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

DSRIP PPS Organizational Application

Catholic Medical Partners-Accountable Care IPA INC

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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: **46_SEC000_Financial Stability Test CMP.pdf**

Description of File

File Uploaded By: dcao
File Uploaded On: 12/22/2014 10:01 AM

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: dcao
Last Updated On: 01/05/2015 03:11 PM

Certified By: dh589496
Certified On: 01/05/2015 03:17 PM
Lead Representative: Dennis R Horrigan

Unlocked By:
Unlocked On:

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Create an integrated delivery system	To provide the information to the PPS providers on the needs of the population by producing reports on quality and utilization that can be used by medical and human services staff to close gaps in care.
2	Insure care is provided at the appropriate level	Need to reduce unnecessary utilization at the hospital level while increasing preventive outpatient care.
3	Improve care to at risk populations	Chronic illness is the cause of the majority of preventable admissions and significant burden of illness for individuals and families. Optimal ambulatory care reduces morbidity and burden of illness and is measurable.
4	Improve PCP access	Regular primary care visits enables providers to identify health risks, engage patients in health promotion and coordinate care within the PPS network. Primary care visits are measurable as are annual wellness examinations and accompanying health screenings. Integration of behavioral health and palliative care and their key metrics are measurable and have demonstrated success.
5	Accelerate health information technology interoperability and establish data governance policies	Population health improvement initiatives require valid data on incidence and prevalence of illness, use rates and quality to direct improvement goals.
6	Improve patient engagement	Patients who are engaged in their care, exhibit better adherence to treatment goals resulting in improvement in quality outcomes.

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

Community Partners of WNY (CPWNY) PPS evolved through a process of community and provider engagement. The group was lead first by Catholic Medical Partners, with its very broad base of 975 providers experienced in population health management, ranked #3 ACO in the country by CMS. Leadership transitioned to Sisters of Charity Hospital, a large teaching and safety net hospital and member of CMP, serving a disproportionate amount of care to vulnerable populations in WNY. Through community forums, provider engagement, focused leadership and results of the community needs assessment, CPWNY recruited a comprehensive group of providers and community based agencies positioned to address health care disparities. CPWNY opted for a collaborative contracting governance model to enable efficient decision making and the ability to have multiple partners exert a strong influence in the future development of the PPS. CPWNY will utilize its PAC to maintain strong community representation, transparency and communication going forward.

***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.

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CPWNY's vision is to continue to develop our clinical competencies and to collaborate with health plans to develop contracts that promote a population health business model aimed at creating a margin from value based shared savings. In 2018, we will be positioned to contract directly with New York State or through health plans for the Medicaid population. CPWNY strategic focus has been developed around the High Performing Health System model that is based on accountability, evidence based care and values given by our commitment to the common good as well as our solidarity with the populations we serve and the foundational focus on interdependency among our network of providers to work collaboratively to improve clinical care and service.

***Regulatory Relief:**

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

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

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

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

#	Regulatory Relief(RR)	RR Response
1	Federal Anti-Kickback statute, Federal Start Law and PHL Section 238-a.	Various federal and state provisions will have to be waived for all of the projects to allow revenue sharing across PPS participating organizations. Provisions in these laws will prevent our PPS from distributing funds within the PPS in the manner required by DSRIP.
2	Title 10 New York Codes, Rules, and Regulations (NYCRR)	-Certificate of Need (CON) rules regarding establishment—specifically based on lead agency powers within the PPS—will require waiver of Part 405.1 & 600.9, regulatory provisions that define when establishment is required. -Parts 405.3 & 600.9(c) rules regarding management contracts & revenue sharing will need to be waived. -Definitive anti-trust protections are required (Certificate of Public Advantage will be helpful); broad state action immunity is necessary. -There is need for a centralized system-wide credentialing authority—involving facilities licensed by multiple state agencies & private practitioners—to include all practitioners who care for patients throughout our PPS (Parts 405.2 & 405.4). -Since our PPS involves a community-wide practitioner base, corporate practice of medicine rules need to be addressed. -Co-location restrictions need to be eliminated for services that integrate behavioral & physical health care & private physician practice. We envision this for 2ai & 3bi. -There needs to be consistent (i.e., a single set) of operational standards and recordkeeping requirements for co-located behavioral and physical health services across all state licensing agencies. -To support the integration of primary care & behavioral health, hospitals need to be able to generate more than one threshold visit bill per day to

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#	Regulatory Relief(RR)	RR Response
		support the costs of multiple providers of service. This is Part 86-4.9(b). Project 3ai. -Practitioner home visits must be enabled/authorized for all Article 28 hospitals & diagnostic & treatment (D&T) centers. (Part 401.1). -Substantial workforce flexibility must be enabled, especially as care provider roles change & staff transition to new roles. This is applicable to all projects. -Impediments to smooth and rapid transition of patients between care levels need to be waived [i.e., admission and discharge and transfer requirements in Parts 405.9 and 400.9, 400.11, 700.3, 415.38 (10 NYCRR), 505.20, and 540.5 (18 NYCRR)]. -Flexibility, consistent with statute, with respect to use of observation services, needs to be enabled /supported (Part 405.19). -Hospice need requirements & geographic limitations will need to be waived or eliminated—previous Public Health and Health Planning Council recommendation (Part 790). -Nursing home regulations, interpreted to protect the safety of other residents that compel nursing homes to transfer patients (especially behavioral patients) to hospitals, need to be modified to allow for appropriate therapeutic interventions within the nursing home (Part 415). -Home care ordering authority should be broadened to allow for medical directors, nurse practitioners, and physician assistants to sign orders for home care (Part 763). -Broader range of clinicians should be able to perform home health aide supervision, including utilizing methods other than on-site supervision (Part 763). -Certificate of public authority to enable PPS ACO's to take advantage of "safe harbors". Part 1003.

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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.

Sisters of Charity Hospital(SOCH), a safety net hospital located in Buffalo, New York, is the lead applicant and will be the sole entity contracting with the State of New York. Sisters of Charity Hospital will utilize a collaborative contracting model of governance with its Community Partners of WNY (CPWNY) Performing Provider System (PPS). Sisters of Charity Hospital is a Joint Commission accredited, 413 bed teaching hospital, which provides a comprehensive range of services including: addiction medicine, ambulatory surgery, bariatric services, cancer care, cardiology, dialysis access, digestive, endocrine, obstetrics, gynecology, orthopedic, mental health counseling, nutrition, palliative care, hospice ,physical therapy and rehabilitation, podiatry, pulmonary, sleep care, senior services, stroke, vascular, wound care and spiritual care services. Sisters provides 75% of its outpatient services and over 30% of its inpatient services to Medicaid, dual eligibles and the uninsured. SOCH is one of Catholic Health System's three member hospitals and is also a member of Catholic Medical Partners (CMP), a Medicare Shared Savings Program Accountable Care Organization (ACO). SOCH and CMP are strategically aligned to deliver population health services. CMP has participating provider agreements with over 1000 physicians as well as with SOCH

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and other institutional and ancillary members and holds 7 managed care contracts and a contract with CMS for shared savings. CMP-ACO has been successful in the CMS shared savings programs ranking #3 in the country in performance with significant development of IDS infrastructure. As a member of CMP-ACO, SOCH has been actively involved in clinical integration performance improvement initiatives and ACO implementation and management. SOCH was a founding member of CMP and has maintained a significant presence on the CMP board. Medical staff have served in key leadership roles including board chair and Executive Committee membership. SOCH has been actively engaged in strategic CMP initiatives including the care transitions program aimed at reducing readmissions and avoidable admissions. SOCH main primary care site, St Vincent's Health Center, utilized CMP's transformation program to achieve NCQA PCMH 2013 Level III status as well as a successful transition to electronic medical records. SOCH will contract with CMP for project management services and CPWNY PPS network development. SOCH has developed an Executive Governance Body (EGB) which includes representatives from key PPS partners. The EGB will be delegated the primary responsibility for the planning, implementation and evaluation of the PPS Project Plan. SOCH will retain ultimate authority to determine the flow of DSRIP funds, the addition and removal of PPS partners and compliance with all contractual and regulatory requirements. The EGB will oversee the clinical, financial, IT/data governance committees of CPWNY PPS. The EGB with the support of relevant Governance Committees will be responsible for: planning and implementation of scale and speed, manpower development, reporting and monitoring of all clinical projects, financial oversight and budgeting, incentive /bonus system development, policy and procedure development, development of contractual agreements and meeting NYSDOH requirements. The EGB has met to review attribution, clinical initiatives, scale and speed, project plan integration, and community needs assessment. The financial team has reviewed an initial budget and funds flow. The Data/IT team has met with the local RHIO (HealtheLink) to plan for interoperability and data connectivity. Draft charters have been developed setting forth meeting requirements, decision making processes and overall roles and responsibilities of the EGB and the Financial, Clinical and Data/IT Governance Committees.

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: **46_SEC021_DSRIP Organizational Chart.pdf**

Description of File

Community Partners of WNY organizational chart

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***Structure 2:**

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

SOCH has drafted a governance charter to ensure broad representation on the Executive Governance Body (EGB) of the CPWNY PPS. The EGB will have board oversight and management of the CPWNY PPS DSRIP Project Plan. We plan to integrate the clinical and utilization goals for the CPWNY PPS into CMP's current clinical integration program and by doing so establish common expectations for performance on each clinical metric for PPS partners' contractual arrangements. With our partners we will set forth roles and responsibilities, distribution of funds flow, clinical and data sharing responsibilities, and dispute resolution. The charter for the EGB sets forth in detail the membership, meeting requirements, decision making and responsibilities of the EGB. The EGC will ensure transparency by publishing its expectations for clinical performance and model for rewarding results. Minutes will be available on the CPWNY PPS web site with resolutions and decision making set forth in clear and understandable manner. The EGB will use a consensus decision model consistent with the delegated responsibilities set forth by SOCH and consistent with the NYSDOH contract.

***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.

For the past 3 years, SOCH, in collaboration with CMP, has participated in a Clinical Integration and Standardization Group (CISG) responsible for overseeing a health system wide clinical improvement program within the CMP accountable care organization. This includes establishing evidenced based guidelines and protocols, reporting on quality and utilization including the patient experience of

care. The CISG operates under the authority of a jointly appointed medical director who has accountability for care management at SOCH and within the Catholic Health System and includes leadership from the SOCH and CMP medical staff. This model was designed to ensure that quality improvement initiatives and metrics were set forth across the Catholic Health System's continuum of care in a manner consistent with ACO measures and metrics. CISG uses best practices set forth by the Institute for Clinical Systems Improvement, HEDIS, NCQA and specialty society guidelines. SOCH governance model will establish a Clinical Governance Committee (CGC). The CGC will not duplicate the work of the CISG but will focus on incorporating and adapting current quality standards, measurement and clinical processes in order to meet the goals of the PPS. The CGC will set forth clinical goals and measurements and monitor overall performance. The CGC will be supported by the CMP project management team which will include a Medical Director, Directors of care management and clinical transformation. CGC will work closely with the Financial Governance Committee to set performance metrics processes and ultimately develop and test value based payment and reimbursement models.

***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.

It is anticipated that the DSRIP program will have an impact all PPS partners in the following areas: contracting, membership, reimbursement, data collection, data analytics, reporting, and manpower as well as require greater collaboration with human and social service organizations. It is also anticipated that there will be an increased level of accountability for CPWNY partners to deliver value based services. In time, managed care contracting will require that CPWNY partners assume more accountability for cost and quality and the CPWNY PPS will design more value based methods of reimbursement. The CPWNYS' data and analytic capabilities will improve and there will be greater integration of claims and EMR data and embedded decision support to identify gaps in care. It is expected that the workforce will be expanded and better trained in evidence based practice and how to make optimal use of electronic health information. Patients will receive their care from a team of providers including physicians, nurses, nutritionists, social worker and other ancillary health care providers. Patient and population-based interventions will be guided by predictive modeling systems and we will be able to customize care to the population in need with care management support for patients with the greatest burden of illness. With the integration of health care and human and community services, community health workers, navigators and educators will become an integral part of the care team. These initiatives and improvements will enable CPWNY to perform successfully and meet target goals.

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.

EGB members w/roles and responsibilities: Catholic Health CEO, SOCH CEO (workforce, compliance & hospital triage), CMP CMO; PCMH level 3 practicing internist w/high Medicaid; Hospice CMO Hospice (clinical initiatives, PCMH, IDS development, cardiac care improvement, palliative care); President Health Home Partners & Spectrum Behavioral Health (health home, care mgmt. & behavioral health initiatives); CEO McCauley Home Care (care transitions); CHS VP Finance (financial, implementation oversight); CEO WCA Hospital (rural leadership); Sr VP Mission (patient & community engagement); Ex Dir Catholic Charities; Urban League-Coordinator of Community Health Workers (community health worker integration & community agency collaboration). The CPWNY PPS EGB is assigned responsibility for the planning, implementation and evaluation of the PPS and will receive direct support and assistance from CMP in carrying out its responsibilities. The EGB team has experienced physician and non-physician executives and the leadership of major human service agencies. The EGB will also conduct an annual review of board governance and oversee the CPWNY provider remediation and correction action programs.

***Process 2:**

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

Initially, CMP took the lead and convened a number of meetings to begin the formation of Community Partners of WNY. The initial meetings were focused on the overarching goals, DSRIP project guidelines, developing collaborative communication and exchange of ideas, and determination of representation on the governing body. There were sessions in which the participants' brain-stormed improvement initiatives and discussed how those ideas and strategies aligned with the DSRIP project guidelines. Following completion of

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the CNA, the CMP board and subsequently the SOCH Board approved a collaborative contracting governance structure and initial appointments to the EGB were made. CPWNY EGB members were selected with demonstrated experience to lead CPWNY's clinical initiatives and to bring the skills and knowledge necessary to create a high performing IDS that supports the CPWNY providers in achieving the selected DSRIP project goals. Qualities included but were not limited to: understanding of the community and its needs inclusive of (but not limited to) health literacy and cultural diversity; experience in improving the clinical care systems in multiple settings, knowledge of patient experience and cost of care metrics; and willingness to commit time for board meetings. Appointments were also made based on experience working with Medicaid beneficiaries and an understanding the social determinants of health and health disparities. The EGB board was selected to include partners with experience in setting organizational goals and strategic direction and who had experience in organizational decision making. The EGB selection also required partners to understand regulatory, compliance and reporting requirements related to NYSDOH contracting. The governance committees were selected based on similar requirements with subject matter expertise in financial, clinical and data governance.

