and housekeeping. These entry level workers often have skills needed in new and emerging jobs, such as bilingual skills and knowledge of communities targeted for DSRIP services. The DSRIP training funds will be used to offer these workers retraining opportunities as community health workers, outreach workers and medical assistants, building capacity from within the Bronx community.

***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.

Based on rough estimates, we anticipate that approximately 150 positions will require redeployment due to a combination of eliminating hospital beds and marginal changes in ambulatory care; and approximately 95% of these changes will be absorbed through attrition with compensation equivalent to current levels. For the remaining workers, DSRIP provides an opportunity for growth, and BPHC is committed to implementing a minimally disruptive process for workers selected for redeployment while mitigating downward mobility or job loss. Redeploying existing employees will allow BPHC to utilize the skills and experience these individuals offer. The BPHC redeployment vendor will conduct cross-comparisons of compensation and benefits with regards to position vacancies and areas of employee surplus. These comparisons will provide the template for the strategic redeployment of workers and their potential impact on compensation. While employment relationships are dictated by the contract terms of PPS member organizations, BPHC will strive to ensure that redeployed workers will be placed in new positions with compensation equal to or above the previous position.

***Redeployment 3:**

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

BPHC is committed to securing positions for workers who wish to be part of the BPHC team. The ramifications for employees who do not wish to be retrained or redeployed will vary by whether an organization is governed by a collective bargaining agreement. In the limited number of cases where a staff member is facing lay off due to the PPS, we will make every effort to find suitable employment at the same partner organization. If this is not possible, we will provide services of 1199 Job Security Fund including assessment, counseling, case management and retraining. We do not foresee any staff member losing employment as a result of the PPS. Any worker in jeopardy after job security efforts will be referred to the Workforce Advisory work group, facilitated by the Labor Management Project.

***Redeployment 4:**

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

BPHC recognizes the importance of working with labor representatives in developing and implementing redeployment processes—both for their specialized expertise in workforce development issues such as collective bargaining agreements and the critical importance of their members in deploying DSRIP projects. During the planning phase, labor representatives served on the Workforce Development Workgroup, where the redeployment strategy was primarily developed; the Steering Committee, where the strategy was reviewed and approved; and the Clinical Delivery/Program Planning Committee, which recommended clinical projects for BPHC to pursue. The Workforce Development Workgroup convened for two, two-hour working sessions where workgroup members developed workforce strategy recommendations. During these meetings, BPHC engaged representatives on industry best practices for redeployment. The Workgroup will reconvene in 2015 to continue its work. In the implementation governance beginning April 1, 2015, workforce strategy development and implementation will fall under the newly elevated Workforce Subcommittee, which will be part of the PAC and report directly to the Executive Committee.

Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

Description:

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

***New Hires:**

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



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The need for new jobs by position follows and track the chart below; BPHC is in the process of conducting a more detailed analysis to determine an estimated number of new positions for each category:

- 1) Administrative. Human resources professionals will support recruitment, labor relations and compensation processes related to DSRIP's human capital, and consult with management and Member organizations' HR staff. Marketing Professionals will develop and implement campaigns specific to the Bronx and its many cultures. Project managers will manage, measure, and evaluate all aspects of the PPS projects.
- 2) Physicians will be required to address existing shortages and increased demand for primary care services and to support colocation with behavioral health.
- 3) Mental Health Providers Case Managers. Care managers, care coordinators, patient navigators, community health workers are critical to implementing the care coordination model throughout the PPS. We will require multicultural, bilingual staff in these roles to manage the patient care plan services ensuring that the patient is connected and adheres to prevention and treatment services. The more needs the patient has, particularly chronic needs, the more intense the services required, and the smaller the case loads. Either social workers or RNs will serve as care managers. Peer navigators and community health workers also will be key. BPHC will create a common lexicon for care management roles with defined qualifications that will be used to provide structure to the recruitment process as well as providing common minimum standards for care management teams. Some care managers will require specialized training to service populations with behavioral health needs. Mental health specialists, psychologists, MD psychiatrists, licensed clinical social workers (LCSW) will be required to provide expanded mental health services to population including co-location in primary care sites.
- 4) Social Workers will perform care management for high need patients; LCSW will support the provision of expanded mental health services.
- 5) IT Staff will support IT selection and deployment. Data analytics professionals will collect data, conduct analysis and report findings related to planning and decision making.
- 6) Nurse Practitioners, Physician Assistants, and Family Nurse Practitioners will staff clinics, multispecialty clinics, emergency departments and co-located primary care facilities. RN and Nursing Assistants are needed to staff expanded primary care facilities and support expanded care management functions in PCMHs.
- 7) Other. Nutritionists will provide preventive engagement with the populations served by the PPS in various formats based on community needs and forums. Translators will assist with healthcare communication, navigation and chronic disease counseling.

BPHC recognizes the necessity and value of including soft skills, such as patient engagement, across position descriptions.

BPHC will use a combination of strategies to attract new workers, including developing common templates for job descriptions and postings for use by PPS Members, connections to job placement vendors including TEF, and providing technical assistance to PPS Members on recruiting, onboarding and retention strategies. We intend to develop a job dashboard accessible through the BPHC website to serve as a central point for potential employees to access information regarding employment opportunities across Member organizations. BPHC also will work closely with the CUNY schools in the Bronx, Hostos, Bronx Community and Lehman Colleges as well as the New York State Area Health Education Center (AHEC) at Lehman College and the regional office at our partner organization, Institute for Family Health, to ensure access to develop a pipeline to ensure the sustainability of the new workforce over the life of DSRIP and beyond.

