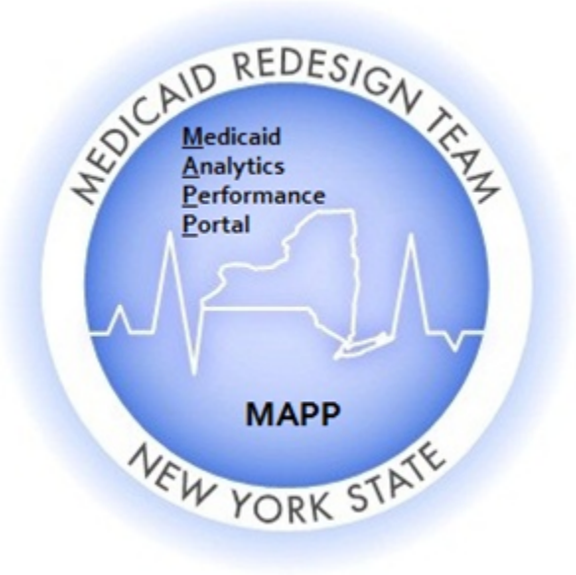
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



CNY DSRIP Performing Provider System

CNY DSRIP Performing Provider System (PPS ID:8)

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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: **(none)**

Description of File

File Uploaded By:
File Uploaded On:

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: cjaconsk
Last Updated On: 12/22/2014 09:14 AM

Certified By: sc1234
Certified On: 12/22/2014 09:22 AM
Lead Representative: Shawna Craigmile-sciacca

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	Build an integrated health care delivery system for Medicaid members and the low-income uninsured.	To effectively and efficiently meet the needs of Medicaid and low-income uninsured individuals in CNY by delivering accessible evidence-based high quality care in the right setting at the right time, at the appropriate cost. Also to educate, align, and support providers and community organizations in a structured collaborative with the purpose, staff and resources to transform care services and to respond to changes in the market through right sizing and re-purposing to better meet population needs based on a comprehensive needs assessment.
2	Build, improve, and integrate primary care and behavioral health access and coordination.	To improve and sustain the regional ability to maintain health, prevent acute disease, and reduce the morbidity associated with chronic illness through improved access, prevention and disease management strategies.
3	Ensure access and transform care, systems, coordination, and transitions of care across sectors.	To reduce gaps and inefficiencies in care, coordination, communications, and service delivery among providers and community organizations, improving the experience of care, compliance with therapies and prevention, and reducing by 25% the preventable emergency visits and hospital admissions.
4	Engage the workforce in understanding and accessing health care transformation opportunities.	To foster awareness of job changes in the health system and to develop the workforce for anticipated changes in services, skill requirements, and opportunities.
5	Assure a sustainable network.	To create a representative governance structure to provide a sustainable organization that is effective, ethical, compliant, accountable, and responsive to community needs and that matures into an ACO-like organization to establish value-based payment arrangements and align provider compensation to patient outcomes.
6	Implement a comprehensive population health management strategy.	To provide a new model of care which will deliver appropriate preventive, routine services to the population at large, and evidence-based care to medically complex patients.

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

Initially, Auburn Community Hospital, Faxton St. Luke's Healthcare, St. Joseph's Hospital Health Center, and Upstate University Hospital led 4 separate PPSs with overlapping networks, separate PACs, and independent Projects.

PPS Partners, PAC Members, DOH, KPMG, and others advised against separate PPSs, encouraging cooperation. The PPS leads listened to the community and their Partners and established a single PPS on October 22. This collaboration demonstrates a common vision to make significant differences in the lives of the most vulnerable populations in CNY.

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The co-leads developed a governance model for representative decision-making, network accountability effective performance, and sustainability. The bylaws assure balanced decision-making, a robust committee structure, inclusive communications and transparency, joint planning and strong oversight of network performance.

One CNY PPS ensures adequate representation and participation by Partners, more engagement of the community, increased access to care, smoother transitions of care across settings, and an increased ability to target efforts where most needed to address healthcare disparities and community needs.

***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.

CNYCC's vision is to transform the systems of care for Medicaid beneficiaries and low-income uninsured.

CNYCC will provide the structure and technical support, as well as the resources and operating systems for engaging providers, employees, and community-based organizations in practical service delivery change across a six-county region.

With providers in regional groupings, CNYCC will improve both access and coordination involving primary care, behavioral health, preventive health services, and community supports.

CNYCC will use professional staff, peer supports, subject matter experts, along with technology and resource availability, to develop a cohesive and sustainable infrastructure that assures DSRIP goals are achieved, both in the areas of population health and in a cumulative 25% reduction in preventable emergency and hospital use over five years.

Beyond DSRIP, CNYCC will develop the knowledge, analytical infrastructure, and professional expertise to accept Medicaid post-FFS payment methodologies.

***Regulatory Relief:**

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

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

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

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

#	Regulatory Relief(RR)	RR Response
1	14 NYCRR § 599.3(d), 599.4(r) & (ab), 599.5(f) and 599.12	2.a.i, 3.a.i: The cited regulations require licensure by DOH of mental health providers if the provision of medical services exceeds a certain percentage of total annual visits, licensure by OMH of certain Article 28 providers that provide mental health visits, prior approval for changes to existing operating certificates and the submission of a plan to be approved by OMH prior to

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#	Regulatory Relief(RR)	RR Response
		sharing program space with other programs. These regulations are barriers to integrated care as they require providers to go through lengthy licensing and approval processes. An alternative to integrated care is to strengthen the referral process between separate and distinct primary care and behavioral health providers. This alternative requires patients to make multiple visits to providers, which increases the likelihood that patients will not seek the care they need. This is especially true in rural areas where the distance between providers is great. Additionally, CNYCC has determined that patients suffering from mental illness prefer to receive their medical care in a behavioral health setting. Thus, integration will ensure that the medical needs of this population do not go unaddressed. As a result, this alternative is less efficient and would affect the overall success of the project. There are no patient safety concerns associated with this waiver as it will make it easier for providers to treat patients in a holistic manner, which increases their health and safety.2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. CNYCC will increase access to primary care providers in order to shift care from hospitals, and this will result in greater utilization of mental health providers. CNYCC will also fill gaps in access to care by coordinating care in one location. The waiver is needed to make it easier for CNYCC to add services in existing provider locations and adjust premises accordingly without undue delay. 3.a.i: The goal of this project is to integrate behavioral health and primary care services so that patients can receive care for all conditions in one place. In order to achieve this integration, CNYCC intends to place behavioral health providers in primary care settings, and vice versa. This expansion of services requires licensure by OMH and DOH under the cited regulations. The process for applying for licensure or certification from these agencies is time consuming, and would impede CNYCC's ability to integrate services.
2	10 NYCRR § 400.9	2.b.iii & 2.b.iv: This regulation imposes certain requirements with regard to transfer and affiliation agreements between hospitals and treatment and diagnostic centers, CHHAs, LHCAs and hospices. Compliance with this regulation would require that CNYCC develop a template transfer and affiliation agreement to be used by CNYCC providers. However, this would require that time and resources be dedicated to: 1) surveying providers to determine existing agreements as well as partnerships that are not currently governed by agreements, and 2) developing the template agreement. This alternative is time consuming and could result in delays in transferring patients to community providers. This waiver will help to ensure that there are not any unnecessary roadblocks to transitioning patients from EDs to community primary care providers in connection with the below projects. CNYCC believes that policies and procedures governing the transition process will avoid any patient safety concerns. 2.b.iii: The goal of this project is to impact avoidable ED use by helping patients to access primary care and other community resources in CNYCC's service area. Among other things, CNYCC intends on establishing navigation teams in participating EDs. These teams shall assess patients identified as having utilized the ED for non-urgent services, and connect those users with primary care providers in the community. The ability of the navigation teams to transfer patients to community providers in a timely manner is essential to the success of this project. If CNYCC were required to ensure that all hospitals had an agreement that complies with the regulation in place before transferring a patient to another provider, this would thwart the implementation of the project. 2.b.iv: CNYCC intends to reduce 30-day readmissions in part by concentrating on referring patients to community-based providers such as CHHAs and hospices that are well-equipped to monitor and care for patients with chronic health conditions during the discharge process. The ability to facilitate transfers to providers who can closely monitor and support patients post-discharge is essential to the

