The Brooklyn Study: Reshaping the Future of Healthcare

Restructuring and investing in healthcare delivery in the communities of central and northeastern Brooklyn
This report is driven by a strategic vision for the future of healthcare in Brooklyn. This vision focuses on a sustained commitment to improved health outcomes in quality, safety and service to community residents; embraces health prevention to creatively address the social determinants of health through innovative partnerships with government and community-based organizations; includes the latest advances in medicine; and provides care within a system that is more efficient and requires a significant expansion in access to primary and ambulatory care services to ensure the longer-term viability of these improved medical outcomes for the community.

It is a daunting task for any community hospital to transform its decades-old clinical model of care, operations and facilities at a time of rapid marketplace change. It is even more daunting when the objective is to align the governance, management, clinical leadership and cultures of multiple financially struggling, independent hospitals in a new regional partnership. Through a multi-year effort, with objective analysis, informed planning and continued funding, however, this transformation can be achieved.

Recognizing the importance of maintaining healthcare access for the most vulnerable communities of Brooklyn and concerned about the long-term sustainability of the independent hospitals serving local residents, the State of New York is prepared to make significant capital and operating investments, provided that its support is directly linked to a long-term solution that would transform care in the region, align both strategic investments and operations in a more efficient, effective manner and improve the overall quality of care for the communities served.

In 2015, the New York State Legislature authorized the appropriation of $700 million as part of the Kings County Health Care Facility Transformation Program (Transformation Program). These capital funds were specifically designated to support projects that will transform the organization and delivery of health services as part of a merger, consolidation, acquisition or other significant corporate restructuring intended to create a more financially sustainable system of care.

The statute requires the funds to be distributed to eligible providers serving communities in Brooklyn whose residents are experiencing significant levels of healthcare disparities compared to other communities within Kings County. These disparities are evidenced by a number of specific factors, including dependency on Medicaid, health status indicators and socioeconomic determinants of health. Providers applying for funds must also demonstrate sustained operating losses as well as other specific financial indicators for the past three years. Additionally, the application must detail the transformation actions that will be taken by the applicant.

The communities and hospital providers of central and northeastern Brooklyn meet the requirements of the Transformation Program. These communities are currently served by the following hospitals: Brookdale University Hospital and Medical Center (Brookdale), Kingsbrook Jewish Medical Center (Kingsbrook), Interfaith Medical Center (Interfaith), Wyckoff Heights Medical Center...
Northwell Health   |
Executive Summary: The Brooklyn Study: Reshaping the Future of Healthcare

Northwell Health and its business consulting division, Northwell Ventures, to develop recommendations on how to realize increased value from the capital investment provided through the transformation of the healthcare delivery system for the communities of central and northeastern Brooklyn, as well as funding provided by the State for continued operating support of the hospitals. A major objective of this project was to develop a more robust, sustainable organizational framework to help the hospital providers better address current and future operating challenges and focus on improving the health of the communities they collectively serve. The study was conducted with the participation of hospital leadership and incorporated the input of healthcare professionals, the workforce and its designated representatives and community stakeholders.

Northwell is one of the few health systems in the nation with a proven history of creating multiple, successful partnerships with community hospitals that have improved clinical quality outcomes, enhanced access to an expanded array of clinical programs and services and improved operating performance through economies accompanying network scale. Additionally, it has transformed its facilities and operations in a respectful and productive partnership with its workforce, their union representatives and the communities they serve.
Service Area Challenges

The challenges confronting the provider community of central and northeastern Brooklyn have been well documented. Previous studies have noted that the financial condition of the most troubled institutions is to a large extent a product of an inefficient expense structure; revenue challenges associated with declining inpatient admissions and a patient mix that approaches 90 percent public payers and charity care; significant liabilities; and an aging or even obsolete physical plant that undermines attempts to provide safe, quality care.

Simply stated, these hospitals have undergone a decade of financial and organizational trauma. Some of the responsibility for the circumstances in which they find themselves must be attributed to poor decision making by prior management. Other New York hospitals in similar circumstances addressed their challenges through successful partnerships or mergers. The study hospitals, however, either chose to remain independent, tried and failed to enter into partnerships or mergers or entered into poorly conceived and ultimately destructive arrangements. Fortunately, at the time of this study, the hospitals have all taken significant steps forward in improving the quality of their leadership teams.