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	50
Physician	20
Mental Health Providers Case Managers	550
Social Workers	50
IT Staff	10
Nurse Practitioners	20
Other	50

✔ 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



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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	2,000,000	2,000,000	700,000	700,000	300,000	5,700,000
Redeployment	100,000	100,000	50,000	50,000	20,000	320,000
Recruiting	250,000	200,000	100,000	25,000	25,000	600,000
Other	2,000,000	2,000,000	600,000	600,000	280,000	5,480,000

✔ Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

Based on a survey of PPS members, BPHC estimates it currently has 14 Partner organizations, together totaling 1,230 staff members, participating in one or more of the following state-funded workforce programs: 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. BPHC intends to capitalize on the assistance these programs provide. BPHC will review the array of State-funded initiatives and charge the Workforce Liaison to monitor programs that align with BPHC's retraining, redeployment and recruitment efforts and identify additional opportunities to pursue. BPHC recognizes that the Bronx has historically had difficulty recruiting providers. The Doctors across New York, Physician Loan Repayment and Physician Practice Support initiatives offer opportunities to support physicians who wish to base their practices in the Bronx area. If the State issues a request for applications for Doctors across New York, BPHC will provide technical assistance to interested physicians to help increase the Bronx primary care capacity BPHC recognizes the importance of education as the key to sustaining the growth initiated by DSRIP through the steady supply of competent providers and skilled workers. BPHC also has organized a group within the PPS to further investigate the opportunities available from primary care providers to receive loan forgiveness and other incentives to work at primary care sites.

✔ 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.

BPHC's workforce strategy is the result of extensive collaborative planning efforts. BPHC formed a Workforce Development Workgroup led by the Curtis Dan-Messier, Assistant Director of Continuing Ed at CUNY, which includes 21 representatives, including from 1199SEIU, NYSNA, the 1199 TEF, and Members' clinical staff and Human Resources department professionals. The workgroup oversaw the preparation of two workforce surveys (completed by over 100 Members each), provided input for the application, identified recruitment challenges in the Bronx, and designed communication to Members' workforce about BPHC. The BPHC Workforce Liaison also conferred with the Area Health Education Center staff at Lehman College and the Regional Office at the Institute for Family Health on Bronx recruitment and career ladders. BPHC also has included members of organized labor at the highest level of our planning governance, the Steering Committee and on our Clinical Delivery/Program Planning Committee.

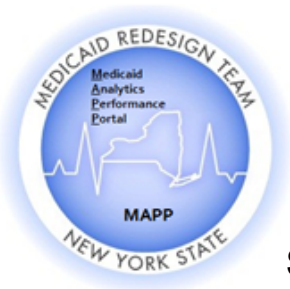
***Engagement 2:**

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

BPHC has included members of organized labor at the highest level of our PPS governance, the Steering Committee. We also have labor representatives on our Clinical Delivery and Program Planning Committee, which is part of our PAC, and on our Workforce Work Group.

a) Steering Committee- Gladys Wrenick: Vice President, 1199SEIU and Rona Shapiro - Executive Vice President of Home Care, 1199SEIU

b) Clinical Delivery/Program Planning Committee: Mary Fitzgerald –Delegate, New York State Nurses Association



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c) Workforce Development Workgroup: Mary Fitzgerald –Delegate, New York State Nurses Association, Todd Austin and Teresa Pica, 1199SEIU delegates, Damaris Rankin – 1199SEIU Organizer

Worker representatives will be invited participate in the implementation governing body and additional forums will be created, as needed.

***Engagement 3:**

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

A communication subgroup of the Workforce Workgroup has been tasked with preparing ongoing communication about BPHC's goals and progress related to the workforce including regular updates and other vehicles such as town hall meetings for workers and providing speakers for union-management meetings. We will leverage the BPHC website and all-Member meetings, which provide basic information about BPHC's mission and activities, transparency into key strategic decisions, and the ability to provide input into the planning process. We will also solicit workers' feedback on planning efforts through surveys and/or focus groups, as appropriate.

When we transition to the implementation governance structure on April 1, we will include frontline workers on our Workforce Subcommittee. We also plan to engage at least one frontline worker in the activities of our Quality and Care Innovation Subcommittee. Finally, frontline workers will have the opportunity to participate in the 4 Rapid Deployment Collaboratives under the Quality and Care Innovation Subcommittee to transfer the knowledge they have gained from being "on the ground" to the broader group of Partners participating in each project.

***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.

BPHC is committed to actively engaging stakeholders and workers in the design and implementation of its workforce strategy. A Workforce Advisory Group facilitated by the 1199 Labor Management Project including workers and labor representatives is being developed to provide frontline staff input on planning and implementation of the workforce strategy. The group will meet regularly to provide information on workforce concerns, including identifying and resolving structural barriers such as need for remediation, resistance of supervisors to release staff for training, and use of backfill. This group will fall under the Workforce Development Workgroup which will next convene in early 2015, and will be elevated to a Workforce Subcommittee as BPHC transitions to its implementation governance structure on April 1, 2015. When this transition occurs, the Nominating Committee will ensure that frontline workers are represented on the Subcommittee, providing a high-level venue for worker input.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.



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

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

Description:

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

This section is broken into the following subsections:

- 6.1 Data-Sharing & Confidentiality
- 6.2 Rapid-Cycle Evaluation

Scoring Process:

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

- 6.1 is worth 50% of the total points available for Section 6.
- 6.2 is worth 50% of the total points available for Section 6.

Section 6.1 – Data-Sharing & Confidentiality:

Description:

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

***Confidentiality 1:**

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

BPHC will execute the below data sharing plan to coordinate care, track effectiveness of interventions and monitor/report quality, process and performance metrics:

- a) Incorporate a data sharing agreement into the MDSA between SBH and Partners, with terms for: (1) Minimum dataset and process for initial and ongoing Partner data sharing; & (2) Partner commitment to EHR Stage 2 Meaningful Use attestation; 2014 Level 3 PCMH standards; active participation in Bronx RHIO to support care coordination; logging and reporting data required for tracking performance against improvement goals; and HIPAA compliance and other privacy protections
- b) Establish processes for partner data sharing compliance and oversight by the IT Subcommittee and Central Service Organization (CSO) staff
- c) Monitor data sharing and use shared data for care coordination, BPHC operations, reporting and Rapid Cycle Evaluation

RHIO & Health Home experience with protecting privacy while sharing data will guide the approach.