***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.

Our representation includes leadership in all key DSRIP projects and a strong representation from ambulatory based providers including health home, behavioral health, hospice, private practice physicians, home health care and community and human service agencies serving the target population as well as key hospital providers. This representation is optimal as it includes leadership that can accelerate change and foster accountability. The structure and representation of CPWNY EGB and Governance Committees will be assessed on an annual basis and will evolve as we learn from our experiences how to best care for the target population.

***Process 4:**

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

The CPWNY Executive Governance Body (EGB) and the Finance, Data/IT Governance and Clinical Governance Committees will be composed of PPS coalition partners with the skills and ability to oversee the planning, implementation and evaluation CPWNYDSRIP Project Plan. The EGB includes key coalition partners including practicing physicians, medical leaders from hospice / palliative care, behavioral health and health home , leadership from Catholic Charities and the Urban league, county representation as well as health system leadership from acute care and home care. Included in the committees are health plan representatives from our local health insurance plans, the Executive Director of the local RHIO, CIO of Catholic Health System, hospital and community based care coordinators and human services and community agencies.

***Process 5:**

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

CPWNY will utilize the principles of Consensus Decision Making. The current SOCH Board successfully utilizes the Consensus Decision Making Model. The CPWNY Executive Governance Board will use a consensus decision model consistent with the delegated responsibilities set forth by SOCH and consistent with the New York State Department of Health contract. The goals of the consensus process include 1) Better Decisions: through the inclusion of input from all stakeholders - the resulting proposals can best address all potential concerns. 2) Better Implementation: A process that includes and respects all parties, and generates as much agreement as possible- sets the stage for greater cooperation in implementing the resulting decisions. 3) Better Group Relationships: A cooperative, collaborative group atmosphere fosters greater group cohesion and interpersonal connection. These goals are intertwined in the CPWNY EGB charter as well as their member roles and responsibilities, inclusive of conduct at board meetings.

***Process 6:**

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

Conflicts and /or issues are resolved by the current SOCH governing team utilizing the Collaborative Problem Resolution (CPR) method. If consensus cannot be reached a separate meeting strictly for handling the problem(s) will be held. A 90-minute session could be scheduled to resolve a problem and could accomplish resolution in that time period if three ground rules are upheld: (1) focus on the primary issue; (2) concentrate on resolution, not placing blame; and (3) center discussion on the problem resolution, not on other operational issues. Depending on the issue, agreeing to disagree is acceptable. Alternatively, a vote on an issue may also be utilized to resolve a conflict.

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***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.

The CPWNY PPS Executive Governance Body will ensure transparency by publishing its expectations for clinical performance and its model for rewarding results. EGB and Committee minutes will be published on the PPS website with resolutions and decision making set forth in a clear and understandable manner.

***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.

A Medicaid beneficiary will be included in the Project Advisory Committee (PAC). The PAC will also convene an ad hoc committee comprised of Medicaid FFS beneficiaries, managed Medicaid beneficiaries as well as an uninsured representative. This ad hoc committee will be convened to shed light on issues and challenges faced by the Medicaid and uninsured population. The ad hoc committee will be utilized to provide input into formulating communications and patient engagement strategies and quality improvement activities. The PAC is expected to offer regular feedback to the Executive Governance Body on the implementation and oversight of the Project Plan.

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.

Initially, CMP convened partners of the emerging PPS on 5/29, 6/17, 8/20, 10/21, 12/17. These meetings were designed: to review the DSRIP objectives, CNA, the NYSDOH DSRIP initiatives; to get engagement of the PPS collaborators on the requirement of the planning grant; and to begin the planning process and design our improvement initiatives. At these meetings, the parties discussed the role of the PPS in supporting population health, reviewed RHIO and interoperability requirements and Community Needs Assessment (CNA) progress. On 10/21 the CNA was presented and comments were elicited. Based on these meetings, the PPS partners who had the skills and knowledge to govern the PPS were identified and other providers were identified who will provide needed services as a non-partner or vendor. Legal advisors were consulted to develop the collaborative contracting governance model. The initial PAC meetings were focused on the overarching goals of the DSRIP project, the project guidelines and developing collaborative communication and exchange of ideas. There were work sessions in which the participants' brain stormed improvement initiatives and discussed how ideas and strategies align with the DSRIP project guidelines. CPWNY chose an alternative structure for its final PAC due to the size and diversity of the PPS. The membership of the CPWNY PAC includes but is not limited to the designated leaders of the CPWNY project teams, representatives of Medicaid managed care plans, representatives from Chautauqua, Niagara and Erie Counties, Regional leaders, non-managerial and union representatives, a representative of the local RHIO, two providers who serve a high volume of Medicaid beneficiaries and a Medicaid beneficiary representative. The PAC will also establish subcommittees as well as ad hoc committees and focus groups as projects evolve and the IDS develops. For example, there will be a PAC subcommittee to solicit information and provide recommendations on Workforce strategy which shall include non-managerial and union representatives and an ad hoc committee comprised of Medicaid beneficiaries convened to shed light on issues and challenges faced by Medicaid, dual eligible and uninsured populations. CPWNY leadership will attend all meetings and coordinate reporting to the EBG and SOCH board.

***Committee 2:**

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

As described above, the PAC served as the initial organizing body for the PPS. As the governance structure of the CPWNY has evolved with the formation of the Executive Governance Body (EGB) and the Clinical, Financial and Data/IT Governance committees, the PAC role will be advisory to the EGB. After April 1, 2015, the PAC will hold meetings at least quarterly. The PAC meetings will be open forum for providers, Medicaid beneficiaries, health care workers and other stakeholders to receive reports on the progress of the CPWNY Project plan implementation and performance. The PAC will gather stakeholder feedback during its meetings and provide reports and recommendations to the EGB.

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***Committee 3:**
Outline the role of the PAC in the development of the PPS organizational structure, as well as the input the PAC had during the Community Needs Assessment (CNA).

The CPWNY PAC was involved in the development and dissemination of the Community Needs Assessment Survey and Provider Conversations. When these aspects of the CNA were completed, the CPWNY PAC reviewed the responses and incorporated the prevailing messages the respondents provided into the ten (10) projects, scale and speed and the formation of the project leadership teams.

***Committee 4:**
Please explain how the selected members provide sufficient representation with respect to all of the providers and community organizations included within the PPS network.

The PAC will continue as an advisory body to the EGB throughout the DSRIP program. It membership has the knowledge, skills and confidence to make recommendations to the EGB on the implementation and performance of the selected DSRIP project plans. The PAC will be a forum for providers, Medicaid beneficiaries, health care workers, and other stakeholders to receive progress reports and provide feedback on the operations of the PPS. In addition to representatives of the PPS partners, CPWNY has included in the PAC membership community organizations, providers, and managed care health plans that serve a high volume of Medicaid beneficiaries. The PAC will create ad hoc committees and focus groups to enhance the knowledge of "what works best" when working with people struggling with poverty, the disadvantaged, culturally and ethnically diverse populations, and health literacy challenged community members.

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.

SOCH currently has an established compliance program. Initially, the Financial Governance Committee of CPWNY will be responsible for compliance, including health information privacy & security. The Committee will coordinate with the Data/IT Governance Committee assisted by the Project Management Office staffed by CMP. In the future, CPWNY may establish a separate Compliance Committee. CPWNY will designate a Compliance Officer to oversee and monitor the Compliance Program of CPWNY. The Compliance Officer will be a part time administrative position that reports directly to the EGB, and will be expected to collaborate with CPWNY's partners and the SOCH Compliance officers. The Compliance Officer will not be legal counsel to SOCH or the CPWNY. Responsibilities include but are not limited to the completion of periodic audits designed to address relevant compliance issues, such as contractual arrangements, government reporting and any other areas designated for special review and focus.

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

It is the policy of SOCH and the CPWNY PPS to ensure it conducts its business in compliance with all applicable laws, rules, regulations and other directives of the federal, state and local governments, departments and agencies. Mechanisms for identifying and addressing compliance problems are: CPWNY partners and providers will be required to bring concerns to the attention of the Compliance Officer. Reports may be made anonymously (if desired), in person, in writing, or over the telephone; CPWNY Partners may be asked to conduct audits in identified areas of potential risk and to measure progress against the baseline audit results as well as participate in annual training. Failure to comply with the HIPAA policies and procedures and participate in required training may result in notification to appropriate authorities and possible expulsion from CPWNY PPS; SOCH also has a complaint policy in place that is available to patients attributed to the CPWNY PPS. The policy indicates that the patient has the right to file a complaint with SOCH regarding any component of SOCH operations, exclusive of coverage issues, and to receive a response from SOCH following an investigation.

***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.

CPWNY will conduct Compliance training for all PPS Partners and network providers. Attendance and participation will be a condition of PPS participation and failure to comply will result in disciplinary action up to, and including, termination. CPWNY will make available on its website to all PPS partners and contractors a copy of the CPWNY Compliance Plan and Code of Conduct (in development). Additional focused training may be required as part of a PPS partner's performance improvement measure or action plan or for particular groups of personnel who require specific training seminars.

***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.

SOCH has a compliance concern and complaint policy in place that will be extended to all patients attributed to the PPS. In addition, a complaint form and instructions for the Compliance Hotline will be available on the CPWNY website. CPWNY will communicate through the PAC and also with its Partners and providers regarding the complaint process and encourage dissemination of information to patients, community providers and other community-based organizations about where and how to file a compliance complaint.

Section 2.5 - PPS Financial Organizational Structure:

Description:

Please provide a narrative on the planned financial structure for the PPS including a description of the financial controls that will be established.

***Organization 1:**

Please provide a description of the processes that will be implemented to support the financial success of the PPS and the decision making of the PPS' governance structure.

The SOCH organizational structure is established to maximize our ability to meet the DSRIP goals and objectives and serves as the foundation for the CPWNY PPS. CPWNY will have an established Financial Governance Committee that includes PPS partners and reports directly to the Executive Governance Body. The CMP project management team will support the EGB and the Financial Governance Committee. A DSRIP Project Director of Finance will be responsible for managing financial operations and will report regularly to the EGB and the Financial Governance Committee. CPWNY will conduct an annual review of its governance structure and make the necessary adjustment to improve decision making, partner engagement, performance and overall adherence to the NYSDOH contractual obligations. Processes and controls will be in place for all financial transactions including compensation to PPS Partners and providers. All CPWNY expenses and payments will be reviewed to ensure the project funds are being utilized efficiently and in compliance with the NYSDOH DSRIP contract.

***Organization 2:**

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

The CPWNY Financial Governance Committee of the EGB will be delegated responsibilities encompassing key finance functions inclusive of: setting financial standards; monitoring the financial performance of the PPS partners; developing a methodology for receiving and distributing project funds; financial reporting integrity and capital expenditure oversight. This Committee will be the impetus for financial sustainability of the PPS and is governed by a Committee Charter that outlines its purpose and responsibilities. The Committee reports to and makes recommendations to the CPWNY EGB.

***Organization 3:**

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

The Financial Governance Committee will engage a third party independent auditor to audit the integrity of financial statement reporting as well as the PPS's internal control policies. The results of this audit will be reviewed by the committee and reported to the EGB. Internal controls will be in place to ensure financial transactions performed by designated staff members receive final approval by the chief financial officer. Internal audits will be performed in addition to the external auditor review that will ensure compliance with all project rules and finance/accounting regulations. Internal audits will be performed that: evaluate the effectiveness of the internal control system with respect to financial reporting and controls over receiving and distributing project funds: and review the adequacy of accounting and financial controls with financial personnel along with external auditors and present any recommendations for improvement to the Committee.

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***Organization 4:**

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

A compliance program will be established in accordance with New York State Social Services Law 363-d. The program will designate a compliance officer with responsibilities of assuring compliance with all project regulations and maintaining compliance amongst all participants in the CPWNY. The compliance officer will conduct periodic audits and report the results to the EGB. The compliance officer will oversee the compliance training and will be available to address any compliance concerns or requests from all CPWNY participants. The compliance program will: Have an effective compliance plan that promotes prevention, detection and resolution of instances of conduct that do not conform to federal and state law as well as ethical and business policies; Be accountable for findings of examinations by regulatory agencies and auditor observations; Obtain regular updates from management and legal counsel regarding compliance matters; Review and approve compliance policies, procedures and plans; Assure substantial compliance with federal HIPAA privacy and security laws and regulations; Review with counsel and others any legal or regulatory concerns as necessary.

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 CPWNY EGB, with the assistance of the Project Management team will be responsible for the oversight of Partner contracts. Such oversight will include monitoring performance and initiation of corrective action, as well as recommendation to SOCH for removal of a CPWNY Partner for poor performance. Participating Partner Contracts will address corrective action, due process rights, as well as sanctions, including but not limited to financial penalties and removal from the PPS. Monitoring performance will include but not be limited to quarterly reports on quality outcomes, utilization, patient complaints, and patient experience surveys.

***Oversight 2:**

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

The CPWNY will provide progressive improvement interventions with Partners that do not meet objectives as well as for those who are not committed to the implementation plan and timeline. CPWNY will conduct meetings with the accountable personnel of the lower performing partner to develop an improvement plan focused on the specific areas needing remediation. Notice will also be provided to the specific Partner regarding their performance shortcoming and will specify a timeline line and specific recommendations for active engagement by the Partner.