Government insurance programs such as Medicare and Medicaid reimburse these hospitals for services provided at rates that are below the actual costs they incur for delivering services. The hospitals in this study also have considerable inpatient or outpatient volume with Medicare Advantage and Medicaid Managed Care plans, which both apply significant denial rates, resulting in effective payment rates below those of traditional Medicare and Medicaid. Unlike many other hospitals, they lack the ability to offset these below-cost payers and earn a positive operating margin from commercial payers, because the overwhelming majority of commercially insured patients living in the service area choose to receive care elsewhere in Brooklyn or travel to Manhattan. The study hospitals are in a very weak position to negotiate with the insurers of the commercial payers they do treat.

Hospitals of central and northeastern Brooklyn also have to confront a new economic reality in which federal and State resources are constrained and new payment methodologies require major transformation of the clinical and business model of care. Due to advances in medicine, many healthcare services that were once the exclusive domain of hospitals are now delivered as effectively and often more efficiently in an ambulatory or home setting. Access to emergency and acute hospital services is still important; however, future facility investments must strike a balance between maintaining a safe, effective inpatient environment and building ambulatory care capacity beyond the hospital campus. Organizations such as the study hospitals, which have not developed robust and geographically dispersed ambulatory care networks, are at a disadvantage, because the availability of such networks permits hospitals to offset declining inpatient revenues with growing ambulatory revenues, which are foundational to success under value-based purchasing.

Not surprisingly, the five study hospitals report staggering operating deficits with no independent access to capital to invest in program and facility transformation. In State Fiscal Year 2017, Brookdale, Interfaith, Kingsbrook and Wyckoff will require over $300 million in direct State operating assistance to remain open. (See Figure 2, Estimated Hospital Support, SFY 2017.) These State subsidy estimates do not include the cost to support University Hospital, which continues to face significant financial...
challenges. As described later in this report, SUNY Downstate, of which University Hospital is a part, is embarking on its own long-term financial and strategic planning process. This study develops a financial and new operating plan for the four voluntary hospitals in central and northeastern Brooklyn but we have not projected losses for University Hospital. Absent significant restructuring efforts targeted at reducing fixed and variable operating costs and increasing revenue, the need for State support to fund the operating deficits for the four voluntary hospitals will continue to grow to an estimated $405 million by State Fiscal Year (SFY) 2021. The cumulative cost of these baseline gaps through SFY 2021 is projected to be nearly $1.8 billion.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>State FY17 Estimated Support</th>
</tr>
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<tbody>
<tr>
<td>Brookdale</td>
<td>$140M</td>
</tr>
<tr>
<td>Interfaith</td>
<td>$50M</td>
</tr>
<tr>
<td>Kingsbrook</td>
<td>$50M</td>
</tr>
<tr>
<td>Wyckoff</td>
<td>$70M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$310M</strong></td>
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</tbody>
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Source: New York State Department of Health
Managing Expectations

The market and financial forces confronting these hospitals make it virtually impossible for them to succeed as stand-alone hospitals. This is not simply a management issue; no management team could be expected to achieve breakeven from operations given today’s market realities. Even with strong health system partners, these hospitals could not survive without sustained operating support and additional investments to transform their clinical and operating model of care. Therefore, as a preface to the recommendations, it is important to establish realistic expectations for the transformation of the healthcare delivery system in central and northeastern Brooklyn:

The time has come to stop conducting further studies or analyses and implement solutions. There have been many studies, analyses, reports and discussions documenting the challenges confronting the study hospitals and recommendations as to what must be done. All of the previous studies have generally been aligned in defining the problems and proposed recommendations. In the interim, the losses mount and the solutions become harder to fund and implement. The time has come to act and begin the process to implement a course of action.

There is no quick fix; the transformation will take at least five to seven years to accomplish. This study recommends the creation of a new governance structure, appointment of management and clinical leadership, restructuring of clinical services among the hospital campuses, development of a significantly enlarged, geographically dispersed ambulatory care network, major capital investments in inpatient facilities and the creation of a shared services infrastructure to attain efficiencies and support transformation activities. The changes will impact each and every function and activity.

The hospitals all enjoy the passionate support of their communities and share a commitment to improving the health of the residents. The hospitals have few shared interactions, however; in fact, their trustees have never met one another. Once this study is issued, it will take time to form a consensus around a strategic vision for the new health system.

At the beginning, in order to move swiftly later on, it will be important to proceed slowly to align the new organization and stakeholder groups around a new strategic direction. There are no shortcuts in this phase of the development of a new health system. It will take several years to implement the proposed transformational changes if the new system is to fully realize the benefits of doing so.