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#	Regulatory Relief(RR)	RR Response
		success of this project. CNYCC may be unable to ensure the execution of transfer and affiliation agreements that comply with all the requirements in 10 NYCRR § 400.9 between the participating EDs and every community care provider to which the EDs seek to transition patient care.
3	14 NYCRR §§ 587.5(h), 587.8(h), 587.9(h), 587.10(h), 587.11(h) and 587.12(h) and 587.15	2.a.i, 3.a.i: These regulations apply to outpatient programs providing services to children and adults diagnosed with mental illnesses and contain numerous requirements that could operate as barriers to the integration and co-location of mental health, substance abuse and primary care services. Specifically, § 587.5(h) requires OMH approval of changes to physical space or location, use of additional sites, and change in capacity of a mental health provider; §§ 587.8(h) - 587.12(h) require OMH approval for the provision of services not set forth therein and § 587.15 sets forth staffing requirements. These approval processes are significant impediments to the co-location and integration of services as they are often time consuming and constrictive. An alternative to integrated care is to strengthen the referral process between separate and distinct primary care and behavioral health providers. This alternative requires patients to make multiple visits to providers, which increases the likelihood that patients will not seek the care they need. This is especially true in rural areas where the distance between providers is great. Thus, this alternative is less efficient and would affect the overall success of the below projects. CNYCC does not anticipate any patient safety concerns associated with this waiver as it will make it easier for providers to treat patients in a holistic manner, which increases their health and safety.2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population and reduce unnecessary acute care by promoting service integration activities in community providers. This will involve the co-location of medical and behavioral health services in community providers. Co-location of services will likely result in: 1) the addition of new services to existing outpatient programs; 2) expansion and physical changes to existing outpatient programs to account for new services and higher utilization, and 3) changes in staffing. 3.a.i: The goal of this project is to integrate mental health, substance abuse, and medical services so that patients are able to receive care for all conditions in one place. CNYCC intends to place primary care and substance abuse specialists in existing outpatient mental health programs that have not previously offered such services and/or expand those services where appropriate. Compliance with the cited regulations will impede CNYCC's ability to implement this project as integration and co-location will likely result in: 1) the addition of new services to existing outpatient programs; 2) expansion and physical changes to existing outpatient programs to account for new services and higher utilization, and 3) changes in staffing.
4	14 NYCRR §§ 814.2, 814.3(d), 814.6, 814.7, and 814.8	2.a.i, 3.a.i: The regulations cover 1) building code requirements applicable to OASAS providers; 2) general building requirements applicable to OASAS providers; 3) additional requirements for outpatient facilities; 4) requirements related to shared space; and 5) written approval from OASAS for changes to physical space. These regulations are barriers to the integration of mental health, substance abuse and primary care services, as they restrict providers' ability to share space and alter physical premises used for chemical dependence services and impose a lengthy approval process. Integration of these services is a key component of the below projects. An alternative to integrated care is to strengthen the referral process between separate and distinct primary care and behavioral health providers. This alternative requires patients to make multiple visits to providers, which increases the likelihood that patients will not seek the care they need. This is especially true in rural areas where the distance between providers is great. Thus, this alternative is less efficient and would affect the overall success of the projects. CNYCC does not anticipate any patient safety concerns associated with this waiver. Patient safety will be increased

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#	Regulatory Relief(RR)	RR Response
		as a result of greater access to care through integration and a greater emphasis in existing facilities on holistic care. 2.a.i: This project seeks to reduce unnecessary acute care by promoting service integration activities in community providers. This will involve the co-location of medical and behavioral health services in community providers in order to effectively address patient's health needs in a holistic manner. Co-location of services will result in: 1) the addition of new services to existing chemical dependence programs, and 2) alterations of existing physical space and possible expansion of chemical dependence programs to account for new services provided and higher utilization as a result of greater coordination between CNYCC providers. 3.a.i: The goal of this project is to integrate behavioral health and medical services so that patients are able to receive care for all conditions in one place. CNYCC intends to place primary care and mental health specialists in existing chemical dependence programs that have not previously offered such services and/or expand those services where appropriate. Compliance with the regulation will impede CNYCC's ability to integrate and co-locate medical and behavioral health services in community providers in order to effectively address patient's health needs in a holistic manner. For instance, co-location will result in: 1) the addition of new services to existing outpatient programs and 2) alterations of existing physical space and possible expansion of existing chemical dependence programs to account for new services provided and higher utilization as a result of greater coordination between CNYCC providers.
5	14 NYCRR § 822-4.9	2.a.i, 3.a.i: 14 NYCRR § 822-4.9 provides that an outpatient chemical dependence service provider must complete an application for approval of an additional location. The below projects seek to increase utilization of community providers through the co-location of services. This may result in the need for additional locations to account for new services provided and higher utilization as a result of greater coordination between CNYCC providers. This regulation presents a barrier to the successful implementation of the projects as the application process for an additional location is a time consuming process. As a result, a denial of this waiver will thwart CNYCC's efforts to fill gaps in access to care by coordinating care in one location. An alternative to integrated care is to strengthen the referral process between separate and distinct primary care and behavioral health providers. This alternative requires patients to make multiple visits to providers, which increases the likelihood that patients will not seek the care they need. This is especially true in rural areas where the distance between providers is great. Thus, this alternative is less efficient and would affect the overall success of the below projects. CNYCC does not anticipate any patient safety concerns associated with this waiver. Patient safety will be increased as a result of greater access to care through integration and a greater emphasis in existing facilities on holistic care. 2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. In order to reach this goal, CNYCC intends to expand the integrated care models currently being utilized by the three participating Health Homes. CNYCC may seek to place medical and mental health specialists in existing outpatient chemical dependency or opioid treatment programs so that patients are able to have access to many types of care in one location. Co-location of services may result in possible expansion of existing chemical dependence programs to account for new services provided and higher utilization as a result of greater coordination between CNYCC providers. 3.a.i: The goal of this project is to integrate mental health, substance abuse, and medical services so that patients are able to receive care for all conditions in one place. In implementing this project CNYCC will likely seek to place mental health and primary care specialists in existing outpatient chemical dependence and opioid treatment programs that have not

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#	Regulatory Relief(RR)	RR Response
		previously offered such services. This integration and co-location of services may result in the need for additional locations as facilities see greater utilization by patients.
6	10 NYCRR § 405.1	2.a.i, 2.b.iii, 2.b.iv, 3.a.ii, 3.b.i: Any entity with the authority to operate a hospital must be approved for establishment by the Public Health Council (PHC). An entity will be deemed an operator if it has authority over: (i) adoption or approval of hospital operating policies and procedures or (ii) approval of hospital contracts for management or for clinical services. The below projects will likely require that CNYCC be able to create policies and/or approve contracts related to management or clinical services. It is difficult to conceive of an alternative to the waiver request, as standardized protocols will be essential to ensuring that all effected providers are implementing the projects consistently, and in such a way that ensures CNYCC will meet the project requirements and milestones. The requirement that CNYCC be approved for establishment by the PHC will hinder its ability to develop and implement the processes and procedures necessary to make the projects successful. There are no patient safety risks to this waiver, to the contrary, standardized processes and procedures will likely increase patient safety. 2.a.i: This project seeks to reduce avoidable hospital activity by shifting care to community-based providers. One of the metrics associated with this project is the development by CNYCC of care coordination protocols as well as integrated delivery system protocols and processes, which will likely apply to its participating hospitals. 2.b.iii: One of the key components of this project is the development of processes and procedures to establish connectivity between EDs and community primary care providers. In order to meet this project's requirements, CNYCC must have the ability to develop such processes and procedures to be implemented by its participating hospitals for the triage of patients that present to the ED for non-acute care. 2.b.iv: CNYCC intends to utilize ED transition teams to assess patients with chronic illnesses upon discharge from participating hospitals' EDs to determine their need for community provider support following discharge to reduce the likelihood of readmission. CNYCC intends to develop standardized processes and protocols to be used in all of its hospitals related to topics including, but not limited to, patient assessment, discharge planning and transition of care. 3.a.ii: One of the goals associated with this project is the development of procedures and protocols in to be used in EDs for diversion to crisis stabilization services when appropriate. 3.b.i: CNYCC will be developing standardized treatment protocols related to disease management to be implemented in its participating hospitals.
7	10 NYCRR § 405.9(f)(7)	2.a.i, 2.b.iii, 2.b.iv: Pursuant to 10 NYCRR § 405.9(f)(7), hospitals are not to transfer, remove or discharge patients based on source of payment. However, many of CNYCC's projects seek to reduce avoidable hospital activity by Medicaid patients by shifting care of non-acute conditions to community providers. CNYCC will do this by assisting patients in accessing care outside of hospitals. CNYCC will in turn receive DSRIP funds related to its achievement of metrics aligned with these projects. Given that data demonstrates that CNYCC's service area has high rates of admission of Medicaid patients to hospitals for conditions that could be controlled with appropriate primary care, and that the project requirements and metrics specifically focus on the transition of Medicaid patients from hospitals to community providers, CNYCC does not think there are any alternatives to requesting this waiver. There are no patient safety risks to this waiver. CNYCC's promotion of increased utilization of primary care services will increase patient safety as these providers are better-equipped to monitor and coordinate care for patients. Additionally, Medicaid patients presenting to EDs will continue to be assessed to ensure they do not require emergency care before the appropriate personnel begin to concentrate on transferring them to community providers. CNYCC's ability to transfer