***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.

During a period of remediation by the Partner, all CPWNY resource assistance will be held pending a response by the Partner and submission by the Partner of an acceptable corrective action plan. The Partner shall provide his/her written response and corrective action plan to the EGB or designee within 30 days of the Partner's receipt of notice. If the Partner does not respond or if the response does not meet the requirements set forth by the EGB, sanctions may be imposed. In addition, a CPWNY Partner may be terminated from the program for failure to comply with the standard terms and conditions of the waiver. A termination hereunder shall be subject to appeal as set forth by the CPWNY Participating Provider Agreement. Where the provider has not demonstrated active engagement in the DSRIP Program, a non-renewal decision shall be applied and the Partner may be removed from the network in accordance with the DSRIP program timelines. Such non-renewal shall not be subject to appeal, but shall be subject to SOCH approval.

***Oversight 4:**

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

CPWNY has a complaint process which permits patient to file a complaint via SOCH regarding any component of operations, exclusive of coverage issues, and to receive a response from SOCH following an investigation. This includes but is not limited to complaints about

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providers, facilities and partners. Complaints and findings will be trended regarding a CPWNY Partner and factored into the renewal and removal process. Outcomes of patient experience surveys will also be taken into account for the renewal and removal process.

***Oversight 5:**

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

Medicaid beneficiaries and their advocates will receive advanced notice according to CPWNY policies and procedures, regarding the removal of their provider from the PPS. Medicaid beneficiaries and their advocates will be I informed that they may still see their provider. The PPS website will identify who CPWNY partners are and will be updated to reflect any partner changes.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

- Implementation plan outlining the PPS' commitment to achieving its proposed governance structure (Due March 1, 2015).
- Periodic reports, at a minimum semi-annually and available to PPS members and the community, providing progress updates on PPS and DSRIP governance structure.
- Supporting documentation to validate and verify progress reported on governance, such as copies of PPS bylaws or other policies and procedures documenting the formal development of governance processes or other documentation requested by the Independent Assessor.

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

***Overview 1:**
Describe the process and methodology used to complete the CNA.

The Western New York (WNY) Community Needs Assessment (CNA) has been jointly conducted and lead by the two "Performing Provider Systems" that cover the eight counties of Western New York: Community Partners of WNY and Millennium Collaborative Care. This collaboration on the production of this community health needs assessment led to the collective identification of the most overarching needs, resulting in six joint projects tied to system wide and community health gaps.

The WNY Community Needs Assessment was compiled in three separate pdf packages: VOLUME ONE- CNA SUMMARY; VOLUME TWO- CNA ASSESSMENT DETAILS; AND VOLUME THREE- CNA RESOURCE INVENTORY.

The detailed Volumes (Two and Three) were compiled by the University at Buffalo Regional Institute, working closely with HMS Associates, the P2 Collaborative of Western New York, and FTI Consulting Center for Healthcare Economics and Policy. The Volume One, the CNA Summary Report (compiled from Volumes Two-Three and additional sources as needed) was orchestrated by the University at Buffalo Primary Care Research Institute with extensive assistance from analytic content experts from Catholic Medical Partners, Niagara Falls Memorial Medical Center, Erie County Medical Center, FTI Consulting Center for Healthcare Economics and Policy, and Computer Task Group.

Two major types of methodology were used: secondary data analysis of existing quantitative data sources and primary data collection for qualitative contextual findings. Quantitative data sources included basic demographics, indicators of "community structure" or social determinants of health need, and detailed health care data describing system- wide performance, quality of care and population health status. Qualitative data sources were from the community in the form of surveys, focus groups, and interviews.

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

Information and Data Sources Used:

The following quantitative data sources were used to conduct this community needs assessment:
(a) DSRIP Performance Data Dashboard (for Medicaid Domain 2 and 3 metrics; zip and county level). New York
(b) State Prevention Agenda Data Dashboard (for Population Domain 4 metrics, county level).
(c)SPARCS Data (for additional needs assessments not covered by Domain 2, 3, or 4, zip and county level).
(d) CDC Mortality Data (for cause of death needs assessment, county level).
(e) US Census (for demographic profiles and assessment, county, zip, and tract level).

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(f) Statewide Perinatal Data system, Western New York dataset (county and zip level).New York State Extended
(g) RFFS Survey (for chronic disease prevalence estimates, county level).
(h) Multiple Sources for provider and resource inventories (DSRIP, NPI database, D&B, 211 Information Referral, and other miscellaneous sources.
(i)Actuarial data on cost and efficacy of services from Catholic Medical Partners two Medicaid contracts.

In addition to the extensive quantitative data sources listed above, three community engagement approaches were used to gather extensive qualitative data that provided dimension and human context to the numbers, providing us with the means to explain some of the dynamics at play in our health care system today:

(a) Regional Health Needs Survey- completed by more than 7,000 people.

(b) Focus Groups- 16 "community conversations" engaging people served by the system to better understand those patient perspectives.

(c)Key Informant Provider Interviews- a series of 42 interviews with providers from every part of the region and every phase of the health care system from primary care to mental health and behavioral care to emergency department settings.

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	22	9
2	Ambulatory surgical centers	11	0
3	Urgent care centers	20	7
4	Health Homes	6	2
5	Federally qualified health centers	4	0
6	Primary care providers including private, clinics, hospital based including residency programs	1416	746
7	Specialty medical providers including private, clinics, hospital based including residency programs	5210	1070
8	Dental providers including public and private	812	0
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	136	11
10	Behavioral health resources (including future 1915i providers)	521	22
11	Specialty medical programs such as eating disorders program, autism spectrum early	46	6
12	diagnosis/early intervention	16	0
13	Skilled nursing homes, assisted living facilities	74	29
14	Home care services	48	3
15	Laboratory and radiology services including home care and community access	1841	36
16	Specialty developmental disability services	135	13
17	Specialty services providers such as vision care and DME	161	2
18	Pharmacies	323	4

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
19	Local Health Departments	8	4
20	Managed care organizations	4	2
21	Foster Children Agencies	16	0
22	Area Health Education Centers (AHECs)	3	0

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

***Infrastructure 2:**

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

Resolving Excess Bed Capacity- There are 22 hospitals providing acute care services across WNY, 9 of which are in Community Partners of WNY (CPWNY). Within WNY, the inpatient occupancy rate varies from 69% in the Central region to 47% in the South region. Hospitals in CPWNY have an inpatient occupancy rate of 53.9%. Rural hospitals have greater challenges with occupancy and minimum staffing. In WNY there are on average 1,240 unused beds. There are 74 nursing home facilities, with 29 in CPWNY. Projected estimates indicate an excess need of 499 SNF beds. Deactivation of unused beds will not have large workforce implications if they are largely unstaffed. We will work to decertify unused, unstaffed beds in hospitals and residential heath facilities and seek new ways to repurpose unused space for essential services.

Addressing Primary Care Shortages- There are primary care (PC) shortages throughout the region, including: (a) inadequate number of primary care physicians (PCPs) and mid-levels (PA, NP) working in PC settings; (b) inadequate number of PC locations; and (c) inadequate number of safety net PC locations. Catholic Medical Partners currently has 30,000 Medicaid patients enrolled from existing health plan contracts most of whom are served by non safety net PCPs. We will work with Area Health Education Center (AHEC) partners to influence PCP career choice, and with health professional schools to place mid-levels and physicians in safety net settings.

Enhancing Primary Care Patient Centered Medical Home (PCMH) Status- Only 21% (110) of the 512 PC locations in WNY are currently level 3 PCMH certified. Various types of Practice Facilitators will be deployed to reach level 3 PCMH rapidly. Evidence-based approaches such as the TRANSLATE model will be used to drive PCMH recognition. We will use PCMH work flow changes in pre-visit planning to address access, transportation, and community linkage gaps in underserved areas.

System Change for Provider Integration- We will explore mechanisms for meaningful integration by overcoming structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross training, etc). We will improve coordination between partners through mandated use of EMRs and the Regional Health Information Organization (RHIO.) We will enhance RHIO interoperability by targeting: (a) care coordination for high risk patients in transition; (b) changes in emergency to prevent inappropriate use;(c) changes in hospital care to prevent readmissions; (d) integrated referral to subspecialists; (e) medication safety enhancements; and (f) interoperability with behavioral health and community supports. We will train key personnel system-wide to participate in the new model. Standard training protocols will be developed for new roles. When possible, excess staff from reductions will be redirected to fill new positions.

Addressing Specialty Gaps- We will work to increase the number of dentists that accept Medicaid or increase dental services in safety net PC settings. We will work with AHEC partners to recruit specialists, such as Psychiatrists, Clinical Psychologists and other subspecialists into shortage a

Section 3.3 - Community Resources Supporting PPS Approach:

Description:

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

***Resources 1:**

NYS Confidentiality – High

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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	370	2
2	Food banks, community gardens, farmer's markets	437	0
3	Clothing, furniture banks	199	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	17	4
5	Community outreach agencies	120	19
6	Transportation services	91	3
7	Religious service organizations	21	7
8	Not for profit health and welfare agencies	120	0
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	172	0
10	Peer and Family Mental Health Advocacy Organizations	23	0
11	Self-advocacy and family support organizations and programs for individuals with disabilities	115	0
12	Youth development programs	121	3
13	Libraries with open access computers	27	0
14	Community service organizations	73	19
15	Education	487	2
16	Local public health programs	150	6
17	Local governmental social service programs	184	0
18	Community based health education programs including for health professions/students	20	0
19	Family Support and training	2212	0
20	NAMI	0	0
21	Individual Employment Support Services	317	0
22	Peer Supports (Recovery Coaches)	41	0
23	Alternatives to Incarceration	16	0
24	Ryan White Programs	32	0
25	HIV Prevention/Outreach and Social Service Programs	43	0

***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.

WNY has a broad array of community resources spanning all counties. With 437 food banks, including food pantries and soup kitchens, as well as community gardens and farmers markets. There are 370 shelter programs, including agencies that provide housing services to special populations, such as: victims of domestic violence, people living with HIV/AIDS, people with mental illness, and homeless veterans. There are 199 basic needs programs that provide clothing and furniture. Every PPS will work with all available community resources in the region to social determinants of health needs.

There are 184 local government agencies such as food stamp programs and Medicaid offices located in each county. There are 317 employment support services such as job centers, located predominantly in counties with urban areas. There are 121 youth development programs, including those designed to keep at-risk youths away from gun violence and substance abuse. There are 487 education programs, including schools, colleges, and community-based organizations providing educational services. Some of these organizations focus on special populations such as children with emotional disturbances, at-risk youth, immigrants, and refugees. There are

approximately 16 programs that offer alternatives to incarceration services located in Erie and Niagara Counties. There is not necessarily a gap in these community resources, the problem is that they are not optimized in the way that the safety net health system utilizes them. Each PPS will strive to optimize the use of these community resources by deploying patient navigators and retooling the care management function in PCP, hospital discharge, & ED settings.

A significant asset that ties resources together is an online 211 Information referral system that is well developed. However many medical providers are not aware of these resources and are not geared to assess patients for social determinants of health and to actively assist patients in accessing these resources. Connecting chronic disease patients to community supports is one of the most neglected components of the Chronic Care Model to improve and sustain self-management skills. This will be done by work flow changes instituted in primary care settings by the 2014 PCMH standards.

There are 42 organizations involved with crisis intervention services. There presently are not protocols to deescalate behavioral health crisis situations and to activate and connect beneficiaries with the health care system. Most crisis services are local with limited coordination across the region and there is virtually no interoperability with the RHIO. Strategies like forming a regional crisis intervention alliance as a collaborative- learning group to implement best practices will help connect this function to all PPSs.

There are 91 transportation service programs, including those providing transportation needs to seniors and the disabled. However, transportation is still a pervasive problem that contributes to no-shows to primary care appointments. This will be addressed in the PCMH setting by making transportation arrangements a vital component of the pre-visit planning work

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 Western New York region has over 1,544,000 population with an age profile that is slightly older than New York State. The age group 65 and above is 15.8% of the total population compared to the State's 13.6%. Niagara and Chautauqua are 16%+ for this age group. There are portions of the City of Buffalo and Lackawanna with younger population where larger numbers of younger refugees and immigrant families have settled over the last decade. Otherwise, there are no significant age differences across the region.

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

African-Americans are heavily concentrated in the cities of Buffalo and Niagara Falls and constitute as much as 90% of the population in several ZIP codes in each city. African-Americans also live in other locations around the metropolitan area (2 to 3 times the 10% WNY rate), such as Cheektowaga.

Latinos/Hispanics follow a somewhat less concentrated, with higher concentrations (2 to 3 times the 4% WNY rate) on Buffalo's West Side, Lackawanna and Niagara Falls, but also in Dunkirk, Jamestown, and Orleans County.

Non-English speakers are concentrated (3 to 5 times the 3% WNY rate) in various locations of the region. Many live in Buffalo, especially on the West Side, with its heavy refugee populations with over 40 languages spoken by non-English speakers. Literacy and health literacy are also low in areas of high poverty.

***Demographics 3:**
Income levels:

The median household income in WNY is $49,304, 15% below the New York State median of $58,003. Erie County is 13% below the State median, however the City of Buffalo is 47% below NYS median. Niagara County is 17% below the State median, however the City of Niagara Falls is 44% below NYS median. Most rural counties are 27% below the State median and some small cities in rural areas are

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46% below the state median.

***Demographics 4:**

Poverty levels:

Poverty status is perhaps the most important indicator of health care need. In the region, 15% of the population lives below federal poverty level compared to 10% for the State. People at 200 percent of the Federal poverty level are overwhelmingly concentrated (2 to 4 times the 15% WNY rate) in the cities of Buffalo and Niagara Falls and spread widely across the Southern Tier counties of Chautauqua, Cattaraugus and Allegany in both small cities and rural areas. These areas also have excessively high rates (50% above the 21% WNY rate) for Children under 18 living in poverty.

In June 2014 the US Census Bureau ranked the City of Buffalo as the 4th poorest city in the nation, where nearly 27% of the population (twice WNY) lives in poverty and nearly two thirds (4 times WNY) under 200% of the federal poverty level.