***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 the PPS, each Partner will sign a data sharing agreement requiring adherence to federal and state privacy requirements, including requirements that (a) data only be used for permitted uses under HIPAA; (b) PPS patients have consented to the disclosure of their information; (c) certain alcohol/drug abuse information is only exchanged in accordance with 42 CFR Part 2; (d) other sensitive data related to mental health, HIV status and STD diagnoses are protected; and (e) data storage complies with HIPAA security standards.

The IT Subcommittee will establish a formal program of participant privacy law trainings, Compliance Officer oversight and monitoring of data sharing compliance, HIPAA audits and policies/processes for corrective actions when necessary for incorporation into the compliance plan and processes described in Section 2-Governance. BPHC will implement an IT system that allows for dynamic tracking of patient consent to ensure privacy law compliance.



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***Confidentiality 3:**

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

SBH is strongly committed to the Bronx RHIO and serves on its board, as do other BPHC partners. Initial due diligence has concluded Bronx RHIO is a viable partner for BPHC health information exchange, shared data management and supporting data analytics, performance monitoring and Rapid Cycle Evaluation. BPHC is developing a Scope of Work for contracting with Bronx RHIO and a comprehensive strategy for increasing RHIO adoption by PPS partners.

BPHC has completed an assessment of partner IT capabilities. The BPHC CSO will immediately establish and begin overseeing a program for monitoring and assisting partners in achieving DSRIP EHR use and attestation, RHIO participation and PCMH recognition requirements. BPHC will likely contract with one or more external service provider experts in these areas. SBH already uses PCIP extensively for MU attestation.

The BPHC program will work with partners to identify EHR/EMR needs and PCMH capabilities. BPHC will assist partners in applying for capital to acquire EHRs and otherwise assist them in upgrading capabilities. BPHC will also provide participant training on how to use EHRs, Bronx RHIO, clinical and claims data and PCMH concepts to improve patient care.

All providers, including those without EHRs, will access shared data through the PPS care coordination management system that is the subject of a current procurement. Fifty-plus care coordination and data sharing protocols have been identified. BPHC recognizes that the CCMS must be integrated with EHRs through the RHIO. Enabling encounter notification services for admission, discharge, transfer and ER notification sharing is an early priority. BPHC is leading an effort for cross-RHIO/cross-PPS notification sharing across 4 PPSs and 4 RHIOs.

Finally, BPHC will draw on its participating Health Homes' experience with data sharing and protecting patient confidentiality in tightly coordinated care to inform PPS policy, in accordance with federal and state privacy laws.

Section 6.2 – Rapid-Cycle Evaluation:

Description:

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

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

***RCE 1:**

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

The Quality Management and Analytics function in the BPHC Central Services Organization, reporting to the PPS's Executive Director, will be accountable for performance monitoring, reporting and making recommendations related to improving PPS performance. The function will be responsible for:

- a) Finalizing performance monitoring framework principles
- b) Identifying and capturing insights from evidence
- c) Translating insights into care delivery protocols consistent with DSRIP project objectives
- d) Reviewing performance evidence gathered in the PPS
- e) Reviewing patient experience with the protocols, as captured in surveys and anecdotally
- f) Reporting progress and recommendations for improvement to the Executive Committee, PPS Members and external stakeholders, including SDOH and CMS

Department findings and recommendations will be overseen by a BPHC Quality and Care Innovation Subcommittee formed based on nominations from PPS participants, which will in turn report to the PPS Executive Committee.



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***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.

Performance evaluation will be based on patient-level data gathered from PPS partners measured against previously identified metrics for each project. Data may originate in medical records, claims, surveys or datasets collected from participants for reporting and analysis.

Working with the BPHC Chief Medical Officer (CMO), Quality Management and Analytics staff will help develop data requirements and protocols for patient targeting, predictive modeling and stratifying PPS patients (as performed by Bronx RHIO), conducting activities related to:

- a) Population modeling
- b) Data/trend reporting
- c) Metrics computation/tracking
- d) Partner performance feedback

Staff will develop recommendations related to overall protocol improvements and individual providers requiring performance assistance, education or oversight. Analysts will review the data for population-level trends that may suggest additional protocols, projects, interventions or other approaches to improving patients' health.

***RCE 3:**

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

The CSO CMO and Quality Management and Analytics staff will develop a monthly report of progress against evidence-based and DOH-defined performance metric objectives, following the IOM Learning Health Care System framework:

- a) Digital infrastructure
- b) Use of data
- c) Clinical decision support
- d) Patient-centered care
- e) Community links
- f) Care continuity
- g) Optimized operations
- h) Financial incentives
- i) Transparency
- j) Culture

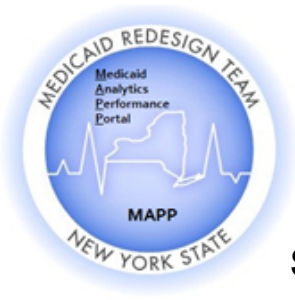
The Quality and Care Innovation Subcommittee will review the report, forwarding recommendations to the PPS Executive Committee (EC). The EC will review the recommendations in monthly meetings and act formally to accept, reject or continue analysis of each. The final report will be posted to the BPHC website and the CSO CMO will implement recommendations by disseminating new or revised protocols, changing PPS operational procedures or workflows, overseeing changes to rules or workflow in PPS systems, contacting nonperforming PPS participants or by other means.

***RCE 4:**

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

Formal monthly processes for data collection, analysis, internal reporting to governing committees and feedback to PPS participants serve to institute a program of comprehensive and transparent continuous quality improvement (CQI), overseen by BPHC's Chief Medical Officer. This sets up a virtuous cycle whereby participants receiving regular evidence-based feedback will be measured against ever-refined metrics, leading to further best-practice standardization, resulting in tighter integration and improved outcomes, encouraging development of more interventions and care innovations to be tested and measured.