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#	Regulatory Relief(RR)	RR Response
		patients from hospitals to other community providers could be impeded by the regulation in the following projects: 2.a.i: The goal of this project is to create an integrated delivery system that incorporates the full continuum of services for CNYCC's Medicaid population. CNYCC will be working to develop a structure that shifts focus from hospitals to community-based providers. In order to meet this goal, CNYCC may implement various components, such as procedures, processes and protocols that focus on shifting care and management of Medicaid beneficiaries that do not require urgent care from hospitals to community-based providers. 2.b.iii: Through this project, CNYCC will seek to reduce Medicaid patients' utilization of EDs for non-urgent services through the development of navigation teams to operate within EDs. These navigation teams will interview and assess Medicaid patients that utilize EDs for conditions that can be managed by primary care providers. The navigation teams will determine the full scope of patients' needs in order to transfer patients to appropriate community providers who can meet patients' ongoing care needs. 2.b.iv: Through this project CNYCC will seek to reduce 30-day readmissions among Medicaid patients by concentrating on the discharge process that hospitals are utilizing, and for patients with chronic conditions, focusing on identifying patients' needs post-discharge. Transition teams will be developing cross-setting plans of care that involve partnering with community providers with capacity to manage patients.
8	10 NYCRR § 710.1(c)(1)(i) & (c)(1)(ii) & (c)(1)(v)	2.a.i: The CON application process is a significant barrier to the level of integration that CNYCC seeks to achieve through its projects. The regulations governing the CON process require various levels of review and approval for projects related to the addition, modification or decertification of a licensed service, acquisition of equipment, conversion of beds and construction of new facilities. The CON process is both complicated and time consuming, and could significantly delay achievement of goals associated with CNYCC's projects. The cited regulations require a CON application for the addition, modification or decertification of a licensed service; a change in the method of delivery of a licensed service, regardless of cost and a conversion of beds or a change in the certified bed capacity of a facility. Some or all of these changes may be necessary in connection with Project 2.a.i as CNYCC seeks to transform the current fragmented care delivery system into one that is integrated and efficiently provides care to Medicaid patients. For instance, CNYCC may seek to convert beds in existing facilities that are not currently utilized or to add licensed services that address a gap in access to care. An alternative to a waiver of this provision would be a change to the process so that any projects associated with the CNYCC DSRIP projects are considered in a timely manner. There are no patient safety risks to this waiver.
9	10 NYCRR § 710.2	2.a.i: The CON application process is a significant barrier to the level of integration that CNYCC seeks to achieve through its projects. The regulations governing the CON process require various levels of review and approval for projects related to the addition, modification or decertification of a licensed service, acquisition of equipment, conversion of beds and construction of new facilities. The CON process is both complicated and time consuming, and could significantly delay achievement of goals associated with CNYCC's projects. For instance, in connection with Project 2.a.i, CNYCC anticipates the need to construct a new state-of-the-art facility in its service area through the affiliation of two existing medical centers. This integration will result in significant clinical, operational, and financial efficiencies not currently afforded by the current fragmented delivery system spread across three aged campuses. An alternative to a waiver of this provision would be a change to the process so that any projects associated with the CNYCC DSRIP projects are considered in a timely manner. There are no patient safety risks to this waiver.
10	14 NYCRR § 551.6	2.a.i, 3.a.i: This regulation governs the prior approval review process

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#	Regulatory Relief(RR)	RR Response
		associated with mental health services projects. There are varying levels of OMH approval based on the scope of the proposed project. For instance, the E-Z PAR review described in § 551.6(c) applies to outpatient program projects submitted by current operators of OMH licensed programs that propose to establish a new outpatient program or satellite office, expand caseload by more than 25 percent, make a substantial change to services provided or undertake a capital project costing under $600,000 and above $250,000. These approval processes are time consuming and will impede CNYCC's ability to integrate services in a timely manner. There are no patient safety risks associated with this waiver as it will make it easier for providers to treat patients in a holistic manner, which increases their health and safety. The following projects are impeded by this regulation: 2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. This project, seeks to shift unnecessary hospital care to community-based providers. As a result, CNYCC anticipates greater utilization of these community based providers, which will in turn require that mental health providers have greater capacity to treat the service area's Medicaid population. Community mental health providers will likely need to add licensed services, add beds and/or expand to additional sites in order to meet the increased need for services. If CNYCC were required to follow the prior approval processes outlined in this regulation it would significantly impede its integration of services, and its ability to meet the increased needs for community based services. 3.a.i: The goal of this project is to integrate mental health, substance abuse, and medical services so that patients are able to receive care for all conditions in one place. CNYCC will likely seek to place substance use disorder professionals and primary care specialists in existing outpatient mental health facilities that have not previously offered such services. This integration and co-location of services will increase the services provided at such facilities and may also result in a need for expansion of existing facilities or the addition of new locations as facilities see greater utilization by patients. The regulation requires approval by OMH prior to implementation of these types of projects. Compliance with the regulation will slow down CNYCC's integration of services, which will in turn thwart CNYCC's efforts to fill gaps in access to care by coordinating care in one location.
11	14 NYCRR § 810.6	2.a.i, 3.a.i: This regulation requires administrative review prior to a substance use disorder provider establishing a new service, expanding to an additional location or increasing the capacity of a service. All of these actions may need to be taken in connection with the below projects, which emphasize integration of services in community providers. The administrative review process is time consuming, and will thwart CNYCC's ability to efficiently implement its projects. An alternative to integrated care is to strengthen the referral process between separate and distinct primary care and behavioral health providers. This alternative requires patients to make multiple visits to providers, which increases the likelihood that patients will not seek the care they need. This is especially true in rural areas where the distance between providers is great. Thus, this alternative is less efficient and would affect the overall success of the below projects. If OASAS is not open to waiving this regulation, CNYCC would request the development of a more streamlined approval process so DSRIP project implementation is not delayed unnecessarily. There are no patient safety risks associated with this waiver as it will make it easier for providers to treat patients in a holistic manner and increase access to care, which increases their health and safety. 2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. This project seeks to shift unnecessary hospital care to community-based providers. As a result, CNYCC anticipates greater utilization of these community based providers,

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		which will in turn require that these providers have greater capacity to treat the service area's Medicaid population. Community substance use disorder providers licensed by OASAS will likely need to add licensed services and expand to additional sites in order to meet the increased need for services. 3.a.i: The goal of this project is to integrate mental health, substance abuse, and medical services so that patients are able to receive care for all conditions in one place. CNYCC will likely seek to place mental health professionals and primary care specialists in existing outpatient substance use disorder facilities that have not previously offered such services. This integration and co-location of services will increase the services provided at such facilities and may also result in a need for expansion of existing facilities or the addition of new locations as facilities see greater utilization by patients.
12	10 NYCRR 401.3	2.a.i: This regulation requires that proposed changes in physical plant, bed capacity and the extent and kind of services provided in existing medical facilities be submitted to the DOH for approval. The CON process is both complicated and time consuming, and could significantly delay achievement of goals associated with CNYCC's projects. 2.a.i: Requires the creation of an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. CNYCC anticipates needing to make these kinds of changes to existing facilities in order to increase efficiency in care and shift to more integrated care models. For instance, CNYCC may seek to convert beds in existing facilities that are not currently utilized or to add licensed services that address a gap in access to care. CNYCC also anticipates the need to reduce inpatient beds and expand ambulatory care services provided in certain existing providers in connection with this project. As a result, CNYCC requests that the CON process be waived for existing providers that seek to make changes to in physical plant, bed capacity and the extent and kind of services. There are no patient safety risks associated with this waiver as CNYCC believes that making these changes will result in better, more efficient existing medical facilities are providing to Medicaid patients. If DOH is unwilling to waive this regulation, CNYCC requests the development of a more streamlined approval process so DSRIP project implementation is not delayed unnecessarily.
13	10 NYCRR 600.1(b)(1) & (b)(3), 600.2(b)(1) & (b)(3)	2.a.i: This regulation sets forth the information to be contained within any application to the Public Health Council for the establishment of a new medical facility. 2.a.i: Requires the creation of an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. In connection with this project, CNYCC anticipates the construction of a new state-of-the-art facility in its service area through the affiliation of two existing medical centers, which will result in significant clinical, operational, and financial efficiencies not currently afforded by the current fragmented delivery system spread across three aged campuses. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of such new facility will measurably increase access to and quality of healthcare for the community being served by CNYCC. This new medical facility will have enhanced clinical and programmatic collaborations with other providers in the CNYCC PPS, resulting in a more tightly aligned integrated delivery system. This project has the ability to substantially impact the health status of the population and better manage service utilization and the overall cost of healthcare. Thus, CNYCC requests waiver of subsections 600.1(b)(1) and (b)(3), and 600.2(b)(1) and (b)(3) as similar reviews will be performed in connection with CNYCC's DSRIP application. Denial of this waiver request would significantly delay the construction process, and affect the speed at which CNYCC will be able to achieve the metrics associated with this project. Denial of the waiver would impede the closure of existing gaps in the care continuum, and result in the continuance of inefficient care as the