***Demographics 5:**

Disability levels:

In Western New York the population with disability is 103,347 or 11% of the total. This is almost double the State percentage. The disability percentage is high in every county and ranges from a low of 9% in Genesee County to a high of 14% in Orleans County. The number of people with a developmental disability is approximately 12,000 or 0.7%.

***Demographics 6:**

Education levels:

Educational attainment is an underlying factor for poverty status and, by extension, health care need. In WNY 11% of the population over age 25 does not have a high school diploma compared to 8% in the State. Highest rates of lack of high school completion are concentrated (2 to 3 times WNY rate) in Buffalo and Niagara Falls and across the Southern Tier, and Orleans County. Based on survey and focus group findings, this is highly associated with low literacy and high poverty.

***Demographics 7:**

Employment levels:

The unemployed civilian population over age 16 is 5%, which is low compared to 9% at the state level. The population over age 16 not in the labor force is comparable to the state (37%). The employed population with a disability is three times the state rate (3% vs 1%).

***Demographics 8:**

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

Institutionalized Population- The region as a whole has 25,155 people living in institutional settings that are not correctional or SNF. Most institutionalized population is in Erie County where a large Psychiatric Center is located.

Correctional Facilities- Region wide there are 13,592 adults in jails, most in Erie, Wyoming, Orleans, and Chautauqua Counties were prisons are located. There are Juvenile Facilities housing 552 people, mostly in Erie County.

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

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

File Name	Upload Date	Description
46_SEC034_WNY_PPS_CNA.pdf	12/20/2014 01:59:29 PM	entire community assessment
46_SEC034_2cii Telemed CNA Addendum12-19.docx	12/20/2014 01:52:44 PM	additional CNA information re: telemedicine

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Section 3.5 - Community Population Health & Identified Health Challenges:

Description:
Please describe the health of the population to be served by the PPS. At a minimum, the PPS should address the following in the response.

***Challenges 1:**
Leading causes of death and premature death by demographic groups:

The leading cause of death (#1) in every county is CVD or heart related for the State, the region, and every county. The top five specified causes of death (#1, #2, #3, #4, and #5) in every county are all smoking related (heart followed by lung).

The African American leading causes of death (#1, #2, #3, and #5) are also predominantly CVD and smoking related.

The leading causes of premature death (#1, #2, #3, #4, and #5) in every county, the region, as well as the state is lung cancer and CVD/heart and/or smoking related. WNY's premature causes are similar to the State, except NYS has death by assault by a firearm in the top five.

The African American leading causes of premature death are lung (#1), followed by violet crime (#2), then CVD/heart (4 and #5), the same profile as for New State. Oher than violent crime, premature African American death is smoking related.

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

As with the leading cause of death, leading causes of hospitalization in every county are CVD/heart related (#1 in most or #2). In addition, mental illness and complication of pregnancy dominate leading cause of hospitalization (in top 4). WNY has high rates of hospitalization for diabetes complications with Erie, Niagara, Cattaraugus, and Orleans performing worse than NYS. African Americans (WNY and NYS) have a similar profile of leading cause of hospitalization- CVD related (#1), complication of pregnancy (#2), and mental disorders (#3). WNY has high rates of preventable ER use in the Medicaid population with county rates ranging from 33.4 to 52.6 visits per 100 beneficiaries. The preventable readmission rate in WNY is 5.8 per 100, with Niagara (7.4), Orleans (8.9) and Chautauqua (7.6) exceeding the NYS rate (6.7). WNY also high Medicaid admission rates for depression compared to NYS (45.5/beneficiary with depression compared to 40.6), with Niagara County performing the worst at 67.0, a 65% increase over the state. Hospital readmissions for Medicaid patients with mental health issues are high in Erie (28%) and Niagara (32%) counties compared to NYS (27%).

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

On many Ambulatory Care Sensitive Conditions (ACS), the Western New York region is below State rates. Where the region differs is for CVD related conditions such as Heart Failure (389.0/100,000) vs 272.0) and Angina Without-Procedure (24.0/100,000 vs 20.0). The county that seems to have the biggest problem with ACS conditions is Niagara.

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

Compared to the State, the region and all counties have higher prevalence for CVD related diseases: High Blood Pressure (32.7% vs 26.8%), Cardiovascular disease (9.1% vs 7.7%, and Coronary Heart disease (7.6% vs 6.3). Diabetes prevalence is higher than the NYS rate (9.3%) in Erie (11.3%), Niagara (10.9%), Cattaraugus (11.4%) and Chautauqua (12.1%) counties. The region was below the State prevalence for Asthma. Compared to the State the prevalence for Asthma, the region and most counties are equal of lower (14.9% vs 15.0%). As is the case for many other indicators, Niagara County is above the State prevalence for asthma, CVD, and diabetes. These estimates were compiled from the NYSDOH Expanded BRFFS Report 2009.
Overall, WNY has a lower HIV infection rate (7.6 per 100,000) compared to the NYS goal rate of 14.7. WNY has high rates of gonorrhea (408.1 per 100,000 women and 315 in men) infection rates compared to the NYS goals of 183.4 and 200 respectively. WNY also has high rates of chlamydia infection at 1,748 cases per 100,000 women compared to the NYS goal of 1,458.

***Challenges 5:**
Maternal and child health outcomes including infant mortality, low birth weight, high risk pregnancies, birth defects, as well as access to and

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quality of prenatal care:

The WNY rate of preterm births (12.1%) is above the NYS Prevention Agenda goal (10.2%), especially in Erie and Niagara Counties and the Southern region (up to 15%). The Medicaid percentages are 26% higher than non-Medicaid, especially in the Central region and Niagara County.
Erie and Niagara had high rates of low-birth weight (10.2%) compared to WNY (9.6%). Erie County has a higher Medicaid rate of high-risk pregnancy (12.7%) compared to WNY (10.9%).
The Maternal mortality rate is 26.8/100,000 births, above the NYS goal of 21, especially in Erie (34) and Cattaraugus (35.7).
In WNY, 69.5% of children in government sponsored insurance programs have had the recommended number of well child visits, below the NYS goal of 76.9%. This is more of a problem in the rural counties (rates as low as 55.7%).
In WNY, 87% of children aged 0-15 months in government sponsored insurance programs have had the recommended number of well child visits, below the NYS goal of 91.3%. Chautauqua (92.7%) is the only county above the State goal.
High Risk Pregnancies occur for Medicaid mothers 10.9% of the time, and are highest in Erie

***Challenges 6:**

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

Obesity is a major risk factor in the WNY population. The % of adults who are obese is 30.2% compared to the NYS Prevention Agenda goal of 23.2%. Every county has a serious problem. The % of children and adolescents who are obese at the county level is closer to the NYS Prevention Agenda goal of 16.7%. Erie and Allegany Counties are near or below the state goal. The other six are not with rates as high as 20%.

The % of cigarette smoking among adults is 20.8% compared to the NYS Prevention Agenda goal of
15%. Five of the rural counties seem to have higher rates (Genesee, Orleans, Allegany, Cattaraugus, and Chautauqua Counties) with some as high as 28.4%. Declines in use in the past decade (13% drop) have missed: African Americans, Hispanics, those with less than a high school education, those with low incomes (< $25,000) and those with poor mental health.

The age-adjusted % of adult binge drinking in the general population is 18.9%, slightly higher than the
NYS Prevention Agenda goal of 18.4%. High rates of early alcohol use, a risk factor for future binge drinking, exist in Erie county schools (BPS (14.9% before age 13) and Lancaster (48% by grade 12)).

***Challenges 7:**

Any other challenges:

Low Primary Care Utilization - WNY has a 28 % lower PCP visit rate and a lower proportion of beneficiaries (60 %) with a PCP visit compared to NYS (64 %). The WNY PCP no-show rate is 30%.

Problem with Depression and Suicide- WNY's admission rate for depression is high (45.5/ beneficiary with depression), exceeding the NY State rate (40.6). WNY has a high rate of suicide deaths (11.4 per 100,000) compared to the NYS goal (5.9).

Palliative Care – WNY has a high need for palliative care services. 15% of WNY patients currently use these services, compared to 13% for NYS. Cattaraugus and Chautauqua showed higher rates at 20% and 18% respectively.

Transportation issues- The region ranks last (at 12%) among upstate regions for households without access to a vehicle, a crucial indicator of the ability of people to access health care services. Where a vehicle is absent, given the poor state of public transit across the region, getting to appointments and filling prescriptions are onerous, sometimes impossible tasks. As with many other indicators, households with no vehicle are concentrated in the cities of Buffalo and Niagara Falls and along the Southern Tier.

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:**

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Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

The region has a total of 3,455 licensed hospital (non SNF) beds. With an aggregate occupancy rate of 64% (actual bed days / bed days available) translates into 1,240 beds not in use. The reality is that not all used beds are staffed units, except for small rural hospitals with few beds and minimum staffing requirements. The NYSDOH projected (2016) that there are 499 excess beds for residential heath care facilities in WNY.

Gaps in Interoperability- Enhanced communication and care management data sharing between primary care and specialists, mental health, health homes, community support agencies does not exist and the interoperability with hospitals and pharmacies needs to be enhanced.

Primary Care Shortages: Large portions of the inner city and rural areas of the region are designated as population Health Professional Shortage Areas (HPSAs). The City of Buffalo has a high need designation. The ratio of Medicaid population to Safety Net physicians is excessively high (over 4,500:1) in some counties.

Primary Care PCMH Status: Only 21% (110) out of 512 primary care locations in the region are currently recognized as PCMH facilities. Outside of Erie and Niagara Counties the number of PCMH locations is extremely low.

Primary Care Midlevel Workforce in PCP Settings: Only 22% (306) of the primary care providers in the region are midlevel providers (PA or NP). Most midlevel providers are currently working in specialty or hospital settings.

Care Management Personnel in PCP Safety Net Settings: In certain settings, there are inadequate primary care personnel devoted exclusively to the care management and integration of patients with behavioral health services.

Little Behavioral Health Primary Care Integration- With a few exceptions, there is little meaningful integration of behavioral health with primary care due in large part to the structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross training, etc). With the exception of Psychiatrists, physicians are not well trained in behavioral health. Behavioral health conditions have a profound effect of the medical management of chronic complex disease.

Workforce Implications to Achieve BH PC Integration- The emerging Health Home agencies that provide services in the WNY region must make improvements to infrastructure for operationalizing this integration. In addition there is a need to create new functionality in the primary care safety net setting to provide dedicated workflow for this integration. Additional primary care work force such as Licensed Mental Health Counselors (not presently credentialed by Health Plans) and Licensed Social Workers may be needed. In BH settings serving seriously mentally ill, it may be more effective to embed PCP providers in these targeted locations.

Shortage of Psychiatrists and Psychologists – There is a severe shortage of psychiatrists and psychologists compared to NY State. On average, NY State has almost twice as many psychiatrists and psychologists per beneficiary compared to WNY. Orleans County has no Psychiatrists and most other small rural counties have no Pediatric Psychiatrists

***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.

Availability- There are significant gaps in service locations for primary care and behavioral health clinicians as evidenced by large areas designated as Health Professional Shortage Areas and by geographic gap analysis. 100% of all urban and rural areas above the region's poverty rate (15%) are designated shortage areas. WNY has a 28 % lower PCP visit rate and a lower proportion of beneficiaries (60%) with a PCP visit compared to NY State (64 %).

Accessibility- In the "Community Conversation" Focus Groups, a key finding was that waiting to be seen is a barrier to patient engagement in the primary care system. This includes how far in the future an appointment may be as well as how long the patient waits to be seen.

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Affordability- In the "Community Conversation" Focus Groups, a key finding was that out of pocket costs are a significant barrier to health care for lower-income consumers.

Quality- In the Survey, when asked to select from a list of suggested improvements to the primary care delivery system, one of the most common answer was "better follow-up care," and "more responsive staff." In the Focus Groups a key finding was that communication is a problem for Medicaid patients who may not fully understand a doctor's instructions or explanations, either because the doctor speaks too technically or because the patient speaks another language, or because the doctor "talks down" to the patient. More generally, provider sensitivity to cultural differences is seen as a need. Many Focus Group participants also felt that the quality of care provided to Medicaid enrollees is perceived by some as inferior in quality to the care that people receive when they are otherwise insured.

Hours of Operation- In the Survey, when asked to select from a list of suggested improvements to the primary care delivery system, the most common answer was "shorter time to schedule appointments," followed by "longer hours of operation."

Transportation- In the Focus Groups, a key finding was that transportation is a pervasive problem. Many low- income households lack access to a vehicle, public transit services in the region are weak or non-existent, and use of Medicaid funded services requires significant advance notice. An analysis of proximity to providers indicates that many patients, Medicaid and non-Medicaid, have trouble accessing the health system due to a number of issue

***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.

1) Resolve Excess Capacity- We will work collaboratively to decertify unused, unstaffed beds in hospitals and residential heath care facilities, while seeking beneficial ways of repurposing the space for new essential services.

2) Enhance Primary Care, through:
(a) Rapid Practice Transformation to PCMH 2014 Level 3- using evidence-based TRANSLATE model to achieve PCMH recognition
(b) Behavioral Health – Primary Care Integration
Create new functionality within safety net PCPs for behavioral health integration
Offer Evidence based behavioral health training for PCP providers
Aid targeted behavioral health settings to co-locate primary care services or train providers in supporting patient self-management.
Accelerate integration of emerging Health Home agencies into the infrastructure.

3) Enhance Coordination–Explore mechanisms for meaningful integration by overcoming structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross training, etc). Improve coordination between partners through mandated use of EMRs and the RHIO. Enhance RHIO interoperability by focusing on six areas: (a) Care coordination for high risk patients in transitions; (b) Hospital care- prevent readmissions and avoidable admissions; (c) Emergency care- prevent non-emergent use; (d) Referral to Subspecialists; (e) Medication safety; and (f) Interoperability with Behavioral Health and Community Supports.