One last RCE feature BPHC will implement is to vest the Committees, staff and individual partners with the authority to act immediately to implement improvements or correct protocols that may cause harm, without waiting for Executive Committee review and approval, so long



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as the Council and Executive Committee are notified in writing of the intention and justification for doing so.



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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

Description:

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

This section is broken into the following subsections:

- 7.1 Approach To Achieving Cultural Competence
- 7.2 Approach To Improving Health Literacy
- 7.3 Domain 1 - Cultural Competency / Health Literacy Milestones

Scoring Process:

This section is worth 15% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

- 7.1 is worth 50% of the total points available for Section 7.
- 7.2 is worth 50% of the total points available for Section 7.
- 7.3 is not valued in points but contains information about Domain 1 milestones related to these topics which must be read and acknowledged before continuing.

Section 7.1 – Approach to Achieving Cultural Competence:

Description:

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

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

*Competency 1:

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

The Bronx is extraordinarily culturally and ethnically diverse, containing the highest proportion of non-white residents of any NYC borough. Bronx health care providers must be equipped to address the cultural customs, language needs, and health beliefs and practices of the populations they serve. Over half of Bronx residents (54%) identify as Hispanic/Latino, a culturally diverse group in itself; more than double the rate for NYC and triple for NYS. Approximately one-third of Bronx residents identify as Black or African American, with significant communities from the Caribbean and African nations. While only 4% of residents identify as Asian, the population of South and Southeast Asian immigrants is increasing. BPHC surveys and CNA data revealed particular challenges serving smaller populations, including Albanian, Bengali, Chinese, Creole, Korean, Mandingo, and Russian speakers.

While Bronx providers are committed to meeting the needs of their diverse communities, this is a tall task. National literature and findings within our CNA have found that immigrant and limited English-speaking populations experience barriers to accessing health care, including low quality language services, lack of culturally and linguistically competent providers, and fear of deportation. Approximately 20% of Bronx residents are not citizens, and over half of the population report speaking one of 76 languages other than English at home. Neighborhoods with high rates of residents who are non-citizens and speak English less than "very well" include Hunts Point-Mott Haven, Crotona-Tremont, and Fordham-Bronx Park, areas that also rank high in poverty. BPHC surveys and member focus groups also identified challenges recruiting Spanish-speaking and locally-based health care professionals and limited funding to provide cultural competency training.



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BPHC must address these cultural competency challenges in order to improve population health.

***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.

BPHC has developed a strategic plan to ensure a culturally competent organization and a culturally responsive system of care based on a PPS member survey, expert and member interviews, and a literature review. These strategies will be incorporated into clinical program design and operational standards throughout BPHC.

- a) BPHC has hired a multilingual Director of Collaboration (DoC) with 15 years of experience serving the Bronx community, who will conduct culturally and linguistically sensitive community outreach and education about BPHC's services.
- b) BPHC will develop cultural competency standards and training processes based on National CLAS Standards that will be disseminated across PPS members and incorporated into the design of DSRIP projects. Standards will be modified to meet the needs of various sub-populations, such as age and ethnic groups.
- c) BPHC will work with 1199 TEF, NYSNA, and Bronx-based CUNY to develop culturally-competent training materials and ensure recruitment maximizes locally-based and bi-lingual employees. We will engage front-line healthcare workers from the community by promoting community-based English as a Second Language (ESL) and GED training programs, providing customized on-site training opportunities, and working with PPS member organizations who have expertise recruiting frontline staff. Many of our DSRIP projects leverage local, peer-based staff who are equipped to provide cultural competent patient engagement.
- d) BPHC will hold PPS members accountable to these standards by (1) ensuring all new hire and refresher trainings incorporate cultural competency principles and promote a culture of inclusion; and (2) integrating cultural competency hiring/training standards into PPS member service agreements and related milestones to which members must adhere.
- e) BPHC will employ a Senior VP of Care Delivery within the CSO to conduct ongoing assessment of the PPS' cultural competency activities and related quality improvement efforts.

***Competency 3:**

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

Community-based organizations are critical to culturally-responsive systems of care, as they provide health and social services to many of the immigrant, uninsured, and non-citizen populations described above. BPHC will engage with community-based organizations who have established practices for cultural competency as part of its efforts to strengthen and maintain culturally and linguistically competent care throughout the DSRIP program.

First, BPHC is planning to contract with Health People: Community Preventive Health Institute (HP), a Bronx CBO specializing in evidence-based patient education. HP will help BPHC strengthen the evidence-based disease management models in Project 3.c.i (Diabetes disease management) and Project 3.b.i (Cardiovascular disease management) by training Bronx residents as peer educators who will deliver the Stanford Chronic Disease and Diabetes Self-Care, as well as the LEAP amputation prevention patient engagement models. These models emphasize peer-based goal-setting, mutual support, and problem solving rather than didactic information. Leveraging members from within the community and training them to provide culturally-sensitive education and support will help BPHC achieve and maintain cultural competency throughout the DSRIP program.

Second, BPHC will contract with a.i.r nyc for implementation of its home-based asthma model. a.i.r nyc is a CBO that has provided home-based services to families with asthma since 2001. The organization sends trained community health workers who reside in the community and speak the families' language into homes affected by asthma to provide education and other services. We plan to work with a.i.r. nyc, CUNY, and other CBOs to educate, train, and recruit community members from different cultural and ethnic groups to serve as community health workers.

BPHC will continue to explore opportunities with other CBOs, as well.