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		existing medical facilities do not have the systems in place to triage ED patients or redirect them to urgent care, primary care, and/or behavioral health in lieu of ED usage. There are no patient safety risks associated with this waiver as similar reviews will be completed in connection with CNYCC's DSRIP application. If DOH is not open to waiving this regulation CNYCC would request the development of a more streamlined approval process so DSRIP project implementation is not delayed unnecessarily.
14	10 NYCRR 670.1	2.a.i: This regulation sets forth the factors for determining the public need for the establishment of a new medical facility. 2.a.i: Requires the creation of an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. In connection with this project, CNYCC anticipates the construction of a new state-of-the-art facility in its service area through the affiliation of two existing medical centers, which integration will result in significant clinical, operational, and financial efficiencies not currently afforded by the current fragmented delivery system spread across three aged campuses. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of such new facility will measurably increase access to and quality of healthcare for the community being served by CNYCC. CNYCC requests a waiver of the public need portion of the application process as a similar review will be performed in connection with CNYCC's DSRIP project plan application, negating the need for a separate public need analysis. There are no patient safety risks to this waiver. Indeed, because the details surrounding the establishment of a new medical facility will be reviewed in connection with the project application, waiver of the public need analysis is simply eliminating a duplicative process. Furthermore, such new medical facility will be better equipped to meet the medical needs of CNYCC's Medicaid population and help to provide greater access to care, which will result in greater patient safety.
15	10 NYCRR 709	2.a.i: This regulation, and its individual sections set forth the factors for determining the public need for the establishment of new medical facilities. 2.a.i: Requires the creation of an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. In connection with this project, CNYCC anticipates that it will need to construct a new hospital in its service area in order to meet the medical needs of its Medicaid population. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of such new facility will measurably increase access to and quality of healthcare for the community being served by CNYCC.CNYCC requests a waiver of the public need portion of the application process as a similar review will be performed in connection with CNYCC's DSRIP application, negating the need for a separate public need analysis. There are no patient safety risks to this waiver. Indeed, because the details surrounding the establishment of a new medical facility will be reviewed in connection with the project application, waiver of the public need analysis is simply eliminating a duplicative process. Furthermore, such new medical facility will be better equipped to meet the medical needs of CNYCC's Medicaid population and help to provide greater access to care, which will result in greater patient safety.
16	10 NYCRR 710.9	2.a.i: This regulation requires both an onsite inspection following construction of a new medical facility and a preopening survey prior to occupation of the premises. Both of these processes are time consuming, and the statute fails to impose a time limit in which these must be done. As a result, they are a barrier to the opening of new medical facilities in connection with DSRIP projects.2.a.i: Requires the creation of an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. In connection with this project, CNYCC anticipates the construction of a new state-of-the-art facility in its service area through the affiliation of two existing medical centers, which integration

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		will result in significant clinical, operational, and financial efficiencies not currently afforded by the current fragmented delivery system spread across three aged campuses. In addition to reducing costs, strengthening core clinical services and introducing new clinical initiatives, the construction of such new facility will measurably increase access to and quality of healthcare for the community being served by CNYCC. CNYCC requests a waiver of the pre-opening survey requirements set forth in this regulation. There is currently no timeframe associated with such requirement, and this process will be a barrier to the timely opening of any new medical facilities constructed by CNYCC. Alternatives to requesting a waiver of such regulation would be to impose a requirement that DOH complete all pre-opening surveys within 15 days of a written request by a facility to DOH. There are no patient safety risks to this waiver, as the Bureau of Architectural and Engineering Review will still take place to ensure that the construction is acceptable as completed.
17	10 NYCRR § 401.2(b)	2.b.iv: 10 NYCRR § 401.2(b) states that an operating certificate shall be used only by the established operator for the designated site of operation. The goal of this project is to reduce 30-day readmissions for patients suffering from chronic health conditions. CNYCC has determined that across its service area, poor discharge planning is a barrier to preventing avoidable admissions. As a result, CNYCC will be establishing transition care teams to operate within EDs in order to assess the post-discharge needs of patients and develop cross-setting plans of care that concentrate on collaboration between providers. One possible service that the transition teams may provide to discharged patients is home visits by practitioners, likely behavioral health nurse practitioners, to assist patients with compliance with discharge regimens. Compliance with 10 NYCRR § 401.2(b) would impede a medical facility's ability to provide home visits to patients identified as having a high risk of readmission. Alternatives to home visits by these individuals would be the performance of home visits by health home care managers, or requiring patients to present to ambulatory behavioral health sites. These alternatives are less appealing than home visits by behavioral health nurse practitioners. Health home care managers do not have the clinical background that behavioral health nurse practitioners. This clinical background makes behavioral health nurse practitioners better equipped to deal with the types of patients that are at a higher risk of being readmitted within 30 days of discharge. There are no patient safety issues associated with this waiver request, on the contrary, enabling these provider to perform home visits will increase patient health and safety.
18	10 NYCRR § 717.4	2.b.iv: This regulation states that hospice residences may not be located in an Article 28 facility. The goal of this project is to reduce 30-day readmissions, many of which stem from patients who return to hospitals for pain management. CNYCC has determined that there is a lack of necessary resources and facilities to care for these patients in parts of CNYCC's service area. As a result, this regulation is a barrier to increasing access to hospice care for CNYCC's Medicaid population. A waiver of this regulation to allow the establishment of hospice residences in Article 28 facilities would fill a large gap that currently exists in the continuum of care. Greater access to these services would result in better care and a higher quality of life for the effected Medicaid population. It would also cause a reduction in 30-day readmissions related to pain management, and ED visits generally. There are no patient safety risks to this waiver. To the contrary, standardized processes and procedures will likely increase patient safety.
19	14 NYCRR §§ 590.5(d)(6), 590.7(b)(1), 590.7(b)(9) and 590.9(c)	3.a.ii: CNYCC will be utilizing the services currently offered by the Comprehensive Psychiatric Emergency Program (CPEP) at St. Joseph's hospital to meet the goals of this project. Specifically, CNYCC currently intends to expand the geographic scope of the mobile crisis team