4) Strengthen Emergency Department -To reduce improper ED use we will incorporate services for care coordination, linkages to primary care, and access to social services at these sites. EDs will be linked to other providers through the RHIO.

5) Workforce Training and Recruitment – Our organizations and employees need to be trained to participate in the new model. Standard training protocol will be developed for new roles. When possible, excess staff from reductions will be redirected to fill new positions. We will also work with AHEC partners to influence primary career choice, place midlevels and physicians in safety net PCP settings, and recruit specialists into shortage areas.

6) Access and Overall Health – Prevention campaigns, education and support programs, and better access to rehabilitative services are needed to improve overall community health. Problems of access and transportation will be addressed through enhanced coordination such as

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Section 3.7 - Stakeholder & Community Engagement:

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

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

A three part engagement process was designed to ensure that the needs assessment understood clearly the voice of the consumer. These elements included a robust community survey, facilitated conversations with community groups and an ambitious series of interviews with providers across the region.

Community Health Needs Survey- The survey was adapted from the Behavioral Risk Factor Surveillance System survey, which seeks information from consumers on their health care experiences and health status as well as basic demographic information. Two open-ended questions were included: one asking what the respondent believes is the most important health problem in the community, another asking what they believe is the most critical health system need. The survey was deployed online and as a hard- copy version of the survey was distributed in health care settings across the region with the assistance of partner organizations. In the aggregate, the more than 7,000 responses track roughly with the age demographics of the region, population of constituent counties, and the ratio of Medicaid to non-Medicaid insured individuals.

Focus Groups (Community Conversations)- Outreach to hear the voice of the customer also included a series of 16 "community conversations" with Medicaid enrollees and others. These small group discussions – involving up to a few dozen participants in each – provided an open-ended opportunity for residents to reflect on their experiences in the health care system and suggest some improvements. The sessions were facilitated by the P2 Collaborative of Western New York and produced in collaboration with provider organizations and community groups across the eight counties.

Key Informant Provider Interviews- Interviews included a wide range of front-line health care providers to gain valuable insights into the dynamics of health care provision on the ground. The panel included hospital administrators, emergency department staff, urgent care providers, primary care doctors in a range of settings, mental health providers, discharge planners, care managers, wellness educators, plus providers who focus on maternal and infant care, childhood asthma, tobacco cessation, addiction treatment and more. All 45 interview subjects were suggested by representatives of the Performing Provider Systems.

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

Three community engagement approaches were used to gather extensive qualitative data that provided dimension and human context to the numbers, providing us with the means to explain some of the dynamics at play in our health care system today:

Community Health Needs Survey- completed by more than 7,000 people

Focus Groups- 16 "community conversations" engaging people served by the system to better understand those patient perspectives.

Key Informant Provider Interviews- a series of 42 interviews with providers from every part of the region and every phase of the health care system from primary care to mental health and behavioral care to emergency department settings.

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

Community Survey Key Findings- Those insured by Medicaid were three times more likely to report ill health in the past month and more than three times more likely to be smokers. Roughly half of all respondents reported being overweight or obese. When asked to select

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from a list of suggested improvements to the primary care delivery system, the most common answer was "shorter time to schedule appointments," followed by "longer hours of operation," "better follow-up care," and "more responsive staff."

Community Conversations Key Findings- Transportation is a pervasive problem. Use of Medicaid funded services requires significant advance notice. The quality of care provided to Medicaid enrollees is perceived by some as inferior in quality to the care that people receive when they are otherwise insured.

Provider Interview Key Findings- Patients who fail to appear for scheduled appointments make it hard to maximize the benefit from scarce resources. Capacity is a key issue across primary care, specialist care and mental and behavioral health care. Better coordination of care is identified as a pressing need across the system.

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

[Catholic Medical Partners-Accountable Care IPA INC] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Niagara Falls Memorial Medical Center (NFMMC)	Full service 171-bed regional medical center, extensive inpatient and outpatient services, designated stroke center, comprehensive range of surgical services.	Represents stakeholders in Niagara and Orleans Counties. Hosted "Community Conversation" Focus Group.
2	Mt. St. Mary's Neighborhood Health Center	Provides primary health care services serves as a medical home to one of the poorest neighborhoods in Niagara Falls. Features primary care physicians, obstetricians/gynecologists and pediatricians.	Represents stakeholders in western Niagara County. Hosted "Community Conversation" Focus Group.
3	Group Ministries	Human service organization that provides HIV-related programming/services, re-entry mentoring, Women services programming, and substance abuse non-clinical counseling. Linkage agreements with various organizations in the city of Buffalo to provide referrals to clients in need of any services not provided.	Represents inner City Buffalo minority faith community. Hosted "Community Conversation" Focus Group.
4	Eastern Niagara Hospital - Lockport	General medical and surgical hospital in Lockport, NY, with 140 beds.	Represents stakeholders in eastern Niagara County. Hosted "Community Conversation" Focus Group.
5	The Resource Center	Comprehensive agency composed of community leaders and family members providing services to persons with all types and levels of disabilities.	Represents developmental disability stakeholders in Chautauqua County. Hosted "Community Conversation" Focus Group.
6	Mercy Comprehensive Care Center (Catholic Health)	Primary care center in Buffalo that provides OB/GYN care, midwifery, diagnostic testing, ultrasounds, and X-Rays. Achieved highest PCMH recognition from the NCQA. Comprehensive stroke center.	Represents stakeholders in Erie County. Hosted "Community Conversation" Focus Group.
7	WCA Hospital	Southwestern New York's largest not-for-profit healthcare provider, extensive range of inpatient and outpatient acute and rehabilitation services.	Represents stakeholders in Chautauqua County. Hosted "Community Conversation" Focus Group.
8	Community Health Center of Buffalo (FQHC)	FTCA deemed Federally Qualified Health Center that provides access to quality and affordable health care to all members of the community regardless of their ability to pay.	Represents stakeholders in inner City Buffalo Erie County. Hosted "Community Conversation" Focus Group.
9	Calvary Tabernacle Food Pantry	Faith based provider of monthly and emergency food distribution for community members.	Represents stakeholders in Orleans County. Hosted "Community Conversation" Focus Group.

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[Catholic Medical Partners-Accountable Care IPA INC] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
10	Bethany Lutheran Church	Evangelical Lutheran church that provides site for the Olean Food Pantry. Involved in many community outreach projects.	Represents stakeholders in Cattaraugus County. Hosted "Community Conversation" Focus Group.
11	Patient Voices Network	Partnership between a group of patients from Jefferson Family Medicine and Jericho Road Family Practice, providers, and the University at Buffalo's Department of Family Medicine.	The Patient Voices Network is a patient-run advocacy group representing inner City Buffalo patients with complex chronic conditions.
12	Buffalo Urban League	Community outreach organization that advocates and provide services for minorities and disadvantaged individuals to secure economic self-reliance, power, and civil rights.	Represents stakeholders in inner City Buffalo and Erie County. Hosted "Community Conversation" Focus Group.
13	St. Vincent's Clinic (Catholic Health)	Provides primary and gynecological care. Offers blood testing with no appointment.	Represents stakeholders on eastside City Buffalo and Erie County. Hosted "Community Conversation" Focus Group.
14	Towne Garden Pediatrics (Kaleida Health)	Pediatric primary care providers that provide sick and well care to children in the city of Buffalo.	Represents pediatric stakeholders inner City Buffalo and Erie County. Hosted "Community Conversation" Focus Group.
15	OLV Family Care Center (Catholic Health)	Primary care center affiliated with Mercy Hospital. Recognized at highest level of PCMH by the NCQA, provides healthcare services for the entire family.	Represents stakeholders on south side City Buffalo and Lackawanna, Erie County. Hosted "Community Conversation" Focus Group.
16	Tuscarora Nation House	Multi-use house for the Tuscarora Indian Nation, primarily used as a medical center for the nation providing dentistry, general health care and community health workers under the direction of Niagara Falls Memorial Medical Center.	Represents Native American stakeholders in rural Niagara County. Hosted "Community Conversation" Focus Group.

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.

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[Catholic Medical Partners-Accountable Care IPA INC] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for delivery system integration across the spectrum of care	Excess bed capacity. Lack of interoperable HIE between health care settings. Primary care gaps. Lack of behavioral health integration with primary care. Behavioral health gaps. Care management inadequate across settings (hospital/ED to PCP, to BH, to community supports).	1,240 inpatient beds not in use region wide. 499 excess SNF beds. More than 40% community level consent with RHIO. Large portions of inner city and rural areas are Primary Care HPSAs. Only 21% of the 512 primary care locations are NCQA PCMH recognized. Structural barriers between medical system and
2	Need for accessible primary care as an alternative to emergency department	Emergency Department is currently the preferred source of care for the uninsured and the Medicaid beneficiaries without access to primary care.	35,053 PPV preventable ED visits per year; current rate is 37.6/100; goal rate for 25% reduction would be 28.2/100. Most EDs have no triage function for dealing with non-emergent care needs. Most have little follow-up with PCP to prevent repeat ED visits.
3	High readmission rates due to poor transitions between settings	Currently many patients with chronic conditions are readmitted within 30 days because there was no support to assist their transition to community, to home, to their primary or to hospice.	2,042 PPR potentially avoidable readmissions per year; current rate is 5.8/100; goal rate for 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community health care system have been identified as impor
4	Need for greater integration of primary care and behavioral health services	Currently primary care settings have few providers trained in BH and their integration with BH is fragmented. Patients with BH needs often view care as inaccessible, stigmatizing, and often feel marginalized by the health care system.	Structural barriers between medical system and behavioral health systems hamper integration. WNY have half the number of psychiatrists and psychologists per beneficiary as does the State. Care management crossing settings is not functional. Health Homes just started, and are not yet a meaningful par
5	Poor perinatal indicators for low income	Many women and their children on Medicaid do not	The % of preterm birth is

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[Catholic Medical Partners-Accountable Care IPA INC] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
	population	consistently receive adequate prenatal or well child care.	12.1%, above the NYS Prevention Agenda goal of 10.2. The Maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000. The 69.5% of children who have had the recommended number of well child visits in government sponsored programs is below
6	High avoidable chronic disease admissions in underserved, low access areas	Many complex patients in underserved areas often do not go to a PCP in their county and do not have nearby access to specialist.	Region lacks a robust public transportation system, vehicle ownership is fundamental for adequate access to care. Overall, in WNY, 12% of households do not own a vehicle. Remote patient care support, such as telemedicine, is not well-deployed. Some specialists, such as psychiatrists, are missing in
7	High cardiovascular disease prevalence & leading cause of death	Currently many patients with cardiovascular conditions or risks do not consistently receive evidence-based care in primary care settings.	CVD/ heart related conditions are the (a) leading cause of death, (b) leading cause of premature death, (c) leading cause of hospitalization, and (d) leading cause of preventable hospitalization for the general population and more so for African Americans.
8	Palliative care shared decision making not occurring when most appropriate	Often times, patients and families have not been engaged in palliative care options prior to reaching end stage ICU care that is not informed by quality of life wishes.	"Community Conversations" Focus Groups key findings called for integration of hospice and expansion of palliative care shared decision- making in more settings.
9	Tobacco use tied to leading causes of premature death and preventable hospitalizations	Currently patients who use tobacco are not consistently presented with offers of cessation assistance in primary care settings.	The % of cigarette smoking among adults is 20.8%, above the NYS Prevention Agenda goal of 15%. Smoking related

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[Catholic Medical Partners-Accountable Care IPA INC] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			conditions are top five causes of death and premature death in every county (heart followed by lung). The same is true for African Americans.
10	Mental, emotional, & behavioral well-being not addressed for the general population	Promotion of community well-being is fragmented at the local level and is not orchestrated at the regional level.	% of adults with poor mental health in the general population is 11.7%, above the NYS Prevention Agenda goal of 10.1%. % of adult binge drinking in the general population is 18.9%, above Prevention Agenda goal of 18.4%. Suicide death rate in the general population is 11.4/100,000, far above the Prev

File Upload: (PDF or Microsoft Office only)
Please attach the CNA report completed by the PPS during the DSRIP design grant phase of the project.

File Name	Upload Date	Description
46_SEC038_WNY_PPS_CNA.pdf	12/20/2014 03:20:29 PM	entire community needs assessment

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

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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)

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

DSRIP PPS Organizational Application

Catholic Medical Partners-Accountable Care IPA INC (PPS ID:46)

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.

DSRIP will impact direct and support staff in all acute care and ambulatory care settings. The workforce of the future will need additional skills, knowledge and abilities to be successful in a population based care model where value will increasingly replace volume in our payment system. It will require Community Partners of WNY to retrain, redeploy and recruit direct care staff as well as clinical and administrative support staff. Physicians, nurses, pharmacists, dieticians, social workers, office managers, LPNs, and case managers will need to learn team based care work skills; evidence based practice and develop technology assisted workflows that optimize staff skills. Support staff will need to use health information technology and comply with data governance and data entry requirements. Managers, financial staff and analysts will need to understand how margins are produced from a population and value based business model and will

have to learn the key value metrics needed to meet business objectives. New job descriptions and skill sets will require staff to be able to use technology, develop and maintain patient registries, learn rapid cycle improvement and demonstrate improved performance on quality and cost in their setting. Additionally staff will need to learn how to better educate and engage patients and establish reliable referral and follow up for no patient left behind.