The health system will require continued operating support and additional capital investment beyond the $700 million provided through the Transformation Program. With a government-dependent payer mix and the other challenges described above, there should be no expectation that the study hospitals will break even in the foreseeable future. However, there should be expectation of realizing greater value for the very significant operating support and capital investments being provided by the State, particularly with respect to increased ambulatory access, quality improvements, operating efficiencies, responsiveness to addressing identified community health needs and participation in new reimbursement models such as value-based purchasing.

While the State will provide more than $700 million in new capital, even this amount is not sufficient to fully address facility infrastructure deficiencies, rebuild the campuses to accommodate the clinical restructuring of services, develop a significantly expanded ambulatory care
network and deploy an enterprise-wide health information technology platform. There will be a need for substantially more capital over the next decade to fully address all of the initiatives described in the report. To complete the implementation of the Transformation Plan, the State and leadership of the new health system will have to develop a long-term plan to provide access to additional capital.

The hospitals and support services must be consolidated, clinical services regionalized, facilities rebuilt and a large, transformative ambulatory care network developed throughout the service area. There must be substantive and transformational changes to the governance, management and organization of clinical services among the study hospitals. The hospital-centric care model must be consolidated and augmented by a significant expansion of primary and ambulatory care services. Redundancies and subscale, inefficient programs must be reorganized to create greater efficiencies and improve the quality of care. Investments in ambulatory care should also permit closer collaborations with the Federally Qualified Health Centers (FQHCs), community-based organizations and other partners in the Delivery System Reform Incentive Payment Program (DSRIP)—funded Performing Provider System (PPS), Collaborative Care of Brooklyn (CCB).

The Transformation Plan will maintain current employment levels and require the commitment of union representatives to support necessary changes in the health system’s clinical and operating structure. The building of a new ambulatory care network will create more than 800 new jobs that offset any workforce reductions, through the restructuring of the hospitals’ clinical services and programs and the development of a shared services infrastructure. The recommendations propose that no current employee covered by labor agreements will experience a reduction in compensation or benefits.

Achieving these objectives will require significant changes and the support of labor representatives to retrain the workforce to support redeployment in the ambulatory care network, and their recognition of the impact of market forces and changes in reimbursement on the operations of the health system. The continued support and commitment of the unions are critical to the success of this plan.

It is not advisable at this time to include University Hospital in a new organizational structure with the other study hospitals. Although the initial scope of this study includes University Hospital, the complex governance and operating structure of Downstate Medical Center, the only academic health center in Brooklyn, part of the State University of New York (SUNY) system, make it difficult, if not impossible, to directly integrate its operations into a non-government-sponsored governance model such as the one proposed for the other study hospitals. SUNY is undertaking a number of initiatives to improve and enhance its operational efficiency and effectiveness. However, SUNY Downstate will need to receive significant State support to accomplish its academic mission.

It is possible, however, for SUNY Downstate Medical Center to collaborate with both its neighboring academic partner, Kings County Hospital Center (KCHC), and the proposed new health system in providing clinical care and accessing shared support services, where appropriate. Because nearly all of the recommendations in this report describe how this new health system would be created and operated, only a few of the recommendations apply directly to University Hospital. Unless specifically identified otherwise, all references in this report to “hospitals” refer to the four voluntary hospitals in central and northeastern Brooklyn.
Transformation of the healthcare delivery system cannot occur in isolation; this is a unique opportunity to address social determinants of healthcare. It has been estimated that approximately 10 percent of an individual’s health can be attributed to the clinical care received, while the balance is a function of social and economic factors, personal choice, health behaviors and environmental issues. These nonclinical social determinants are critically important to the health of the communities of central and northeastern Brooklyn.

Given the magnitude of the State’s long-term investment of more than $2 billion in transforming healthcare, here we have a unique opportunity to innovate and dramatically transform the social and community service safety net for the communities of central and northeastern Brooklyn. An organization whose future financial health is tied to value-based purchasing and population health must integrate services that are both upstream and downstream of healthcare delivery, and focus on the underlying social and community determinants of poor health status. There will be opportunities for the health system to address the issues of housing, education, poverty, hunger and violence. As a major community employer and provider of career ladders for upward mobility, the proposed health system can also become more focused as an economic engine for the long-term benefit of the communities it serves. The health system should create a public (state and city)/private partnership and invest in infrastructure and resources to better integrate clinical care with a coordinated continuum of community safety net programs that address the social determinants of health and the economic health of the service area.