Section 7.2 – Approach to Improving Health Literacy:



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Description:

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

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

***Literacy:**

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

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

Addressing limited literacy and communication skills is critical to ensuring that patients can be active participants in their healthcare and can adequately navigate the healthcare system. A robust evidence-base has found that patients with low health literacy have increased hospitalizations, greater medication non-adherence, higher medical expenses, and poorer health. In the Bronx, 41% of uninsured residents report Limited English Proficiency (LEP) and 39% of residents have less than a High School diploma compared to 30% citywide. These factors are strong indicators of low health literacy. Stigma and the sense of isolation associated with diseases endemic to the Bronx, including HIV/AIDS, mental health, and substance abuse, present additional challenges to patient engagement and self-care. For these reasons, the PPS has committed to implementing health literacy initiatives that will improve patients' understanding of health information and strengthen patients' and providers' self-efficacy in health-related communications, knowledge, and self-care skills.

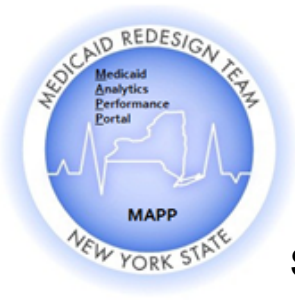
BPHC plans to improve and reinforce the health literacy of patients served on three levels: (1) leverage leading-edge health literacy enhancement strategies currently employed by PPS Members; (2) promote a universal precautions approach to health communications that assumes most patients will have difficulty understanding health information; and (3) employ the specific initiatives described below.

With over 40 years of experience in health education, PPS hospital partner Montefiore Medical Center has a strong track record for providing and refining health literacy tactics, including development of an electronic library of approximately 20,000 patient education materials that meet CLAS and LEP guidelines. BPHC will leverage these materials and the best practices used to develop them to ensure PPS members have access to culturally appropriate and disease specific materials across reading levels.

BPHC will pursue several core initiatives to promote health literacy that will be incorporated into clinical program design and operational standards across the PPS.

- a) BPHC will ensure all new-hire orientation trainings include health literacy principles that help providers identify health literacy gaps and effectively communicate with patients. Trainings will include teach-back, plain language, and CLAS.
- b) BPHC will develop and disseminate plain language, accessible, and culturally-competent materials at 4th – 6th grade reading levels across the PPS network. BPHC will also convert prioritized written materials into audio/video aids to assist individuals with limited to no reading ability. These materials may be disseminated in waiting rooms, on patient portals and provider websites, and through care coordinators. Finally, BPHC plans to standardize discharge summaries and consent forms across the PPS to minimize confusion between provider forms.
- c) BPHC will conduct a needs assessment to identify programs, populations, and neighborhoods that are most at risk for health literacy gaps.
- d) BPHC will host a Rapid Deployment Collaborative on Patient Engagement to develop and promote health literacy standards and advise partner organizations on health literacy best practices.
- e) BPHC has incorporated care coordination services into all of our DSRIP clinical projects to address more intensive communication gaps for at-risk populations.

BPHC will identify and contract with community based providers within our PPS that have deeply-rooted health literacy and patient



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engagement expertise within specific communities. For example, BPHC will work with Health People and a.i.r nyc, community-based organizations specializing in evidence-based patient education and other services, to help design and implement peer-led patient engagement strategies for our disease management and HIV projects.

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

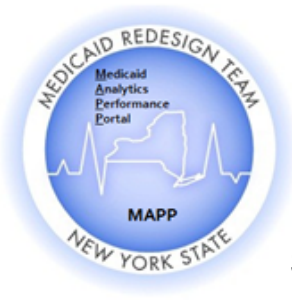
Description:

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

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



Please click here to acknowledge the milestones information above.



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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

Description:

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

This section is broken into the following subsections:

- 8.1 High Level Budget and Flow of Funds
- 8.2 Budget Methodology
- 8.3 Domain 1 - Project Budget & DSRIP Flow of Funds Milestones

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

*Budget 1:

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

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

The BPHC PPS funds distribution plan promotes DSRIP goal achievement by balancing implementation investments and performance incentives that will effectively transform the PPS delivery system infrastructure. The BPHC PPS will allocate DSRIP payments into the following budget categories: Cost of project implementation, revenue loss, internal PPS provider bonus payments, and an innovations fund.

Cost of implementation funding will be distributed across partner organizations and a central services organization (CSO). The CSO will provide PPS administration and will efficiently implement centralized project components in support of all PPS partners. A portion of project implementation funds will be distributed to partners as up-front payments to initiate hiring and project implementation, while the remainder will be provided for services not currently reimbursed and for meeting specific project milestones. Substantial up-front funding is required because most provider organizations in the Bronx are operating at break-even point or with small margins. The milestone portion of this category balances the required up-front funds while incentivizing change to meet specific project goals and service metrics. Implementation funds will be distributed across all five years with the majority in DY 1 and 2.

To protect against potential expenditure overages, 10% of all DSRIP funds will be held in a contingency fund. If these contingency funds are not needed for project implementation, they will be used for internal PPS provider bonus payments in DY 4 and 5.

Revenue loss funds will be distributed to partners to mitigate DSRIP net revenue loss. All partners will be required to submit documentation demonstrating their plans to repurpose assets to ensure ongoing revenue loss funding will not be needed. Any revenue loss funds not distributed will be used for internal PPS provider bonus payments. Revenue loss funding will be utilized most in DY 2 – 4 as the PPS achieves DSRIP goals but has not completed the full transition to value-based contracts.



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Contributions toward achieving DSRIP goals and milestones will be rewarded through incentive-based internal PPS provider bonus payments, which encourage partners to align their practices with performance-based incentives similar to value-based contracts. A portion of bonus payments will be distributed across partners based on overall PPS performance, and the rest will be distributed based on individual partner achievement of performance goals. Goals will be standardized across partners by provider type. Any high-performance funds achieved by the PPS will be channeled directly to high-performing partners. Bonus payments will start in DY 2 and will continue to grow through DY 5, when they will be the main source of funds.