The PPS lead, Sisters of Charity Hospital (SOCH), as a member of Catholic Medical Partners (CMP), has been engaged in a population health business model for approximately 10 years and has been training and redeploying clinical and administrative staff needed to be successful in this business model. As the selected project management team for CPWNY, Catholic Medical Partners will provide the skills, training and resources they have developed. These resources include a mobile team of practice transformation staff trained to assist practices in achieving PCMH designation, meaningful use and conversion from paper to digital records, including certified EMR trainers for eClinical works. The staff that were impacted & successfully retained to date by CMP include former office managers, coders, planning staff and a number of new college graduates trained in mathematics, information technology and public health. In addition a mobile team of nurses, dieticians, pharmacists and social workers has been developed that is trained to support practices in advanced care management and disease management using a proactive approach to patient care. These individuals were formerly hospital based staff nurses and allied health professions in traditional roles. The pharmacy team created a virtual care service where pharmacists do remote entry into a physician's EMR and provide consultation on medication management. SOCH/CHS and the CMP project team have staff educators and trainers experienced in teaching rapid cycle improvement, case management and disease management for chronic illness, palliative care and behavioral health. They are also able to use and teach the PAM-patient activation tool and other patient education materials. These staff have developed training materials and manuals to support practice based education, a learning network, NCQA guideline and population health based education. The training staff had previously been employed by hospitals or health plans. Finally we have developed population health data analysts and technology staff that extract, load and transform EMR data into a data repository to measure quality and utilization and are working to store and integrate CCD with paid claims. These staff were previously employed in quality departments or finance departments in acute care settings and some are new graduates. Sisters of Charity Hospital retaining and redeployment of staff includes both union and nonunion personnel.

***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.

CPWNY, with its lead Sisters of Charity Hospital, is positioned to significantly minimize the negative impact that DSRIP may have on the workforce. Our high level approach is to first retrain and redeploy staff to fill these critical shortages wherever possible, as follows:
1. Increase the capacity of ambulatory clinical practices using the PCMH model that calls for clinical practices to have care/case management and disease management staff as well as navigators. Existing nurses, pharmacists, dieticians, social workers, LPN's and nurses aides from the acute care workforce will fill these high demand ambulatory care practice positions.
2. Increase the skills of workforce in using health information technology in the work flow and conduct reliable and valid data entry. This strategy will focus on retaining and redeploying registration staff, unit administrative assistants and coding staff.
3. Increase the workforce in the area of data base management, data integration, data analytics and reporting and interoperability. This strategy will focus on retaining supply chain, quality, finance and other staff with quantitative skills in data base positions within the IDS.
4. Increase the workforce skills in rapid cycle improvement, six sigma quality, and in understanding the key quality metrics needed to succeed in value based care and population health business model.
5. Develop new value based reimbursement models including bundled payment, care management, and payment for the community and human service agency. Finance and hospital reimbursement staff are ideally positioned to fill these new positions.

During the initial few years of the DSRIP program CPWNY does not anticipate that the declining hospital services volume for the Medicaid population will in itself have a major impact on the size of the workforce. The partnering Catholic Health System (CHS) with 8000 employees did a comprehensive workforce reduction assessment for a 25% decrease in Medicaid inpatient & related services. Combined with normal attrition, CPWNY expects a limited and paced retraining/redeployment from acute care. For many of the new positions, we expect new hires & training will be required. There is a shortage of operations research and analytics, actuaries and human factors engineering staff in the workforce. These positions will be needed in the future to make virtual organizations work effectively and efficiently. Currently the CMP project management team, which will contract with Sisters of Charity Hospital, does employ staff with these

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credentials but more will be needed for CPWNY, which will require external recruitment. Additionally, all the workforce strategies noted will be contingent upon designing new population health reimbursement methods and effectively transitioning from a volume to a value based business model. As noted in our CNA, there are primary care (PC) shortages throughout the region, including an inadequate number of primary care physicians (PCPs) and mid-levels (PA, NP) working in PC settings, both in safety net and non-safety net locations.; (b) inadequate number of staffed PC locations; and (c) inadequate number of safety net PC locations. Sisters of Charity Hospital is a member of CMP, which currently has 30,000 Medicaid patients enrolled in existing health plan contracts most of whom are not served by a non-safety net PCPs or a PCP in their community. We will work with Area Health Education Center (AHEC) partners to influence PCP career choice, and with health professional schools to place mid-levels and physicians in safety net settings.

***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	10%
Retrain	40%
New Hire	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.

During initial DSRIP program years we do not anticipate that declining volume for Medicaid population will have a major impact on workforce. We intend to begin retaining immediately to ensure all of our employees have the training and education necessary to be successful as positions and workforce requirements change for partners that have no care transformation experience, starting in DSRIP year 1. CPWNY will use its major health system partner, CHS, and its regional academic and training partnerships for access to additional training programs, computer-based learning, adult learning principles, and media resources to rapidly retrain staff. We surveyed our partners and overlapping organizations regarding training resources available to be used, shared, or grown to meet our strategy. Catholic Health System already has agreements with over 50 local training and educational institutions from large academic centers to community training organizations, e.g., University of Buffalo, D'Youville College, Daemen College, Erie Community College, EN-AHEC, R-AHEC and BOCES for nursing recruits, PA, NP, technicians, coders, etc. Being a Regional Training Center itself, CHS has ability to expand training capabilities for both clinical non-clinical workforce. Educational/training needs assessment will be conducted and training developed based on required competencies by CHS and select entities with workforce expertise. Once training needs are established, course development/expansion will begin. CPWNY will also partner with local schools/universities to review curriculum so that the students, upon graduation, will be able to function in their new roles.

Various levels of training will be incorporated based on employee status and experience as follows;

New to Organization – Associates who take a new position inside or outside their current organization who come with skills to perform in their new position. Training will include: orientation to the new organization and specific department responsibilities. Curricula will include: Mission and Vision, Cultural Diversity, Patient Experience, Safety, Infection Control and Quality Measures. A preceptor/mentor will be assigned to oversee competency achievement. A department specific orientation will include: Job responsibilities with core competencies being obtained.

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Redesigned Work Assignments - Associates who have technical skills and competencies to perform redesigned work assignments. Training will include: Review of new job responsibilities,
Introduction to new required competencies and on-the-job training with a preceptor/mentor.

New Positions – Associates assigned /selected to take on a new role. The role may be in leadership such as manager, supervisor, lead etc. Leadership training is essential for the success of this redesign. Curricula includes: New Manager Core Orientation Program along with courses offered by CH University which includes: Communication, Delegation, Patient Satisfaction, Mission Integration, Team Building and Monitoring Performance. A preceptor/mentor model will be implemented to support associate during this transition.

New Skills- Associates with minimal or complete lack of knowledge/skills required for their new role. This group may be recent college graduates with little or no exposure to a specific position. Training will include: orientation to employer and department, review of required competencies, shadowing, internships, on the job training etc. A preceptor/mentor model will support the achievement of required competencies for the positions.

Majority of training required for new roles and or positions will not be voluntary. CPWNY will contract for change management workshops for leaders in participating organization and practices to equip them to communicate the need for training in a way that engages and motivates employees.

***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.

CPWNY will work with Human Resources across the entities and the project leads to evaluate te potential impact and mitigate it where possible. CPWNY will benchmark compensation/overall benefits for new positions and existing positions with the help of our consultant, human resources, labor and steering committee. We anticipate that there will be instances where there is no change in compensation and in others slight increases or decreases based on the position and its duties. Job Descriptions will be reviewed, revised and updated to ensure equity, understanding and criteria for training and recruitment.

***Retraining 3:**

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

CPWNY partners will work with their associates to minimize any adverse impact. Current policies & contracts will be reviewed for equity and fairness among the partners to ensure associates are provided as many options as possible. Should they not accept retraining, they are subject to their own organization's policies for restructuring with a prescribed amount of time to find a position. It is anticipated that the management of change, the training of leadership and the participation of workforce/labor in DSRIP project development will minimize the number of employees who refuse retraining. We believe the new population health positions we are developing will provide both career and professional growth opportunity to personnel who will be retrained.

***Retraining 4:**

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

Our PPS is working with labor representatives as partners to design change. An initial kickoff Workforce Strategy meeting took place December 9th with broad representation from CPWNY partners, senior HR leadership and labor representatives including SEIU 1199, CSEA, NYSNA, AFSCME 1095 and CWA 1168. Labor will partner with CPWNY to help develop the future staffing models for DSRIP initiatives and to project staffing needs and redeployment and retaining opportunities. Catholic Health System, as well as the other major health providers (i.e. Mount St Mary's Hospital, WCA Hospital), have working relationships with labor representatives to help them participate and understand the goals and objectives of DSRIP participation and the role of workforce in the PPS. Labor representatives will be engaged through the PAC project committees and ad hoc work groups. We expect the working committees of the PAC will provide broad partner representation.

***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.

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Placement Impact	Percent of Retrained Employees Impacted
Full Placement	98%
Partial Placement	2%

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.

CPWNY will work with our hospital and provider partners to further identify staff in all key clinical, service, support and administrative areas impacted by the DSRIP program. The HR departments of the larger hospital partners will review the skills, knowledge and abilities (SKA) of each staff person and match the SKA of the impacted staff with the new positions emerging from the PPS. Following that match, interviews will be conducted and decisions made regarding redeployment and or retraining opportunities. Every effort will be made to redeploy or retain staff consistent with each partner's policies and procedures and commitment to the workforce. For smaller providers, it is expect that an experienced HR vender will be used to accomplish this internal evaluation, with direction from the PPS. More specific redeployment steps here.
CPWNY expects that retraining and redeployment will be an evolving process as DSRIP projects are developed and new roles and positions become standardized. It is anticipated that CPWNY will implement an internal process to share not only training resources but staff ready/identified for redeployment.

***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.

We anticipate no adverse changes in compensation (wages and benefits) for employees redeployed to CPWNY IDS from CHS or from our other hospital and provider partners. Redeployment will almost always be accompanied by retraining/education/increased competency to meet the new skills and requirements of DSRIP related workforce changes.

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

Redeployment may not always be voluntary. Associates with the same position titles may be asked to work in a different department or location or even entity. Should they not accept a new position, they are subject to their own organization's policies for restructuring or reduction and will enter the redeployment (or recall) pool with a prescribed amount of time to find a position. It is anticipated that the management of change, the training of leadership and the participation of workforce/labor in DSRIP project development will minimize the number of employees who refuse redeployment.

***Redeployment 4:**
Describe the role of labor representatives, where applicable – intra or inter-entity – in this redeployment plan.

Our PPS is working with labor as partners to design change. An initial kickoff Workforce development meeting took place 12/9/2014 with representation from CPWNY partners, senior HR leadership & labor representatives including SEIU 1199, CSEA, NYSNA, AFSCME 1095 and CWA 1168. Labor will partner with CPWNY to help develop future staffing models for DSRIP initiatives and work to place displaced individuals. Catholic Health, as well as other major health providers (i.e. Mount St Mary's Hospital, WCA Hospital), have working relationships with labor representatives to help them participate and understand the goals and objectives of DSRIP participation and the role of workforce in the PPS.
Our plan includes a communication strategy outlining needs for an agile workforce that reduces cost of healthcare delivery, accomplishes objectives of DSRIP, assures our organizations' long-term viability, and outlines the need for changes in workforce. It describes what will be done to maintain quality and safety, as well as avoid layoffs. The plan will be reviewed by our labor representatives. The plan will evolve as circumstances change and includes engagement with labor to deliver the changes.

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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.

Our DSRIP projects will create many new opportunities. While the exact number of new hires will emerge as we implement our projects, we identified needs to hire approximately 158staff at many levels across CPWNY partner organizations including;

Primary care physicians, Nurse Practitioners and Physician Assistants – to increase capacity to provide primary medical care services to the target population in line with DSRIP care transformation goals.(16)

Physician Specialists (e.g., Pediatricians, OB/GYN, Oncologists, Surgeons, Podiatrists) – to meet the needs of patients in multi-specialty clinics.

Pharmacists- to facilitate care transitions and care coordination, including staffing a virtual pharmacy service to provide consultation on medication management

Nutritionist – to provide preventative engagement with targeted population using advanced care & disease management approach

Social Workers – to increase the guidance and assistance to patients and their families, to facilitate prevention, care coordination and disease management and to provide linkages to the community.(24)

Nurses, RN & LPN –to provide new and expanded nursing services at different levels of care commensurate with the DSRIP projects.

Care coordinators/Health Care Navigators – to support patients in effectively navigating health and social services to meet their needs. To assist with patient with coordination of health care services among different providers, levels of care, services and service locations.

Community health workers – to assist community/patients in identifying and securing community resources including healthcare, housing, food, transportation and health education.

Population Health Management experts – to develop, manage, and monitor the creation of an integrated delivery system. Skilled in rapid cycle evaluation (RCE).

Human Resources Professionals – to support all of the facilities, managers, and staff to effectively, retrain, redeploy and recruit workforce required to meet DSRIP care transformation goals

Hospital Case managers – to identify and manage the appropriate length of stay from first encounter of patient in emergency department of our hospitals to discharge to appropriate level of care

Home health workers – to provide enhanced assistance to patients in their home and decrease un-necessary admissions and re-admissions. To provide specially trained workers for the Nurse Family Partnership model.

Allied Health professionals – to staff rehabilitation location and support appropriate care in preparation for patients to be discharged from inpatient facilities

Translators/foreign language speakers – increase staff to assist with healthcare communication, navigation, and counseling, for improved patient engagement.

Communications/marketing professionals– to effectively deliver appropriate messages regarding transformation of health care delivery

Telemedicine technicians –to support operation of telemedicine serves at all hub and spoke sites.

Office Managers/Department Managers – to lead in new or redesigned departments, clinics/facilities, practices or function.

Ambulatory Care practice managers – to manage new or redesigned clinics, multi- specialty clinics, outpatient programs, and post-acute care services

Mental health specialists, psychologists, psychiatrists – to provide expanded Mental Health services to target Medicaid population

Process redesign experts – to work with departments/units to design/redesign workflow, processes, and procedures to assure efficient/effective delivery of healthcare.

Data analysts, data base managers, reimbursement analysts and statisticians – to provide data collection, analysis, reporting, and monitoring to meet the needs of evidence based medicine, performance management, and DSRIP projects

Union/Non-Union – the mix of union/non-union employees is not expected to significantly change

In the table below, please itemize the anticipated new jobs that will be created and approximate numbers of new hires per category.