The community and stakeholder groups must continue to be engaged in the implementation of the Transformation Plan. It was clear from engagement meetings organized by the State that the community and other stakeholder groups care passionately about the needs of local residents. They also care passionately about their hospitals, the challenges that have to be overcome and the need to see improvements in healthcare for their families, neighbors and community. An ongoing, community-based engagement effort that is responsive to the interests and perspectives of local communities beyond the development of an advisory board is essential to strengthen an understanding of the need for a regional approach to transform the healthcare delivery system and of the complex changes that must accompany such an effort.

Safety net hospitals need to be supported through a new funding methodology. Whether reimbursed on a fee-for-service basis or through a value-based purchasing methodology, hospitals that are 90 percent dependent on government payers cannot operate without supplemental support. Although beyond the scope of the current study, it is apparent that State and federal governments have to create a common, narrow definition of an essential safety net provider, establish high and clearly accountable expectations as to their restructuring, cost structure, operations and performance and develop a new methodology to provide access to capital investment and fund ongoing operations.

A major concern is that without a new policy to fund safety net providers, the $700 million in capital investment and $1.5 billion in operating support, as well as the enormous effort expended to transform the healthcare delivery system, will be wasted if the health system reverts back to its current hand-to-mouth existence, which is primarily focused on managing cash flow to pay employees and vendors and meeting other critical operating commitments. More important, without a sustained level of operating support, improvements in health status may not be maintained, or, worse, may be lost.
The proposed Transformation Plan includes several major components:

- **Establish an independent, unified, mirror board governance structure over all the hospitals.**
- **Appoint systemwide management and clinical leadership, and develop a shared services infrastructure.**
- **Develop a large, geographically dispersed ambulatory care network.**
- **Regionalize clinical programs and restructure inpatient services among the hospital campuses.**
- **Create a safe environment in which to provide care.**
- **Create an enterprisewide information technology platform.**
- **Develop a managed care contracting entity.**

**Establish an independent, unified mirror board governance structure over all the hospitals.** Without significant changes in the governance, organization and management structure of the four hospitals, the provision of healthcare to the service area communities will continue to be fragmented and to require an ever-growing subsidy to support a failing model of care from which the community and the State realize little meaningful value.

Therefore, a new governance model has been proposed: placing the hospitals under a single mirror board of trustees composed of representatives from each hospital, with a majority of the trustees newly appointed.

**Appoint systemwide management and clinical leadership and develop a shared services infrastructure.** There are numerous examples of opportunities to achieve operating and organizational efficiencies through the consolidation of administrative and clinical programs. Further, creating a systemwide shared services organization and organizing its capabilities to support the strategic objectives of a Transformation Plan can be structured to benefit not only the four hospitals but University Hospital and other hospitals in the region.

**Develop a large, geographically dispersed ambulatory care network.** The most important transformational element of this plan is the development of a comprehensive ambulatory care network to significantly expand the availability of primary care services. This investment is critical for the health system’s ability to adapt its business model to value-based reimbursement and improve the health of populations. The proposed $245 million ambulatory care development plan includes the recruitment of an additional 120 health providers and the development of a coordinated network of 36 new facilities that will include urgent care, primary care and specialty services organized around community-based diagnostic and treatment care facilities. The network can provide over 500,000 visits annually.
Regionalize clinical programs and restructure inpatient services among the hospital campuses. The inpatient programs should be restructured to more effectively respond to identified community health needs and future demand; they should be organized to foster an operationally efficient regional care delivery model. The movement of services must be carefully planned and deliberately implemented. Many of the opportunities will require capital investment before restructuring can occur, although some can proceed earlier with a high degree of communication and coordination.

Brookdale, Interfaith and Wyckoff will continue to serve as the locus for specialized inpatient care and will be strengthened as community hospitals in their respective regions. Kingsbrook will evolve into a regional campus for post-acute, specialized ambulatory care and programs addressing social determinants of health. While Kingsbrook will continue to provide access to emergency care, it will no longer provide inpatient medical/surgical or behavioral care. The Transformation Plan will require Kingsbrook to transfer its medical/surgical volume to Brookdale and its behavioral patients to Interfaith, once investments are made in those facilities to enable them to accept these programs.

Brookdale must be rebuilt to accommodate medical/surgical patients from Kingsbrook and complex, high-risk, low-volume surgical cases from Interfaith, as well as continuing to serve as a regional trauma center. Investments at Interfaith will permit it to reopen its behavioral health unit and continue to provide emergency, medical, routine surgery, behavioral and specialty ambulatory care services in new, expanded facilities. Investments must be made at Wyckoff to support clinical program development and ambulatory surgical growth, particularly in cardiac, orthopedic and maternity services.