The PPS will create an innovations fund to allow the PPS flexibility to make programmatic changes not envisioned during initial DSRIP planning to more effectively achieve project goals (e.g., by piloting a new clinical intervention or expanding/enhancing an existing program).

The BPHC PPS is a diverse network of providers along the care continuum. Participating partners from all types of organizations and clinical specialties are equally eligible to receive funds, which will be distributed proportionally according to each provider's degree of DSRIP project participation and for meeting the performance goals and milestone requirements specific to each project.

The funds distribution process fundamentally relies on BPHC PPS' governance structure. The CSO and Finance Subcommittee will define project-specific budgets, milestones, and performance goals for each partner. Requirements and funding amounts will be articulated in the Master DSRIP Service Agreement (MDSA) between partners and the PPS. MDSA and revenue loss requests will be subject to Executive Committee review and approval.

✔ 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.

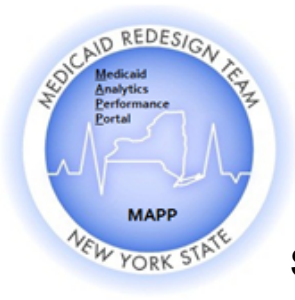
Please complete the following chart to illustrate the PPS' proposed approach for allocating performance payments. Please note, the percentages requested represent aggregated estimated percentages over the five-year DSRIP period; are subject to change under PPS governance procedures; and are based on the maximum funding amount.

#	Budget Category	Percentage (%)
1	Cost of Project Implementation	48%
2	Revenue Loss	15%
3	Internal PPS Provider Bonus Payments	22%
4	(Other) Innovations Fund: Provides additional funds to add new programs not envisioned during initial DSRIP planning	5%
5	(Other) Contingency Fund	10%
Total Percentage:		100%

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

Description:

Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP



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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.



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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

Description:

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

This section is broken into the following subsections:

- 9.1 Assessment of PPS Financial Landscape
- 9.2 Path to PPS Financial Sustainability
- 9.3 Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability
- 9.4 Domain 1 - Financial Sustainability Plan Milestones

Scoring Process:

This section is worth 10% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.

- 9.1 is worth 33.33% of the total points available for Section 9.
- 9.2 is worth 33.33% of the total points available for Section 9.
- 9.3 is worth 33.33% of the total points available for Section 9.
- 9.4 is not valued in points but contains information about Domain 1 milestones related to Financial Sustainability which must be read and acknowledged before continuing.

Section 9.1 – Assessment of PPS Financial Landscape:

Description:

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

***Assessment 1:**

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

To understand the PPS network's overall financial health, BPHC created a survey to identify partner organizations that may be at risk of financial failure. The survey included the NYS DOH's criteria for safety net hospitals to receive IAAF funding, as well as other key financial questions:

- a) Does the organization have 15 days' cash and equivalents on hand?
- b) Does the organization have assets that can be monetized other than those vital to operations?
- c) Does the organization have access to resources from foundations and other affiliated entities that can be accessed if required to sustain operations?
- d) Current payer mix
- e) 2012 and 2013 Current Ratio and Debt to Assets Ratio
- f) Financial impact of achieving the required metrics for DSRIP projects?
- g) Anticipation of major changes to current contracting or grant funding within the next two years?
- h) Has the organization applied for and received IAAF funding?

The survey was sent to all BPHC PPS partners, regardless of size. Individual outreach ensured that responses were received from key participants, resulting in 78% of partners completing the survey. Based on survey results, partners were assigned to one of three risk tiers. The vast majority qualified as Tier 1, Not Immediately Fragile (possessing more than 15 days' cash on hand without any major financial



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concerns). Thirteen partners qualified as Tier 2, Moderately Fragile (possessing less than 15 days' cash, but can access assets to monetize for operations without other major concerns). Only one partner qualified as Tier 3, Fragile (possessing less than 15 days' cash with other major concerns).

***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.

BPHC acknowledges that the successful implementation of DSRIP projects could initially have a negative financial impact on financially fragile PPS partner providers, given that the projects transform care delivery models and payment methodologies on a substantial scale. Some potential negative financial outcomes due to DSRIP project implementation may include:

- a) A reduction in hospital fee-for-service payments for inpatient admissions and readmissions;
- b) A reduction in emergency department visits due to redirection of Medicaid patients to primary care and other appropriate ambulatory care settings, or due to increased care management, coordination and monitoring of Medicaid patients discharged from hospitals;
- c) An increase in care management, home visits or other expenses which are not currently reimbursed through fee-for-service; and
- d) Increased workforce expenditures to retrain and/or recruit staff to support expanded and/or enhanced outpatient services.

According to the financial survey results, five of 78 partner responses in the BPHC PPS expect a negative financial impact from DSRIP projects, citing the reasons listed above. While DSRIP will result in lost revenue for certain institutions and services, we anticipate that other services and business lines will grow.

DSRIP funding alone will not save otherwise vulnerable institutions. However, via DSRIP, it will be possible to identify when critically needed providers are at risk and to help plan for the continuation of the services they provide so that the BPHC PPS can still serve its mission. Our approach has the following elements:

- a) Early identification of financial and programmatic issues through continual monitoring. BPHC PPS plans to continue annual financial surveys in addition to the quarterly performance and financial monitoring being implemented as part of the DSRIP projects. Partner organizations identified by the financial survey as Tier 2 (Moderately Fragile) or Tier 3 (Fragile) will be automatically targeted for monitoring and financial advising;
- b) Proactive work with local organizations and parent companies. BPHC PPS will continue to work with both entities to ensure the parent organization does not unknowingly diminish or withdraw services from the service area and access to services can be sustained;
- c) Creation of a Finance and Sustainability Subcommittee. The subcommittee will work together with financially fragile participants with worsening financial situations. This includes the development of restructuring plans or alternative pathways to support needed services for PPS members. The estimated financial impact will be considered in the budgeting for Revenue Loss mitigation, which is part of the implementation funding pool, and discussed in the Section 8 (flow of funds); and
- d) Commitment to using DSRIP funds to sustain needed services in the most efficient possible manner. Our use of DSRIP funds for revenue loss will be provided only upon demonstration of a negative financial impact caused by DSRIP and assurance that DSRIP funds will be used as a short-term stop gap in a manner that will enhance the overall viability of the sponsoring institution. If the institution itself is not viable, that institution will need to consider merger or restructuring plans.