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		component of the existing CPEP so that it can provide crisis stabilization services throughout the service area of CNYCC. In order to do this, CNYCC intends to locate additional mobile crisis teams in EDs of other participating hospitals. In addition, CNYCC would like to increase the number of extended observation beds currently associated with St. Joseph's CPEP in order to provide stabilization services to more patients being discharged from the CPEP. The cited regulations could serve as barriers to these plans. Section 590.5(d)(6) requires that a CPEP obtain the prior approval of OMH to utilize additional physical locations or initiate changes in the services provided to the program. To the extent these regulations would impede mobile crisis teams associated with the CPEP from utilizing additional locations and providing services in a wider service area, CNYCC requests that it be waived. Section 590.7(b)(1) requires a description of the program's catchment area. CNYCC requests a waiver of 590.7(b)(1) to the extent it requires that St. Joseph's amend its emergency services plan to expand its catchment area to the entire service area of CNYCC. 590.7(b)(9) states that CPEPs are prohibited from operating more than six extended observation beds. The EOBs provide patients with a safe environment where they can continue to be observed and treated by psychiatric professionals. An expansion of access to these beds would ensure that individuals experiencing psychiatric emergencies receive the stabilization services they need before being discharged, and would increase the safety of the patient and others in the community. Thus, CNYCC requests a waiver of 590.7(b)(9) so that it may expand the number of extended observation beds. Section 590.9(c) requires OMH approval of staffing plans associated with crisis outreach services. In order to establish mobile crisis outreach teams in all of the counties serviced by CNYCC where these services do not currently exist, increased staff will be necessary. CNYCC requests waiver of this provision to the extent it would require it to obtain OMH approval of any revised staffing plan that may need to be created in connection with the addition of mobile crisis teams contemplated by this project. Waiver of these regulations will not have a negative effect on patient safety. To the contrary, expansion of these services will allow CNYCC to provide support to patients who have been transitioned back home or to less intensive facilities and are recovering from acute behavioral health crises. This increases the probability of a successful transition for these patients.
20	Policy that prohibits Medicaid beneficiaries from participating in HH and MLTC plans simultaneously	2.a.i, 2.b.iii: Currently, Medicaid patients cannot be members of both a Health Home and a Managed Long Term Care Plan. The rate of patients with poor mental health is considerably higher in CNYCC's service area than the state average, and much of the ED and hospital utilization for the Medicaid population is by patients with psychiatric diagnoses. The fact that Medicaid patients cannot simultaneously be members of Health Homes and MLTCs creates a barrier to the provision of more integrated care that focuses on the needs of patients. Health Home care management is behavioral health focused, while MLTC care is more concentrated on patients' physical health. MLTCs in CNYCC's service area are lacking in behavioral health expertise. Currently, for Medicaid patients with mental health conditions that are not adequately managed and monitored through MLTCs, the only alternative is for patients to go see an independent mental health provider, or present to hospitals for treatment. These are poor alternatives. Requiring patients to see multiple providers creates a barrier to accessing care, and increases the likelihood that patients will not seek the care that they need. This is especially true in rural areas. Health home care managers can make home visits and have the experience necessary to coordinate care related to mental health conditions. There are no patient safety risks to this waiver. Indeed, allowing Medicaid patients to be members of both Health Homes and MLTCs will increase patient safety by bringing needed mental health care and management services to MLTC

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		patients who may currently be lacking this care. 2.a.i: The goal of this project is to create an integrated delivery structure that incorporates the full continuum of services for CNYCC's Medicaid population. CNYCC intends to expand the integrated care models currently being utilized by the three participating Health Homes in order to transform the current care delivery system. An expansion of Health Home services to patients that are members of MLTCs will bring mental health care coordination services to a greater portion of CNYCC's Medicaid population, and will fill a gap in MLTC care. This will also reduce the amount of unnecessary hospital visits. Thus, waiver of this policy is necessary to provide more integrated care to the Medicaid population and will assist CNYCC in meeting its goal of shifting care from hospitals to community providers. 2.b.iii: This project will impact avoidable ED use by helping patients to access primary care and other community resources. CNYCC intends to establish navigation teams in participating EDs. This team shall assess patients who are identified as having utilized the ED for non-urgent services, and connect those users with primary care providers in the community. Allowing patients to be members of both Health Homes and MLTCs will give these navigation teams additional resources in the community for patients with mental health conditions.
21	Expansion of 12-month terminal prognosis definition in Section 400.2 of PHL to Medicaid patients.	2.a.i, 2.b.iv: 2.a.i: Hospice programs are an essential piece of the integrated delivery system project as they promote the delivery of coordinated and patient-centered care. Expanding access to hospice care for CNYCC's Medicaid population would result in better care for patients, and assist CNYCC in meeting its goal of shifting patient care from hospitals to community providers as hospices are well-equipped to treat the range of symptoms and complications patients with chronic illnesses face. There are no patient safety risks to this waiver. Increasing access for Medicaid beneficiaries to hospice services will lead to an increase in patient safety as more individuals will be receiving the integrated care that is necessary in connection with chronic illnesses. 2.b.iv: CNYCC intends to reduce 30-day readmissions in part by concentrating on referring patients to community-based providers such as hospices that are well-equipped to monitor and care for patients with chronic health conditions following discharge from the hospitals. The ability to facilitate transfers to providers who can closely monitor and support patients post-discharge is essential to the success of this project. Increasing access to hospice services by broadening the definition of a terminal prognosis to a 12-month life expectancy will result in a decrease in the number of re-admissions CNYCC hospitals see related to pain and other symptoms of chronic illness that could be managed in the hospice setting. There are no patient safety risks to this waiver. Increasing access for Medicaid beneficiaries to hospice services will lead to an increase in patient safety as more individuals will be receiving the integrated care that is necessary in connection with chronic illnesses.
22	Permit hospices to bill Medicaid for palliative care services.	2.a.i, 2.b.iv: Currently hospices are not able to contract to provide or to provide palliative care services, and bill Medicaid for such services. 2.a.i: Palliative care is an essential piece of the integrated delivery system project. Expanding access to palliative care for CNYCC's Medicaid population would result in better care for patients, and assist CNYCC in meeting its goal of shifting patient care from hospitals to community providers, as currently many hospital admissions are related to the need for pain management. Providing a mechanism for hospice to bill for palliative care will help them to be better-equipped to treat the range of symptoms and complications patients with chronic illnesses face. There are no patient safety risks to this waiver. Increasing access for Medicaid beneficiaries to palliative care will lead to an increase in patient safety as more individuals will be receiving the integrated care that is necessary in connection with chronic illnesses. 2.b.iv: CNYCC intends to reduce 30-day readmissions in part by concentrating on referring patients to community-based providers

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		such as hospices that are well-equipped to monitor and care for patients with chronic health conditions following discharge from the hospitals. The ability to facilitate transfers to providers who can closely monitor and support patients post-discharge is essential to the success of this project. Increasing access to palliative care services will result in a decrease in the number of re-admissions CNYCC hospitals see related to pain and other symptoms of chronic illness that could be managed in the hospice setting. There are no patient safety risks to this waiver. Increasing access for Medicaid beneficiaries to palliative care services will lead to an increase in patient safety as more individuals will be receiving the care that is necessary in connection with chronic illnesses.
23	Policy that denies care in Transitional Care Units to Medicaid beneficiaries	Section 2802-a of the PHL defines transitional care units as sub-acute care services provided to patients of a general hospital who no longer require acute care general hospital inpatient services, but continue to need specialized medical, nursing and other hospital ancillary services and are not yet appropriate for discharge. Stays are limited in duration and designed to resolve a patient's sub acute care medical problems and result in the timely and appropriate discharge of such a patient to a home, residential health care facility or other appropriate setting. CNYCC requests that TCU services be made available to its Medicaid population. There are no patient safety concerns associated with this request. On the contrary, patient safety will be increased if such services were made available to Medicaid patients. 2.a.i: One goal of this project is to create an integrated, collaborative and accountable service delivery structure that eliminates fragmentation and concentrates on delivering high quality care in the right setting. CNYCC has determined that there is an absence of sufficient post-discharge services for patients who require continued care post-discharge in a nursing home or other appropriate setting. Allowing Medicaid patients to access care in TCUs will ensure that they are receiving the care they need and ultimately result in reduced lengths of stay. 2.b.iv: The goal of this project is to reduce 30-day readmissions. Receipt by Medicaid patients of care in TCUs will ensure that they are not discharged from hospitals in situation where they could benefit from the specialized medical, nursing and other ancillary services hospitals can provide. This in turn will reduce readmissions, and result in more collaborative relationships between hospitals and long term care providers in the community, which will help bring about more efficient allocation of patients between the two settings.
24	18 NYCRR § 505.10	2.a.i, 2.b.iii, 2.b.iv: This regulation requires that prior authorization for non-emergency transportation services be granted prior to transportation expenses being incurred. In CNYCC's service area, DOH has contracted with Medical Answering Services (MAS) to service as the transportation manager and prior authorization official. Transportation is a significant problem in CNYCC's service area. In many areas the distance to providers impedes access to regular preventative and primary care. As a result, any actions that can be taken to facilitate more rapid transfers to care facilities would result in more efficient care for CNYCC's Medicaid population. CNYCC has identified the dispatching practices of MAS to be barriers to accessing care for Medicaid patients. Patients are often dropped off for appointments late or are made to sustain long car rides. Thus, CNYCC requests that: 1) its participating providers be enabled to request non-emergency transportation directly from individual transportation vendors, and 2) individual transportation vendors be authorized to generate prior authorizations. CNYCC believes that there will be greater utilization of community based providers if these waivers are granted. There are no patient safety concerns associated with this waiver request as it will lead to increased access to care, and an order from a patient's medical practitioner would still be required. 2.a.i: One goal of this project is to create an integrated, collaborative and accountable service delivery structure that

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		eliminates fragmentation and concentrates on delivering high quality care in the right setting. Waiver of the regulation would make utilization of nonemergency transportation services easier for Medicaid beneficiaries and will lead to a more integrated and accessible care delivery system. 2.b.iii: The goal of this project is to impact avoidable ED use by helping patients access primary care and other community resources in CNYCC's service area. Waiver of the regulation would make utilization of nonemergency transportation services easier for Medicaid beneficiaries. This effects this project in two ways: 1) navigation teams will have a greater ability to connect frequent ED users to community providers, and 2) patients will have an easier time accessing care through community care providers. 2.b.iv: The goal of this project is to reduce 30-day readmissions. The patient population that is the target of this project includes patients that have diagnoses such as cardiac, renal and behavioral health disorders who are at a high risk of readmission. These patients will continue to need care post-discharge, and ED transition teams will be concentrating on referring patients to appropriate community providers with capacity to see patients in a timely manner. Waiver of the regulation will make utilization of nonemergency transportation services easier for Medicaid beneficiaries, resulting in fewer 30-day readmissions.