At the end of the transformation period, Brookdale, Interfaith and Wyckoff will continue to provide regional access to a range of medical/surgical, behavioral and other specialized inpatient services. The inpatient programs of these hospitals must be clinically integrated with a significantly expanded regional primary and ambulatory care network.

Creating a safe environment in which to provide healthcare. The inability to access capital combined with minimal preventive maintenance has by necessity resulted in a “fix-when-fail” approach to facilities and equipment. To facilitate and support the clinical programs’ restructuring and the ongoing operations, there are significant infrastructure issues that must be addressed at each facility. Many of these investments will never be visible to the public, because they address a variety of mostly hidden though mission-critical elements that include environmental, emergency generation, mechanical, electrical and plumbing systems.

For the hospitals to win back the trust of the community, they must provide a safe, modern, patient-centric environment in which to render care. The rebuilding of the Brookdale and Interfaith campuses is critical to achieving the operating savings generated by the restructuring of the inpatient capacity from Kingsbrook and supporting the expansion of primary care capacity. Facility investments at Wyckoff will enable the hospital to develop new programs and expand services needed by the surrounding community.
Creating an enterprisewide information technology platform. The new health system will need to make critical infrastructure investments in technology, applications and equipment to provide a strong foundation for clinical and operational integration and program growth, positioning the health system to thrive in the new world of payment reform and population health. In particular, there will be a need to establish a common information technology platform to effectively support clinical decision making, improve quality and patient care outcomes, develop effective care management capabilities, optimize revenue cycle activities, attain operating efficiencies through the shared services infrastructure and integrate those activities with a new ambulatory electronic medical record (EMR).

Develop a managed care contracting entity. The health system must develop a managed care contracting entity that would be responsible for joint fee-for-service and value-based contracting for the hospitals and its independent practice association (IPA). There may also be opportunities to collaborate with University Hospital, CCB partners and a network of community-based providers such as the FQHCs. This contracting vehicle can stimulate the development of important partnership opportunities to better meet the healthcare needs of the service area communities.

Capital Investments

The amount of capital required to make transformative changes in the healthcare delivery system significantly exceeds the $700 million made available through the Kings County Health Care Transformation Program. We have proposed that the transformational investment for ambulatory care development and information technology be given priority, and facility investments to support the clinical restructuring initiatives and infrastructure phased in over a number of years. As noted above, it is anticipated that capital funds in excess of the extraordinary $700 million appropriation must be accessed by the new regional health system over the next decade from other available sources, both public and private.
Operating Impact

A financial model of the Transformation Plan was developed with the assistance of Kaufman Hall & Associates, Inc., which was retained by Northwell as a member of the project team. A baseline financial projection was prepared based upon detailed revenue and expense data provided by the hospitals. This projection depicted a five-year, status quo run-out of each organization’s performance on an individual and consolidated basis for all operating entities. Without changes to the current organization or operations of the four voluntary hospitals, the estimated SFY 2017 operating deficit loss of $310 million is projected to grow by $95 million to $405 million in 2021.

As the full impact of the Transformation Plan is realized by the four study hospitals, the projected deficit to operate the hospitals may decline from its current level of $310 million to approximately $288 million by 2021. Therefore, once the transformation is fully implemented the annual projected operating deficit of $405 million may be reduced to $288 million by 2021, a difference of $117 million. However, these savings are dependent on consolidation of shared services, investment in information technology and support for ambulatory care expansion, which accompany the restructuring of the inpatient facilities.

Continued operating support will be required for several years through the transformation period. It will be challenging to reduce it further unless the health system can attain greater efficiencies in its clinical care model and diversify its payer mix. Investments in the Transformation Plan will support improvements in the quality of care, restructure the organization and provision of clinical services, achieve operating efficiencies and produce new or improved facilities, all of which should result in higher levels of patient satisfaction. Most importantly, there will be a significant investment in the creation of an ambulatory care network that will shift the locus of care into the service area communities by establishing 36 new locations and providing more than 500,000 additional primary and ambulatory care visits annually.
Summary

It is obvious that an undertaking as complex as this will generate many questions; additional work will need to be done to arrive at answers. However, it is important that the hospitals’ current leadership, community members, elected leaders, other stakeholder groups, union representatives and the DOH are given the opportunity to fully understand and discuss the recommended changes and activities that must occur in the weeks and months following the issuance of the report. It is also important that, once consensus on direction is achieved, the new health system move forward with clarity of purpose to avoid another missed opportunity. Management accountability for timelines and milestone objectives should be clearly established for the service area communities to realize the benefits of these actions as soon as possible.