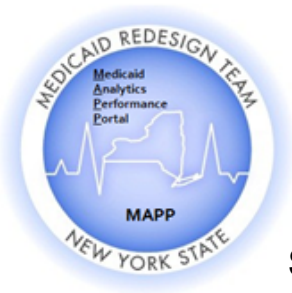
Section 9.2 – Path to PPS Financial Sustainability:

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



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efforts that will require completion.

SBH and its BPHC Partners view DSRIP incentive payments as essential to the transformation of the delivery system. However, if new ambulatory services and payment methodologies do not rapidly become value based, all PPS partners, especially the financially frail, will be negatively impacted when DSRIP funds go away.

The transition to value-based payments will require the PPS and its partners to develop a strong governance structure and to employ sound clinical programs and health information technology that improve health outcomes and manage ongoing costs of care. Revenue loss payments in DSRIP years 2-4 will be crucial to support partners undergoing financial/programmatic transformations following project implementation.

Through key partners, the PPS has significant experience and existing infrastructure to build upon. Montefiore currently has 300K lives under full risk or value-based arrangements; 43% (96K) of current lives are Medicaid with Healthfirst (62%), Emblem (26%) and Fidelis (12%). SBH has ~30K lives in risk contracts and population management; 85% of those lives are Medicaid. Both systems have enhanced earnings based upon risk business performance and owner distributions. Montefiore was one of the first Pioneer Accountable Care Organizations (ACOs) and has achieved greater cost savings than all other Pioneer ACOs in both performance years 1 and 2. The ACO, and other managed care business, is supported by a centralized Care Management Organization.

Most other BPHC partners do not have value-based reimbursement arrangements besides FFS with quality bonuses. The PPS' sustainability plan will be based on expanding this base of experience and leveraging existing infrastructure to bring value-based contracting to a broader set of providers participating in the integrated delivery system. The sustainability plan will be developed by the CSO and the Finance Subcommittee in parallel with the implementation plan due March 1st. The plan will further define the distribution of funds to support sustainability of critical PPS partners as well as the required financial performance expectations to be maintained. It will detail the shift to value-based contracting, including the expansion of existing risk-bearing entities and contracting infrastructures.

There are currently no known restructuring efforts required.

***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.

BPHC PPS' Finance and Sustainability Subcommittee will monitor a set of operational and financial metrics, based off the indicators described above in the financial landscape assessment (e.g., if a partner has 15 days' cash on hand, Current Ratio and Debt to Assets ratio). Full financial assessments will be completed annually, supplemented by quarterly financial performance reports.

To ensure DSRIP project funds have been properly invested, if indicators/activities are not aligned with expectations, the CSO Provider Engagement team will work with the provider to identify and immediately address the causes, focusing on creating operational efficiencies, redeployment and rightsizing of limited resources, and managing outmigration of services. PPS-wide action plans and reports will be reviewed by the Executive Committee, Finance Subcommittee and other subcommittees. As noted in Section 8, implementation funds will be used to offset DSRIP project implementation costs. A portion of funds will be available upfront for Safety Net and other providers unable to proceed otherwise, subject to terms and conditions, including agreement to ongoing monitoring by the PPS.

***Path 3:**

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

BPHC PPS believes that the DSRIP program will lead to further development of care management approaches and infrastructure currently in place, resulting in capabilities able to produce better cost and quality results. Participants in the BPHC PPS will be clinically, financially and technically integrated, creating a provider network that will perform at much higher levels than today's disjointed, episodic system allows. Core components of contracting negotiations will include funding the expanded care management infrastructure and agreements to avoid duplication of effort with respect to care management, data sharing, network management and other functions.

The BPHC PPS, led by its key participants SBH and Montefiore, will continue conversations about expanding the transition to value-based contracting with leading MCOs, starting with Healthfirst and Emblem, which have 40% of all Medicaid Managed Care enrollment in the Bronx – 47% of that enrollment is already attributed to SBH and Montefiore. BPHC PPS will leverage the experience and infrastructure already in place in the Bronx to successfully expand value-based purchasing arrangements to sustain new programs and capabilities.



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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.

Successful demonstration of BPHC's care model in the first few years of DSRIP is essential to engaging MCOs in substantive discussions regarding the expansion of value-based reimbursement. In Y1, BPHC PPS will formalize a Finance and Sustainability Subcommittee that will include one or more representatives from leading MCOs, as well as key participants to guide the transition to value-based contracts. BPHC may need the support of the State to assist in establishing a framework to define the relationships between MCOs and PPSs that will create the greatest value without duplicating investment.

SBH and Montefiore have approximately 82,000 Medicaid Managed lives in value-based contracts with Healthfirst and 115,000 across all MCOs. Other BPHC participants have varying levels of experience with managing risk. BPHC PPS recognizes the need to support participants to gradually move from volume to value-based payments under various arrangements, as one size does not fit all. Engaging community-based physicians and smaller outpatient practices in the Bronx with limited experience managing risk will be particularly critical for ensuring the success of payment reform efforts. The PPS will expand existing and create new contracting structures to implement these arrangements, providing support services through the CSO during the transition. Based on the success of DSRIP, the PPS will also seek to engage Medicare and commercial payers regarding extending payment reform and associated clinical programs to additional populations.