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Position	Approximate Number of New Hires
Administrative	21
Physician	12
Mental Health Providers Case Managers	17
Social Workers	24
IT Staff	4
Nurse Practitioners	4
Other	76

Section 5.5 - Workforce Strategy Budget:

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

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	350,000	350,000	200,000	75,000	75,000	1,050,000
Redeployment	225,000	225,000	125,000	100,000	50,000	725,000
Recruiting	225,000	225,000	100,000	50,000	25,000	625,000
Other	200,000	200,000	100,000	75,000	75,000	650,000

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.

Many CPWNY partners have experience with NYS and federal programs for workforce development, training and retraining. CHS has secured millions in workforce retraining, HRSA and DANY support over the past several years. State and federal programmatic support will be pursued as opportunities that align with our DSRIP strategies become available. Several PPS partners have full time Grants Departments that actively research and apply for both state and federal grant and collaborative programs. CPWNY will recruit experts from these organizations to serve on a subcommittee of the PAC steering group. This group will focus on all categories of grant and programmatic funding, public and private, to support the PPS. Subject matter experts will be added as the committee progresses in its development. This group will monitor funding availability based on DSRIP defined work plans, identify grants and programs, and lead application development and submission. Based on what we know now, CPWNY anticipates pursuing HWRI based on its identified training needs, DANY (Physician Loan &/or Practice Support), when released, to fill primary care physician shortages, HRSA Primary Care & Enhancement funds, and HRSA nursing workforce initiatives.
CPWNY will also collaborate with training partners, such as the ENAHEC, RAHEC, in their pursuit of aligned funding.

Section 5.7 - Stakeholder & Worker Engagement:

Description:

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

***Engagement 1:**

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

The workforce strategy was developed using the input of stakeholders over the course of working meetings and written project development work. CPWNY convened the stakeholders of the emerging PPS on 5/29, 6/17, 8/20, 10/21, 12/17. These meetings served to brain storm improvement initiatives & develop DSRIP objectives. Some of these meetings entailed working breakout groups focused on elements of the care transitions projects, including workforce. CPWNY also directly engaged all of the labor unions in a Workforce Development Forum on 12/9/14. Topics included; Workforce Impacts Relative to the Transformation of Healthcare from Inpatient to

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Outpatient Care, Opportunities for New Healthcare Careers, Potentially Available Union Sponsored Training Resources & Opportunities for Workforce Development Communication and Engagement.
Stakeholders also engaged directly in workforce strategy in individual DSRIP project development workgroups.

***Engagement 2:**

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

CPWNY included all of the labor groups in its Workforce Development Forum in December 2014 including SEIU 1199, CSEA, NYSNA, AFSCME 1095 and CWA 1168. Worker representatives were included in all of the full partnership meetings as well as on each of the 10 DSRIP project development teams.

***Engagement 3:**

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

CPWNY will continue to engage workers through our new website, newsletters, interactive surveys, webcasts and topical/educational forums. CPWNY expects that it will establish a working subcommittee during the implementation planning phase to assure full stakeholder/workforce participation and coordination of workforce strategy in DSRIP years 0-4. In addition representatives from this subcommittee, frontline workers (non-managerial) and individuals designated by our labor unions, will be asked to serve on the 10 project teams as determined by the project team leadership.

***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.

CPWNY will continue to engage stakeholders & workers through our new website, newsletters, interactive surveys, webcasts and topical/educational forums. Barriers will be addressed by the workforce subcommittee, staffed by HR professionals, stakeholders and workforce who will monitor the workforce impacts relative to the transformation of healthcare, staying abreast & informing the PAC of resource needs. Committee will facilitate the process of development of new roles/careers (job descriptions/training educational requirements, etc.). Our plan also includes a communication strategy outlining the need for an agile workforce that reduces the cost of care delivery, accomplishes the objectives of DSRIP, assures our organizations' long-term viability, and outlines the need for workforce changes. It describes what will be done to maintain quality and safety, as well as avoid layoff. The plan will evolve as circumstances change and includes engagement with labor to deliver the changes.

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.

Community Partners of WNY (CPWNY) PPS has data sharing, business associates (where appropriate) and confidentiality agreements with each of the PPS partner organizations which allow for transfer of clinical, patient identifiable and business confidential information to the larger PPS. These agreements address issues related to both Federal and State laws. Information will be shared with new partners as agreements are put into place. CPWNY will utilize Catholic Medical Partners secured web based reporting platform and file upload application which encrypts clinical and beneficiary data during transit and at rest with a 256 bit key. This reporting platform has a role-based security system, which limits the ability to view beneficiary level data to a limited number of individuals within the company/partner.

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

The compliance program is the joint responsibility of the Security Officer and the Privacy Officer who will participate on a CPWNY PPS Compliance Committee to insure that all act in unison to ensure privacy and security of data, upholding all HIPAA provisions. CPWNY has developed and implemented appropriate policies and procedures. The policies and procedures, logs, and audit process developed have been reviewed by CPWNY legal counsel and have been determined to be in compliance with all laws and regulations. CPWNY will conduct periodic audits designed to address relevant compliance issues. At least annually, Partners will conduct audits to identify areas of potential risk and measure progress against the baseline audit results Partners will be expected to participate in annual training. Failure to comply with the HIPAA policies and procedures and mandatory training will result in notification to appropriate authorities and possible expulsion from CPWNY PPS.

***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.

Partners in the CPWNY PPS network, with or without EHRs, will be offered a choice of several tools to share real-time, relevant patient information: 1) A web-based clinical portal with Direct Messaging capability and linked to our community Health Information Exchange, 2)

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A web-based, community Health Information Exchange with Direct Messaging capability, and/or 3) A web-based care coordination platform with Direct Messaging capability. Each of these tools is compatible with the required secure SHIN-NY /RHIO integration infrastructure. As the transition to any of these tools will be a multi-year process, we will facilitate non-(compatible) EHR partners to share core data elements with the PPS, drawing upon the SHIN-NY / RHIO infrastructure (specifically, leverage Direct Messaging capability), so that by mid-DY1 we will be able to share the core data elements required for the successful patient management and outcome monitoring in the projects we selected. We have included protocols and guidance within our strategy to support staff in making the patient consent process a central part of the patient / provider relationship. In light of the significant disruption this transition (a true behavioral change) will involve for clinicians and managers alike, we have established a communications and change management plan that will span the life of the DSRIP program and identified staff to implement and develop this plan over time. Significant education and training is a core part of that plan, which includes the ability to understand the required analytics and performance monitoring that will become part of our emerging virtual integrated delivery system (see also the next subsection). These training needs have been accounted for in our workforce strategy.

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.

Clinical Governance Committee (CGC) is the accountable organizational unit within Community Partners of Western New York (CPWNY) PPS for reporting results and making recommendations on actions requiring further investigation into PPS performance. CGC reports to the Executive Governance Body (EGB) who reports to the Sisters of Charity Hospital Board who in turn is accountable to NYSDOH. Since 2012, Sisters of Charity Hospital (SOCH)and Catholic Medical Partners(CMP) practices were taught how to use Rapid Cycle Improvement (1) method otherwise known as the Plan, Do, Study, Act (PDSA) to identify areas for improvement. Targeted interventions were identified to reduce unnecessary medical costs. CMP provided education on the Rapid Cycle Improvement Model (1), incorporating improvement activities into the everyday work environment. This model has proven to be successful for our SOCH and CMP practices therefore will be shared with our partners via training sessions and web education. The PDSA will be utilized on an on-going basis as reports are generated. The Clinical Transformation Team will be accountable for implementation and reporting to the CGC on a semiannual basis.

***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.

CPWNY will utilize a state of the art data repository built by CMP to improve its business intelligence capabilities. This data warehouse will enable the PPS to use collected patient data to attribute patients and produce utilization and quality reports from a variety of sources (claims, EMR, RHIO). These reports will support identification and prioritization of improvement initiatives. CPWNY will use them to: Conduct a systematic review of the prevalence of illness in the member population, utilizing major diagnoses and related costs as well as the quality of care results warehouse, and stratify patients and practices needing assistance; Establish actuarial estimates of cost and frequency using utilization data for its membership. Target areas for reducing utilization will include avoidable admissions, readmissions, emergency room visits, and inpatient days; and Update the annual Clinical Integration Plan with incentives aligned to the organization's goals and gain-sharing model.

***RCE 3:**

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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).

Oversight of the interpretation and application of results will be completed by the Clinical Governance Committee (CGC) and reported to the Project Advisory Committee (PAC) and the Executive Governance Body. The Clinical Transformation and Care Management staff will work with all providers using the PDSA to improve utilization, clinical quality and population health. Reports will be compiled and shared with providers indicating their results against other practitioners, the organization and benchmarks/goals.

***RCE 4:**

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

The RCE method will create a supportive, customer focused and quality driven internal environment fueled by leadership commitment, systematic identification of the processes that are critical to meeting customer needs and expectations; and the creation of measures to continuously improve the efficiency and effectiveness of key processes, amongst all partners. Our PPS is already organized around accountability and an integrated infrastructure. RCE will enables further development to occur in CPWNY over time so that we may provide healthcare that is safe, effective, patient-centered, timely, efficient and equitable. Community Partners of WNY PPS embraces the use of RCE in its highly functioning business model which is organized around accountability for the DSRIP goals.

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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.

Community Partners of WNY PPS's mission is to meet the needs of the community it serves, specifically those who are underserved and in poverty. CPWNY has identified significant cultural diversity and it is committed to reducing the resultant disparities in the health of its targeted population.
According to the Community Needs Assessment (CNA), WNY has a significant Hispanic /Latino population. Over 61,600 residents in WNY, or 4% of the total, are Hispanic/Latino. Two-thirds live in Erie county. Chautauqua county has a disproportionately high Hispanic/Latino populations compared to most counties in the region with a disproportionately high percentage of foreign born (migrant workers). In WNY, 40,155 individuals ages 5 and up speak English less than well. This is 3% of the population, or about 1 out of 35 individuals. Non- English speaking populations may have barriers to health care resources, information and Medicaid usage. Lack of English fluency is a key barrier to health care and other wellness supports for this population as well as to good paying jobs with health benefits. Foreign born persons, experience many challenges, cultural, language, informational, to income, health care and supports. One out of twenty persons across the region was born in a foreign country. This is over 75,700 individuals across WNY. Many have been brought to WNY through the services of our many relief and re-settlement agencies and religious organizations, including the Daughters of Charity who are sponsors of our PPS lead, Sisters of Charity Hospital (SOCH). For those who are undocumented immigrants, there is additional reluctance to seek healthcare due to the fear of deportation. The large majority of foreign born residents, 76% of the total, live in Erie County, primarily in the City of Buffalo and suburbs to the north. Over 8500 foreign born live in Niagara County, with concentrations highest in and around Niagara Falls.

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***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.

Sensitivity to cultural, ethnic and language needs impacts all ten projects selected by the PPS as all project engage Medicaid, poor, and uninsured patients with specific needs and expectations. Catholic Medical Partners (CMP) conducted a cultural competency survey of almost 1000 providers in 2014, including SOCH providers, regarding their abilities to meet the needs of their population. Providers Physicians and mid-level practitioners were asked about the cultural and linguistic needs of their population and their comfort level in meeting these needs. Community Partners of WNY used this information to develop its strategic plan, as follows: Instruct providers on how to analyze their registries to determine impact of language and cultural barriers upon clinical quality and patient satisfaction; Ascertain through survey provider and staff "comfort level" in providing healthcare to those of other cultures and their needs; Make interpretation services readily accessible , with initial and ongoing training of staff on how to properly utilize interpretation services; To promote sustained competency implement the use of a standardized cultural and linguistic assessment tool for providers to use in comprehending deficiencies in the office; Hire and train staff based on the cultural , linguistic needs of the patient population; and Insure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.

***Competency 3:**

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

The PPS includes a comprehensive and diverse group of community based organizations well suited to assist with addressing the needs of a culturally diverse region. The PPS will evaluate its membership as well as outside parties to identify community based organizations with a proven track record of bridging cultural and communication gaps that may exist in the PPS. A contract focusing on cultural competency skill- building will be developed and executed based on provider and patient needs assessments. The PAC will be involved in recommendations to Executive Governance on worthy community based organizations to be considered in the contracting process and will be informed with regular updates on the progress of cultural competency of the PPS by the DSRIP program director.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

According to the Community Needs Assessment, educational attainment is an underlying factor for poverty status (poverty is the most important indicator of health care need). Lowest rates of high school completion are concentrated in Buffalo and Niagara Falls and across the Southern Tier Counties. Cultural backgrounds and the inability to navigate health system impacts literacy. Community Partners of WNY PPS strategy to address health literacy will focus on improving communication with patients. This includes education of providers and staff on the following: assessment of health literacy using AMA model, use of plain, nonmedical language, the slowdown approach,

methods to demonstrate or draw pictures, selection of the correct amount of information at each visit and information repetition, use of the "teach back method" and creation a "shame free "environment. In addition, a target population health literacy advisory group will be utilized to gain insight on educational materials for patients.

Community Partners of WNY PPS will promote health literacy as an organizational responsibility. CPWNY will provide the following: Education and training (initially and ongoing) to providers and staff on the use of and adoption of health literacy assessment tools (workforce strategy); Training to enable providers to define the scope of the health literacy problem and combat it with a "no shame: environment. This environment implements an improved method of verbal and written communication especially with respect to patient education and recognizes the barriers faced by patients with low literacy, It includes use of Plain language.gov.; Partnerships building with community focused groups (involving members of the target population) to review materials and provide input into the design of health care information, written and on a website;
Review of health and safety information to ensure it is culturally and linguistically appropriate and motivating; Training and promotion of the use of technology and electronic health tools to deliver health information and services to patients and their advocates. As an example, Sisters of Charity Hospital and Catholic Medical Partners providers have adopted the approach to assessing and improving Health Literacy utilizing the "Can I help you "campaign that was an AMA initiative. An AMA video is on our provider website that is specific to the safety issue with literacy on medications. We will expand this campaign to our partners, along with new DSRIP project specific ones, and incorporate them in quality improvement activities.