The common denominator in the mission statements of all the study hospitals is the recognition that these institutions exist to improve the health of the communities they serve. This core aspect of each hospital’s mission will be put to the test when their board leadership and other stakeholder groups assess the benefits of coming together to qualify for the initial investment of $700 million in capital and the ability to receive over $1.5 billion in operating subsidy over the next five years. The hospitals and their supporters will have to decide whether they can best respond to the challenging problems of the communities they serve by working collaboratively, or whether they will be more effective working independently.
Recommendations

Governance and Management
Organizational Structure

Recommendation #1
Create a new regional health system with a unified mission and statement of strategic vision.

Recommendation #2
Establish a new board of trustees for the new regional health system, which also serves as a mirror board for all the hospitals.

Recommendation #3
Include current board leadership on the parent board of trustees and recruit new board members who will constitute a majority of the board.

Recommendation #4
Appoint systemwide management to execute implementation of the Transformation Plan.

Recommendation #5
Establish a systemwide shared services organization.

Clinical Integration

Recommendation #6
Pursue clinical integration through a service line approach.

Recommendation #7
Regionalize clinical programs and restructure inpatient services.

Recommendation #8
Provide a safe environment in which to render care.

Recommendation #9
Continue to operate Brookdale, Interfaith and Wyckoff as community hospitals.

Recommendation #10
Evolve Kingsbrook into a regional campus for post-acute, specialized ambulatory care and programs addressing social determinants of health.

Recommendation #11
Consolidate Article 28 licenses within the central region.

Recommendation #12
Create a continuum of physician alignment programs to engage both voluntary and employed medical staff.
Ambulatory Care Network Development

Recommendation #13
Dedicate staff to guide the building and operations of the ambulatory care network operating division.

Recommendation #14
Recruit 120 primary care and other providers to develop and operate the regional ambulatory care network throughout the service area.

Academic Programs

Recommendation #15
Establish an office of academic affairs and appoint a chief academic officer to oversee restructuring of GME programs.

Recommendation #16
Decrease health system reliance on foreign medical school revenue from student clerkships to accommodate medical students from Downstate.

Recommendation #17
Structure the ambulatory care network programs to support the health system’s GME training and the academic mission of Downstate.

Fostering an Engaged Workforce

Recommendation #18
Maintain employment for the current unionized workforce throughout the transformation period.

Recommendation #19
Partner with the unions to retrain staff to provide care in ambulatory settings.

Recommendation #20
Partner with the unions to support necessary changes in the health system’s clinical and operating structures.

Addressing Social Determinants of Health

Recommendation #21
Develop a comprehensive program to position the health system as an economic engine for the long-term benefit of the service area communities.

Recommendation #22
Focus resources on addressing social determinants of health.

Recommendation #23
Develop a Health Enterprise Zone through a public-private partnership to more effectively address social determinants of health.

Recommendation #24
Provide housing developers with incentives to align with the health system’s ambulatory care network development strategy.
Recommendation #25
Provide economic incentives to enhance recruitment of primary care providers.

Recommendation #26
Provide loan forgiveness programs for primary care physician recruitment.

Recommendation #27
Provide housing support for primary care provider recruitment.

Recommendation #28
Designate the health system and service area to receive priority in awarding government-funded grant programs and contracts addressing social determinants of health.

Brand Identity and Communication

Recommendation #29
Rebrand the health system and its hospitals.

Recommendation #30
Create an effective community engagement and communication plan to inform stakeholders about transformation initiatives and progress.

Role of SUNY Downstate and University Hospital

Recommendation #31
Downstate should be encouraged to engage in the development of the new health system, strengthen its relationship with Kings County and support its explorations of new relationships with other partners.

Operating and Capital Commitments

Recommendation #32
Develop a comprehensive payer strategy aligned with the value-based payment roadmap.

Recommendation #33
Develop a managed care contracting entity.

Recommendation #34
Provide support for enhanced Medicaid rates.

Recommendation #35
Fund working capital to provide 30 days’ cash.

Recommendation #36
Protect capital dedicated to supporting ambulatory care development.

Recommendation #37
Provide capital access beyond the initial $700 million appropriation in later years.
To learn more about Northwell Ventures, visit Northwell.edu/ventures or contact:

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