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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.

From February to October 2014, four PPSs were organized as Collaborative Contracting models under separate PPS leads with independent PACs providing review and input.

Consistent with DOH advice, the four leads combined into a single PPS on October 22, forming a Delegated Model (non-profit membership corporation, (501(c)(3)).

The co-leads serve as Members of the PPS, called "CNY Care Collaboration (CNYCC)," using the name formerly applied to the St. Joseph-led PPS. Articles of Incorporation are pending. CNYCC Bylaws assure decisions are made by a representative Board of Directors, structured to preclude dominance by an individual Partner, region, or category; to provide transparent communications and fair process; and to foster collaboration and achieve consensus. This model recognizes input from PAC meetings.

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The PPS' six counties encompass ~ 9,700 square miles. Population densities range from 21 to 585 persons/ square mile/ county. There are ~ 1,600 PPS Partners. Partner annual operating budgets may vary by a factor 1,000 or greater, reflecting significant differences in scale, expertise, and geography. Partners differ in licensing, payment models, and missions. The size and diversity of the region requires a governing process that is participatory, transparent, trustworthy, and effective.

The Board has 22 Directors, each with one vote, in balanced categories:
- 11 Hospital Partners, from rural organizations (e.g., 40 beds) to large urban centers (e.g., 715 beds);
- 11 Community Partners, including four Community Health Centers (FQHCs).

Bylaws require Community Partners to be elected from multiple organizations: OMH-licensed, OPWDD-licensed, and OASAS-licensed providers; a Skilled Nursing Facility, a licensed Home Care agency, and a designated Health Home; County Health or Mental Health Departments. There are three "At-Large" members (e.g., primary care, behavioral health, community organizations, peer supported agencies).

Bylaws specify a 2/3 supermajority for Project plans, budgets, and funds flow, assuring high levels of consensus, and incentivizing Directors to work toward common goals.

Long-term success of the PPS will result from the give-and-take necessary to align many perspectives. CNYCC believes that balanced, participative governance fosters collaboration and supports progress from a loose network to an effective integrated care model for the post-FFS environment.

To assure proper planning, decision-making and oversight, CNYCC has a robust structure, including Executive, Clinical Governance, Information Technology and Data Governance, Corporate Compliance, and Finance (Funds Flow) Committees (populated with PAC representatives). The PAC is divided into four Regional PACs, meeting monthly, to assure local focus and solutions. The full PAC meets quarterly to monitor Projects, consider changes, track workforce needs, and fund distributions.

CNYCC Members have reserved powers to:
- assure PPS functions consistent with DOH requirements
- demonstrate stewardship for PPS funds they provide, and
- provide long-term PPS sustainability.

To foster communications and transparency, two Directors are elected as non-voting parties at Member meetings (one is from an FQHC). Bylaws allow for additional Members, consistent with their ability to provide capital, contribute knowledge and infrastructure, and to enhance regional collaboration.

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: **8_SEC021_CNYCC Organizational Structure.pdf**

Description of File

CNYCC Organizational Charts

File Uploaded By: cjaconsk

File Uploaded On: 12/18/2014 01:38 PM

***Structure 2:**

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

Bylaws assure a governance structure and process, providing a robust framework for policies, for oversight and accountability, and for sustainability.

The Board will operate with job descriptions for Directors and Committee members. A Board orientation program will be conducted, and

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continuous board education training will be provided, assuring Directors know their responsibilities and how to discharge them. Bylaws detail Committee member qualifications and responsibilities.

Robust participation and continuous learning are basic to successful governance. The Bylaws specify an attendance policy, sanctioning excessive absences. CNYCC professional staff supports governance functions, including a designated liaison for Board and Committees, including the PAC.

When the co-leads came together (October 22), four separate PACs were combined into a large PAC. The PAC is divided into four Regional PACs (R-PACs), meeting monthly, to assure local focus and solutions. The full PAC meets quarterly to monitor Projects, consider changes, track workforce needs, and fund distributions. Each RPAC will have its own PAC leads with a CNYCC Team Leader, who maintains active communications, holds monthly meetings, provides dashboards for providers, projects and R-PACs. Together, the R-PAC leaders form a PAC Steering Committee, reporting to the Board.

Effective management is enabled by proper Board resources and oversight. CNYCC's plan specifies ~ 25 FTEs, including the Executive Director, Chief Medical Officer, Director of Finance, Director of HIT/ Data, plus a Corporate Compliance Officer (reporting directly to the Board). CNYCC's budget provides resources for Project Leaders, Analytics, Program Improvement, HR, and administrative services. Job descriptions will be developed during implementation planning. Some functions may be provided via service contracts.

CNYCC will retain a portion of funds distribution to support the Project Management Office (PMO) infrastructure and provide resources for PPS education, workforce training, peer support, and targeted assistance to organizations, project teams, or R-PACs.

PPS Projects derive from the CNA, and Project Leaders will report performance to R-PACs and Board committees, using scorecards to identify outcomes vs. target metrics on a regular basis by Partner, by Project and by R-PAC. Underperforming results require Team Leader and R-PAC action plans. These will focus on education, training and resources. Planning failures, resource inadequacies, or systems weakness will be reported to the Board through the Committee structure. The Board will adopt a policy on underperforming Partners that addresses analysis and support, as well as remediation and progressive sanctions.

***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.

CNYCC's professional staff, including a Chief Medical Officer, will have analytical and technical expertise to report on and recommend improvements necessary to support and improve clinical performance. A CNYCC contract will identify Partner responsibilities to participate in and support Project initiatives. CNYCC will produce monthly scorecards that compare actual vs. target metrics for Projects, Partners, and R-PACs. Scorecards will be posted on the CNYCC website and reported to the Board through the Clinical Governance Committee.

The Chair appoints the Clinical Governance Committee (with Board concurrence). With up to 11 members, the Committee will have expertise in areas such as management, quality measurement, process improvement, patient safety, care coordination and population health. The Committee is responsible for overseeing CNYCC care delivery, care coordination, quality standards and Project quality performance, evidence-based pathways, recommendations for workforce training, etc.

The Board will adopt a policy on underperforming Partners that focuses initially on education, training, Peer Supports, and resource adequacy.

Underperforming Partners will require Team Leader and R-PAC action plans accepted by the Clinical Governance Committee. If not accepted, the Committee will refer the matter to the Board, along with recommendations that may involve resources, remediation, or progressive sanctions. In this process, CNYCC will consult with DOH and consider network adequacy.

***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.

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CNYCC sees formation of the non-profit membership corporation (Delegated Model) as the basis for its stability, sustainability, and ability to mature as an effective integrated care network.

The organization and structure are broadly representative, intended to generate a high-degree of learning and multiparty collaboration. These features are necessary for effective DRSIP performance and for developing a mature network for Medicaid MCO contracting.

CNYCC's funds flow model embeds functions, measurements, and trust-building to oversee DSRIP Projects. CNYCC intends to develop Partners' knowledge and skills in anticipation of Medicaid's value-based payment structure. CNYCC expects to link Partner rewards to performance success using objective measures. The network will develop a comprehensive plan to move beyond incentive payments for Partner behavior to shared rewards for improving system performance.

The Board has the structure, the processes and the resources for success. The Board nominates Directors and Officers, approves Committee members, adopts CNYCC policies, hires management and oversees Project planning, performance, and rewards.

Directors are accountable for DSRIP Project performance. Board committees encompass all the critical functions – clinical governance, data integrity and ongoing information management, funds flow and compliance accountability in addition to expected governing functions involving executive, finance and nominating Committees.

As a fail-safe mechanism, CNYCC's co-leads (Corporate Members) assure the network functions and develops properly. Members also accept additional responsibility for CNYCC financing. Accordingly, the Members have reserved powers not for casual or arbitrary use but for additional assurance the PPS will develop as an effective integrated care model.