*Strategy 2:

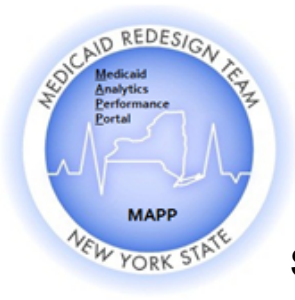
Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers

Payment transformation will assist the PPS to achieve a path of financial stability by transitioning participant and individual provider compensation from FFS to value- and outcomes-based methodologies. The full scope of services providers will offer via DSRIP funding to their patients is not reimbursed under FFS Medicaid. The value-based arrangements the PPS will seek to negotiate with MCOs will aim to reduce or eliminate providers' reliance on FFS reimbursement and afford them the flexibility to deliver the best care possible while providing savings to invest in sustaining effective DSRIP interventions and other programs proven to improve the target population's health and reduce costs. In this model, MCO and provider interest are aligned.

BPHC plans to introduce its partners to value-based contracting arrangements at a lower level of risk by pursuing shared savings arrangements, gradually converting to risk-sharing arrangements over time. This will allow the PPS to evaluate member performance in value based arrangements and the PPS's internal quality and cost reporting mechanisms to ensure it is equipped to gauge performance and appropriately structure future risk-sharing agreements. Shared savings alone will not provide enough funding to support long-term sustainability of the full scope and breadth of the programs created by DSRIP. In DSRIP years 4, 5 and beyond, the PPS will look to expand the level of risk and capitation it assumes as the capabilities of its partners and the PPS as a whole increase. Since SBH and MMC already have existing fully capitated arrangements, they will look to expand the lives in their respective programs starting in DY2.

Payment transformation negotiations with MCOs will be framed to help support financially fragile safety net providers whose performance meets or exceeds quality and cost goals, and whose services are critical to the PPS and its patients. The BPHC PPS will also work with financially frail safety-net providers to optimize the use of space and human resources through repurposing and retraining with the goal of aligning resources to patient need in order to provide services in the most efficient manner possible, while reducing outmigration. The PPS believes this alignment will increase provider capacity, thereby driving patients back to these providers for newly available services and subsequent payment.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:



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Description:

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

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



Please click here to acknowledge the milestones information above.



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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

Description:

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

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

Proven Population Health Management Capabilities (PPHMC):

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

A key enabler of the BPHC strategy is the inclusion of PPS member Montefiore Medical Center's IPA and Care Management Organization (CMO). The IPA accepts insurance risk and the CMO manages the risk and patient-centered care on the IPA's behalf.

The CMO has been coordinating care across multiple settings since 1996 and is recognized as a leader in value-based care delivery. More than 400 care management employees work with over 3,400 physicians and ancillary providers to coordinate care to more than 300,000 individuals across employer-sponsored coverage and Medicare and Medicaid managed care. The CMO already performs nearly all the care coordination services associated with population management including chronic care management, transition and readmission management, provider and customer service and other administrative functions. Montefiore's Accountable Care Organization (ACO), the Bronx Accountable Healthcare Network (BAHN), was designated one of the first Pioneer ACOs in 2011 and is ranked as the highest performing Pioneer ACO by CMS.

SBH Health System also has significant experience with value-based contracting, managing 28,000 Medicaid and Medicare lives through its relationship with two Medicaid Managed Care plans (MCOs) and its participation in Montefiore's Pioneer ACO. Other partners, CenterLight and the Visiting Nurse Service of New York (VNSNY), operate managed long term care plans and have robust population management based infrastructures to support them.

BPHC estimates that approximately 45-55% of the Medicaid beneficiaries expected to be attributed to the PPS are already under management by the CMO and SBH via contracts with MCOs.

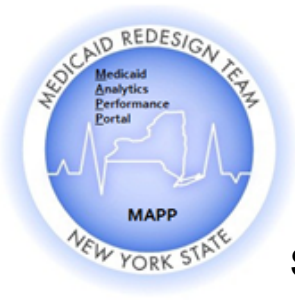
Finally, as recognized in the New York State Health Innovation Plan, Bronx RHIO has developed the Bronx Regional Analytics Database, analytics tools and staff, a workforce development program and interventions focused on high prevalence chronic diseases in the Bronx with under a \$12.8 million Innovation Grant from CMS.

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.

Respect for the workforce is a core value of Bronx Partners for Healthy Communities. This involves having members of the workforce and the labor unions in our committee and governance structures. We will be providing opportunities for development with further education and training, including career paths for the new jobs that will be created through DSRIP transformation.

We will be working with the 1199SEIU Training and Employment Funds as a key workforce vendor. With 45 years' experience, it has covered 250,000 workers and 600 employers throughout the healthcare field, currently serving 40,000 healthcare workers per year, This includes: identifying or creating training programs and providing training administration; Labor Management Project initiatives for facilitation of processes and agreements; a Job Security Fund that retrains displaced workers and facilitates redeployment; and an Employment Center, which fills 40% of the 5,000 vacancies it receives per year. Our goal in selecting vendors is to be assured that we



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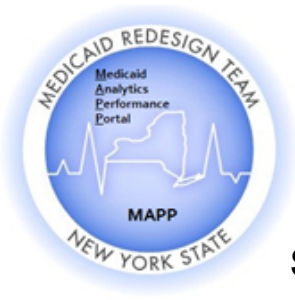
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have the most competent providers for our needs, and that we have vendors with a proven track record working in the Bronx. Along with the 1199 TEF, it is our intention to work with the CUNY schools in the Bronx, Hostos, Bronx Community and Lehman Colleges, where programs already exist or are in the planning stages.

We will also be working with the New York State Area Health Education Center (AHEC) at Lehman College and the regional office at our partner organization, the Institute for Family Health to assist with our talent pipeline.

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



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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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



I hereby attest as the Lead Representative of this PPS St. Barnabas Hospital (dba SBH Health System) that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Primary Lead Provider Name: ST BARNABAS HOSPITAL

Secondary Lead Provider Name:

Lead Representative:	Leonard Walsh
Submission Date:	12/22/2014 12:53 PM

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