The CPWNY PPS includes a comprehensive and diverse group of community based organizations well suited to assist in improving health literacy such as the Catholic Charities, People Incorporated and the Urban League of Buffalo New York. There are also many community groups outside of the CPWNY PPS that are able to assist in overcoming health literacy issues such as: EHS Inc. HIV Education/Risk Reduction in Jamestown New York, the Alice Hyde Medical Center in Malone NY (won a NYS award for the program "Creating an Action Plan for Improving Patient Outcomes through Clear Communication"), and the Literacy New York Organization, Buffalo region. The CPWNY PPS will research its membership as well as outside parties to identify community based organizations with a proven track record of bridging cultural and communication gaps. A contract focusing on health literacy skill- building will be developed and executed based on provider and patient needs assessments. The PAC will be involved in recommendations to Executive Governance Body on worthy community based organizations to be considered in the contracting process and will be kept apprised of progress with health literacy activities of the CPWNY PPS by the DSRIP program director.

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 CPWNY plan for distributing funds is focused on supporting our PPS providers who have the greatest volume of Medicaid beneficiaries in three key target areas. The first area will be to strengthen the capacity of the primary care office in order to improve access and the overall effectiveness of care. Our four clinical improvement initiatives, as well as our care transition and ED triage projects all require strengthening the capacity of our primary care practices. In addition we will use funds to achieve interoperability and PCMH status for all of our primary care practices. Our second target area will be to fortify the emergency room setting to ensure effective triage, patient care and education, coordination and successful referral to ambulatory care providers. Our ED triage, care transitions and telemedicine projects support this ED enhancement. The final target area involves improving coordination of care using best practice interoperability systems that are being developed for our entire network of physician and community service providers. We will improve information flow and coordination of care between the acute care setting and ambulatory care as well as among and between ambulatory care providers and community resources using our local RHIO and direct secure e-mail communication.

Our budget was developed to support the improvement initiatives namely the people, technology and process improvements known to achieve results. Our proposed budget includes: project costs for implementation and transformation including centralized administrative costs and administration, costs for services not currently reimbursed or under reimbursed, revenue loss, performance/bonus payments for achieving goals and for high performance, and contingency funding. This strategy/allocation of funds will enable us to achieve our DSRIP goals. CPWNY PPS will focus funding on clinical settings with the greatest potential to produce results and will be tailored to providers who serve the largest number of Medicaid beneficiaries. We have budgeted for revenue loss and uncompensated or under compensated services and our bonus pool of 23.22 % will support payment for value and enable CPWNY PPS to transition to our sustainability model. Our funds flow processes will be managed by a financial staff which includes individuals from CMP-ACO who have extensive experience in all aspects of clinical integration, surplus distribution and incentive payments. Governance will have oversight of funds flow through the Finance Committee and we will retain an outside accounting firm to conduct our annual audit and annual reporting to the CPWNY

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Executive Governance Body.

Sisters of Charity Hospital brings extensive population health management and health care transformation experience to the PPS through its affiliation with Catholic Medical Partners (CMP). This relationship, which will be formalized as a management services agreement with the CPWNY PPS, brings the skills, knowledge and experience of this nationally ranked ACO for CMS shared savings to the CPWNY PPS. SOCH and CMP currently have managed care agreements with risk and clinical accountability for over 30,000 Medicaid patients. SOCH and CMP has extensive experience in supporting clinical improvement initiatives and managing funds flow from managed care contracts. Annual clinical integration budgets support innovation in multiple clinical settings and include staffing, technology, and performance targets by clinical specialty. SOCH and CMP currently have performance models in place for distributing surplus and incentive programs that reward results. CPWNY's approach will enable success in meeting the DSRIP goals because it is based on the very successful SOCH and CMP model with proven strategies for overall success in managed care agreements, population health improvement and sustainability.

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	51.52%
2	Revenue Loss	18%
3	Internal PPS Provider Bonus Payments	23.22%
4	Costs for Services Not Covered	5.87%
5	Contingency Fund	1%
6	Other	.39%
	Total Percentage:	100.000000000000 1%

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

Description:
Progress towards achieving the project goals and core requirements specified above will be assessed by specific milestones for the DSRIP program, which are measured by particular metrics. Investments in technology, tools, and human resources will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Domain 1 process milestones and measures will 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

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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.

Community Partners of WNY (CPWNY) has performed an initial review of its PPS partners by evaluating their financial viability through an analysis of data obtained from audited financial statements. The audited financial statements were reviewed for an unqualified opinion and any going concern issues. Financial metrics were analyzed for each partner and a scoring system was developed to identify PPS partners that demonstrate any sign of financial stress or could possibly experience future financial stress. Any PPS partner that displayed signs of financial stress was further analyzed for the impact it would have on each project. CPWNY understands the role each partner has in achieving success within each project plan. It will be the responsibility of the Finance/Audit Committee to continue monitoring the financial viability of all PPS partners and report to the Executive Governing Body any signs of financial stress that will have a negative impact on achieving any project goals.

***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.

The DSRIP targets will reduce overall hospital volumes based upon lower admission and readmission rates as well as lower ER utilization. These declining rates of acute care will also impact non-Medicaid patients creating opportunities for our hospital partners to establish additional revenue sources from affiliated home care providers, ambulatory rehabilitations services, ancillary services and possible joint

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ventures. Our overall PPS budget does account for lost Medicaid volumes but our hospital partners will also have to bring their respective acute care capacity in line with demand. There will be additional pressure on cash flow from reduced revenues which will require continually matching new care delivery competencies to new payment models. CPWNY and our major hospital PPS partners currently participate in population health risk contracts with five health plans and also participate in the CMS shared savings program. Our population health business model has achieved significant results that have and will continue to support our PPS partners' transition from volume based to a value based population health business model. CPWNY acknowledges this will be a challenging transition but SOCH and CMP have been successful over the past eight years operating in a value based contracting environment while investing in infrastructure to support a business model where a significant portion of margin is achieved through population health initiatives. It is this model that was envisioned by NYSDOH and is one SOCH and CMP have been strategically focused on since 2006 that will support our CPWNY PPS partners as acute care volumes decline.

Section 9.2 – Path to PPS Financial Sustainability:

Description:
The PPS must develop a strategic plan to achieve financial sustainability, so as to ensure all Medicaid members attributed to the PPS have access to the full ranges of necessary services. In the narrative, please address the following:

***Path 1:**
Describe the plan the PPS has or will develop, outlining the PPS' path to financial sustainability and citing any known financial restructuring efforts that will require completion.

Financial sustainability will be directly correlated with achieving project goals and participating with financially viable PPS partners. The role of the Finance/Audit Committee will be crucial in developing and following a path to financial sustainability. It is the role of the committee to monitor the financial viability of each partner and the achievement of certain milestones within each project plan. Each PPS partner will be required to submit internal along with audited (when available) financial statements for the committee to monitor financial viability and determine if each partner can continue to achieve the milestones of each project. Financial metrics will be analyzed for each partner and a scoring system will be used to identify partners in financial stress. Monitoring of milestone achievements against budgeted targets and proper grant resource allocation will be an important role of the Finance/Audit Committee. Understanding the PPS partners' impact on each project and how the overall goals of each project will affect the operations and financial health of each partner will be an important piece to sustain overall financial viability. At this time, there is no financial restructuring required by the PPS partners. Sisters of Charity Hospital (SOCH) and Catholic Medical Partners (CMP) have established population risk contracts with health plans and will expand this model with our PPS partners to position them for full risk contracting with either NYSDOH or with our health plan collaborators. This will ensure a path to financial sustainability beyond the term of the grant. We will also be exploring investment in a third party administration platform if this becomes necessary or if it provides a strategic advantage in our future contracting.

***Path 2:**
Describe how the PPS will monitor the financial sustainability of each PPS partner and ensure that those fragile safety net providers essential to achieving the PPS' DSRIP goals will achieve a path of financial sustainability.

The Finance/Audit Committee of the PPS will conduct an analysis of each PPS partner's financial sustainability by analyzing internal and audited statements on a periodic basis. Financial metrics will be analyzed for each partner and a scoring system will be used to identify partners in financial stress. PPS Partners identified as financially stressed will be monitored closely by the Finance/Audit Committee and CPWNY will work to develop a strategy that will ensure the organization can successfully transition to a population health business model. It is important all partners understand how a population health business model impacts revenue targets. CPWNY will responsibly allocate project funds and bonus incentives to partners achieving project milestones to mitigate the financial stress incurred as a result of completing these milestones. CPWNY will also explore opportunities for consolidation, shared services and use of business acumen to assist PPS partners in financial stress providing improvement or recovery strategies.

***Path 3:**
Describe how the PPS will sustain the DSRIP outcomes after the conclusion of the program.

SOCH and CMP currently manage population health risk contracts with five health plans and also participate in the CMS shared savings program. Our population health business model has achieved significant results that have and will continue to support our organizations transition from volume based to a value based population health business model. SOCH and CMP are performance based organizations investing in the education of provider networks on best practice medicine and designing business intelligence systems to measure results

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and provide practice based reporting. We currently produce reports on quality and utilization that include avoidable admission and readmissions. Our provider network is supported by a mobile practice transformation team of PCMH specialists, nurses, dieticians, pharmacists and social workers. SOCH and CMP will continue this work with CPWNY in the future and it will be an essential part of our contracting for sustainability. The PPS partners will be have the opportunity throughout the duration of the DSRIP project to mature into the population health business model by using the tools and experience provided by SOCH as the PPS lead organization.

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.

SOCH through its membership in Catholic Medical Partners (CMP) oversees more than 30,000 Medicaid members in population health risk contracts from three major health plans and continues to negotiate for the inclusion of all health plan managed Medicaid members in its population health risk model. CPWNY has included representatives of the health plans that SOCH and CMP have risk arrangements with in the CPWNY PAC. To achieve our PPS vision, it will require us to continue to demonstrate success and work collaboratively with all Medicaid managed care insurance companies. We recognize there will be challenges contracting with all Medicaid managed care providers due to size, strategic approaches toward contracting, system constraints and financial expectations. It is expected that CPWNY PPS partners will gain operating experience in the population health business model and will be well positioned to continue the transformation to value based payment models by the completion of the DSRIP initiative. The partners will gain the understanding of how to successfully manage the cost and quality of care for their populations and this will dictate their success within value based payment models. To achieve success, these payment models need to be fair and straightforward so both the payers and providers understand their goals, the population they are managing, the cost and quality of care, along with the impact this will have on revenue targets.

***Strategy 2:**
Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers

SOCH and CMP successful approach to payment transformation is to establish shared savings contracts based on managing a percentage of the overall medical premium and managing financial targets based on historical performance trended forward. Under these risk sharing budgets, shared savings are driven by quality and utilization improvements. For success, it will be crucial for our safety net providers to understand the impact any shared savings goals will have on revenue and expense targets, understanding the impact on overall total cost of care within a provider network along with understanding the population they are at risk for. Payment transformation will also extend to bundled payment opportunities and CPWNY partners already have experience to share with inpatient case rate payments for chronic health conditions, PCP capitation payments and utilization of health home resources. SOCH and CMP have experienced success in this model and it will continue to serve as our business and contracting model after the DSRIP project has ended. CPWNY PPS partners, particularly the financially fragile partners, will understand how to manage within a population health business model through their experience gained from working directly with SOCH, CMP and other successful CPWNY partners. The PPS partners may elect to begin contracting in a shared savings agreement initially with limited to no downside risk exposure and transition into a full shared savings agreement while managing downside risk. Initial shared savings will be allocated to support the population health business model infrastructure and additional savings distributed to participating members. The overall vision is to expand this model to include community health workers, mental health and substance abuse providers and other provider groups that impact utilization and quality. The DSRIP project will lay the groundwork of care transformation for our PPS partners.

Section 9.4 - Domain 1 – Financial Sustainability Plan Milestones:

Description:

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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.

Sister of Charity Hospital (SOCH) is a member of Catholic Medical Partners and as such has been engaged in population management improvement initiatives for over 10 years. Initiatives include training nurses to provide disease management, interventions to patients and using clinical registries to identify patients with gaps in care and needed interventions. In 2011 SOCH participated in the CMP NCQA patient oriented disease management for diabetes, CHF, & CAD through a delegated model. SOCH worked with CMP on establishing a PCMH training team, and currently 70% of CMP's patient population is at Level 3 PCMH. This collaboration between SOCH and CMP will be instrumental in Community Partners of WNY PPS' success. In 2011 SOCH collaborated with CMP to develop an advanced care management model based upon the Massachusetts General care management pilot study that demonstrated cost-saving and quality improvement by requiring care management for high-risk patients. These higher risk patients were identified by HCC scores and were attributed to our risk contracts. SOCH's participation with CMP CMS Shared Savings program demonstrated a reduction of hospitalizations per 1000 by 26%, ER visits by 13%, and Ambulatory sensitive condition admissions by 15%. SOCH project management team from CMP outperformed all Pioneer savings ACOs in the first year & in 2014 was the 3rd highest in the nation receiving shared savings. Through the DSRIP grant we would be able to engage Medicaid patients and provide a more comprehensive approach with use of social workers and community outreach workers adding to this team concept.

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.

CPWNY intends to contract with proven and experienced entities to help carry out some portions of workforce strategy. CPWNY's major healthcare system, Catholic Health System, has significant skill and capacity in this area, utilizing its new centrally located Regional Training Center. Due to the speed and scale of the DSRIP initiative, their expertise will be augmented by firms such as Navigant, Mercer and Chartis, all of which have been used with good results for major transition projects in WNY. CPWNY also expects to contract with a change management firm to train leadership in participating organizations and practices to equip them to communicate the need for training in a way that engages and motivates their organizations and workforce.

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 Catholic Medical Partners-Accountable Care IPA INC that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: SISTERS OF CHARITY HOSP
Secondary Lead Provider Name:

Lead Representative:	Dennis R Horrigan
Submission Date:	01/05/2015 03:17 PM

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