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.

The Board will have 22 Directors, balanced between Hospital Partners (11) and Community Partners (11). The Hospital Partners include the 4 hospital co-leads, and the Community Partners include 4 FQHCs. Other Community Partners elected from among licensed Providers (OMH, OPWDD, OASAS, SNF, Home Care, and Health Home) and County Health or County Mental Health Departments. There will be 3 at-large Directors among Community Partners (consideration given to primary care, behavioral health, peer supported organizations and others).

Each Director will cast one vote to exercise Board authority for control of CNYCC affairs, property and business, to adopt policies, and assure compliance with laws and regulations. Key votes require 2/3 supermajority. The Board will assure conformance with Bylaws and compliance with DSRIP program requirements.

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

Subject to Board approval, the Chair appoints a 9-member Nominating Committee. The Chair may not serve on the Nominating Committee. Represented on the Nominating Committee are Member and non-Member hospitals, plus Community Partners (at least 1 FQHC). The Nominating Committee must give consideration to geographic inclusiveness and assure Directors have necessary expertise. Nominees are expected to come from within the PAC.

The Board will approve a job description setting forth qualifications and responsibilities of Directors. The Nominating Committee identifies qualified nominees in balanced categories and puts forward a slate for Director positions for election by the Members. It also nominates Officers and Executive Committee members (except the Chair and Executive Director who are appointed by Members).

Members act to elect the slate. If the slate is not elected, Members appoint another Nominating Committee from among the Board of

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Directors, which nominates another slate for Member election. This process assures the Members elect Directors as nominated by Directors themselves. If there is disagreement, the process is iterative, fostering communication and facilitating resolution.

The Nominating Committee also recommends an orientation process for new Directors and Director education programs regarding CNYCC and the DSRIP Project Plan.

***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.

Balanced Board representation is essential for understanding, trust, and collaboration. The Board has 22 Directors to provide meaningful representation that takes into account provider, organizational, and regional representation. Board Committees are populated with PAC members.

There are 11 Hospital Partners and 11 Community Partners. Hospital Partners include the 4 Member hospitals. Community Partners include 4 Directors from FQHCs, 3 from non-hospital licensed providers, 3 at-large Directors, and 1 elected from a County Health or Mental Health Dept. Collaboration is enforced by 2/3 supermajority voting on project plans, budgets, and funds flow.

The full PAC meets quarterly. The PAC Steering Committee reports to the Board. The PAC Steering Committee is composed of leaders of four Regional PACs (R-PACs). The R-PACs meet monthly and are supported by CNYCC Projects Leaders to maintain communications, dashboards, and support.

***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 four co-leads have worked to be inclusive, identifying providers and organizations that provide meaningful services and supports within the region. CNYCC agreements will be executed with all Partners, outlining the responsibilities and benefits of partnership. This includes meaningful participation in Regional PACs (R-PACS), Project teams, etc.

CNYCC fully expects some non-Medicaid organizations will be integral to meet Project milestones, and CNYCC plans to develop participation agreements for necessary services, e.g. transportation. In the event Partner organizations reconsider their affiliation CNYCC (e.g., due to limited Project exposure, involvement in multiple PPSs), CNYCC would seek participation agreements to the extent their role is necessary for Project success. Contracting with non-Partner, participation-only organizations is expected during implementation planning, January-Mar 2015.

***Process 5:**

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

CNYCC governance is by the Board of Directors of the 501(c)(3) organization having 22 Directors equally divided between Hospital and Community Partners. Appointed by the Chair with Board concurrence, the Nominating Committee identifies a slate of nominees for election by Members (PPS co-leads). If the slate is not approved, there is an iterative process by which a new Nominating Committee is named to propose a new slate.

The Board is organized into Committees, chaired by Directors and populated with Directors and non-Directors (i.e., PAC members). The PAC itself will have a Steering Committee, reporting to the Board. Its Steering Committee will be comprised of the leaders of four Regional PACs (R-PACs) that meet monthly. Other Board Committees report on Project performance, budgets, quality, compliance, etc.

Each Director has one vote. A quorum is a majority of Committee or Board membership except for the Executive Committee (quorum is 2/3). Board decisions are by majority vote except for key issues (i.e., project plans, operating and capital budgets, and funds flow) that require a 2/3 supermajority vote.

CNYCC Members assure the PPS is funded, functions and develops properly. Accordingly, Members have reserved powers. Reserved powers are not for arbitrary use but to provide fail-safe assurance the PPS conforms to DSRIP requirements and develops as an effective integrated care model.

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***Process 6:**

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

CNYCC governance is by the Board of Directors, which addresses conflicts through a conflict of interest policy, governance process, corporate compliance, documentation, transparency, and adherence to NYS regulations on non-profits.

Bylaws determine quorums and supermajority rules. If not approved by the Board, a matter is reconsidered by Committee in an iterative process assuring disclosure, transparency, and engaged decision-making.

If Members (co-leads) do not elect a slate proposed by the Nominating Committee, a new Nominating Committee is formed and the process repeated until a slate is elected. This conflict process protects Member responsibilities, assures nominations arise within the Board, and satisfies both interests.

For conflicts among Partners or R-PACs, CNYCC will use direct engagement, facilitation, and Peer Support – an approach that worked successfully to resolve differences with FQHCs re: the governing structure.

***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.

Board meetings will be open to the public. Board and Committee work will be available to the PAC and Regional PACs. Minutes, work plans and budgets will be posted on CNYCC's interactive website. Public information will include Project Team reports, DOH communications, audit findings, minutes, and other pertinent documents. Board committees will include PAC members. The PAC itself reports directly to the Board. To foster communications and transparency, two Directors (one representing an FQHC) will be elected to attend Member meetings.

Board and Committee matters involving patient confidentiality or personnel matters are confidential. All Board and Committee work will conform to HIPPAA requirements for data security and patient confidentiality.

***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.

CNYCC has engaged stakeholders, including Medicaid members, during the DSRIP planning process, using interview, outreach, and small group formats. CNYCC will continue this process throughout DSRIP, including on-line and survey methodologies.

CNYCC Board and Committee meetings will be open to the public. CNYCC will host an interactive website, posting reports, minutes, and communications and inviting input via the website.

In connection with site visits and Work Team liaison, CNYCC will directly contact Medicaid members to identify issues, garner feedback, and document relevant input.

In addition, CNYCC will establish routine and ongoing liaison with FQHCs to identify issues, concerns and suggestions from Medicaid members, including from those serving on FQHCs' Boards of Directors.

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.

The CNYCC PAC membership totals ~ 1,600 providers and community organizations in six counties, representing a very diverse membership. The PAC was formed in two stages. An early stage involved 4 PACs under separate PPS leaders. Later (October 22) the

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co-leads formed CNYCC as a single PPS.

Early stage: Meetings with prospective Partners began in February. Receiving design grants, four PPS leads convened separate PACs, conducting well-attended meetings re: education, issues identification, CNA development and Project planning. Importantly, all four PPS leads had a common CNA vendor (JSI), assuring identical research to underpin Project selection. Independent PPS websites displayed interactive data and PAC meeting notes. PACs convened in multiple half-day and all-day sessions to review CNA findings, governance models, etc. St. Joseph's hosted 11 PAC calls and 4 regional meetings; Upstate hosted 5 PAC meetings and 10 sub-committee meetings; Auburn hosted 5 PAC meetings; and Faxton St. Luke's hosted 12 PAC meetings.

Late stage: The four co-leads formed a single PPS in October. Through meetings with KPMG (October 8, 10, 16), the co-leads reviewed and discussed heretofore separate Projects. On October 28 the co-leads agreed to Project selection criteria. On October 30, the PAC met in-person and via webinar to review and determine Project selection. PAC representatives formed 11 Project Work Teams to prepare the DSRIP application. Weekly teleconference meetings of the combined PAC began in November, and an interactive website posted draft Project plans, Bylaws, and funds flow model for feedback. The co-leaders coordinated PAC-member Work Teams for business planning, funds flow, and HIT/ HIE, posting results on the website.

***Committee 2:**

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

CNYCC Partners total ~ 1,600 providers and community organizations in six counties. CNYCC will communicate regularly with PAC members through an interactive website. This has the ability to communicate broadly across the network and to receive input directly from literally hundreds of PAC members. The website will post minutes, work plans and budgets, along with Project reports, DOH communications, audit findings, and other documents.

Because the PAC is so large, there are four Regional PACs. Each will hold monthly meetings with Project Leaders to review Projects, Partner performance, and regional scorecards.

R-PAC leaders form the steering committee for the entire PAC, which will meet quarterly. The PAC will report directly to the Board of Directors. The PAC will also serve as the source for nominees to the Board of Directors. In addition, PAC representatives will populate Board Committees.

***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).

With a large geography and a mix of rural and urban members, CNYCC's diversity required on-going efforts to identify and engage Provider and Community Partners, representing a diversity of employees, unions, and professions.

Before joining as a single PPS, the four then-separate leads engaged a single CNA vendor (JSI), assuring they reviewed and discussed the same data on community needs. The combined PAC was prepared to select DSRIP Projects, once CNYCC was formed by four previously separate PPS leaders (October 22). Project selection criteria were vetted with the PAC (October 28), and the PAC selected Projects in a half-day meeting (October 30).

PAC input has been fundamental in developing governing principles, e.g., balanced Board categories and 2/3 supermajority voting on plans, budgets, and funds flow. With PAC input, CNYCC identified Regional PACS (R-PACs) as the structure that best assures regional balance and local collaboration.

***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.

PAC membership is robust and representative of the diversity of the six-county region. There is regional representation that reflects the rural and urban settings. Members represent primary care, behavioral health, community-based, and peer-support organizations such as transportation and housing. Membership includes hospitals, OMH-licensed, OPWDD-licensed, and OASAS-licensed providers; Skilled Nursing Facilities, Home Care agencies, and Health Homes to name a few. In addition, the health care workforce is represented including

union membership.

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.

Corporate compliance will be consistent with regulatory requirements and best practices. CNYCC will rely on guidance from OMIG/ OIG for written policies, management responsibilities, and Board oversight to include, at minimum:
- Written policies and procedures, including a Code of Conduct/ Ethical Principles
- A designated Corporate Compliance Officer (CCO) who makes periodic reports to the Board
- Training and education for PPS board and staff
- Policies on communications, surveillance, and disciplinary practices
- Identification of compliance risk areas/ areas of non-compliance
- Timely and documented response to compliance issues
- A whistleblower policy
- Anonymous and confidential reporting
- A policy on non-intimidation/ non-retaliation

The CCO job description will be drafted, pending Board approval. Recruitment begins in January 2015 with hiring expected in March 2015.

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

CNYCC will designate a Corporate Compliance Officer (CCO), reporting to the Executive Director and providing information directly to the Corporate Compliance Committee (CCC) and to the full Board of Directors.

The CCC is responsible for reviewing the annual compliance work plan and outcomes.

Board approval is required for the Compliance Plan consistent with OMIG/ OIG guidelines. The CCO reviews the plan annually with any changes subject to Board approval. The CCO keeps the Board apprised of compliance issues, including the written annual report.

The CCO is responsible for training and education; investigations and audits; and exclusion reviews. The CCO publicizes an anonymous and confidential hotline for concerns or complaints; establishes whistleblower policies; cooperates with external and internal investigations; and fosters an environment of non-retaliation and non-intimidation.

The CCO has authority to address issues involving the PPS, its Partners, stakeholders, etc., bringing such issues to the attention of responsible parties and supporting their appropriate resolution.

***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.

CNYCC is being formed as a legal entity, and its training programs are to be developed during the implementation period. The CNYCC Corporate Compliance Officer (CCO) will be responsible for training and education, which will encourage ethical and professional behavior and provide an understanding of applicable laws and policies.

Education and training include, but not be limited to:

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- The definition of compliance
- Examples of non-compliance
- Healthcare fraud
- Waste and abuse
- Laws pertinent to federal and state claim violations
- Board and employee responsibilities pertaining to compliance
- Reporting processes for known or suspected compliance issues, including anonymous reports and use of a 24-hour hotline
- Policy of non-retaliation and non-intimidation for good faith reporting
- Whistleblower protection
- Information on how to on access the CCO

***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.

CNYCC's Corporate Compliance Officer (CCO) will publicize information about the compliance function and ways to report concerns or possible violations, anonymously if wished, with assurance there will be no reprisals and no intimidation. This information will include the CCO's name, address, telephone, e-mail, and hot line access number. CNYCC Partners will be directed to display the information prominently in ways accessible to Medicaid members and the low-income uninsured population. In addition, CNYCC's interactive website will include this same information.

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.

Members (co-leads) are responsible for financing the CNYCC start-up. Members have reserved powers as a safeguard for proper PPS function and development. CNYCC's business plan will be approved by the Board of Directors. Project plans, capital and operating budgets and funds flow decisions require a 2/3 Board supermajority. Board Finance Committee responsibilities include CNYCC financial policies and practices, monthly financial operations and variance reports, audited financials consistent with GAAP, risk mitigation strategies, and oversight of internal controls. The CNYCC financial environment will include separation of duties and other controls, error prevention and detection strategies, and compliance education. CNYCC will operate in accord with NYS non-profit governance regulations and demonstrate sound management practices, including normative behavior (e.g., honest communications, example-setting, respect for process, ethical work culture). Management will implement systems with assigned responsibilities; will investigate, document and report discrepancies; and will identify areas for improvement by regular surveillance.

***Organization 2:**

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

CNYCC is a public hospital PPS. Upstate University Hospital is the financial lead with responsibilities to manage IGT transactions and provide PPS funding.

The BOD will have a Finance Committee (FC) for oversight of financial performance, audit, and funds flow.

CNYCC will employ a Director of Finance (DF) as the key financial executive who reports to the ED. The DF serves as the principal staff for the FC. The DF is responsible for financial functions, internal controls, policies, variance reporting, error prevention, and detection strategies with FC oversight.

The FC recommends to the BOD annual capital, operating and cash flow budgets, and will monitor monthly income and expenses, balance sheet and cash positions, identifying areas of interest or concern for Board attention. The FC works with the Corporate Compliance Officer in conjunction with policies, surveillance, and enforcement.

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The FC recommends to the BOD funds flow distribution. The FC monitors the process by which CNYCC develops as a network for value based payment post-DSRIP.

The FC assures CNYCC operates within requirements of NYS' regulations, including executive compensation requirements.

***Organization 3:**

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

The Finance Committee (FC) will obtain the services of an independent auditor to prepare annual financial presentations consistent with Generally Accepted Accounting Principles (GAAP).

The FC will assure that CNYCC meets requirements for NYS' Social Services Law 363-d with the Corporate Compliance Officer (CCO) making reports directly to the FC. The FC will review the CCO's annual work plan and outcomes.

The Director of Finance (DF) is responsible for performing all financial functions, internal controls, policies and practices, variance reporting, error prevention and detection strategies, and adherence to compliance policies – all subject to FC oversight.

***Organization 4:**

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

CNYCC's policy on corporate compliance will conform to Social Services Law 363-d, including but not limited to:
- Corporate Compliance Officer's (CCO) reporting directly to the Executive Director.
- Compliance policies and procedures in writing and available to all on CNYCC website.
- Written policies on ethics and professional behavior, compliance training and education for Board, management, employees, Partner Organizations and vendors; investigation and resolutions, including remedial actions, systems improvements, self-reporting; non-retaliation and non-intimidation for good faith participation and reporting; and disciplinary action for participating in or facilitating non-compliant behavior, or for failure to report issues.
- CCO makes reports to the Board of Directors.
- Any Director, employee, Partner, or vendor has direct access to CCO.
- Compliance risk areas identified routinely for self-evaluation and internal auditing.
- CCO response system for identified issues and complaints .
- Processes for investigating, correcting, self-reporting, and improving compliance systems.

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.

CNYCC governance will monitor and control the network's performance through professionally staffed operating structure, accountable to a representative Board of Directors and working with Regional PACs (R-PACs).

Project Management Operations will involve Project and performance improvement professionals, systems support managers, and Project Leaders working directly with Partners and R-PACs. The Medical Director and Performance Improvement Director, relying upon CNYCC analytics, will track DSRIP Project performance monthly, developing scorecards for Partners, Projects, R-PACS and the Board. They will identify issues and recommend solutions.

Monthly reports will identify Project and financial performance, including variance reporting, areas of success and areas needing improvement. Board Committees will monitor performance of Partners, Projects, and R-PACs to identify performance problems for Project Management Operations and Board.

***Oversight 2:**

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

CNYCC operations will identify any Project that fails to meet performance targets using a monthly reporting process. "Unacceptable" performance will be defined, e.g., a single variation of significant magnitude or a persistent or progressive series of variations.

Utilizing rapid cycle evaluation, CNYCC staff and the Project Leaders will identify systems or Partner issues for focused attention, using resources from the affected Partner, from CNYCC, and/ or from Partners providing Peer Support. The nature of the variation and its impact on Project performance will determine the magnitude of resources and the urgency of remedial actions.

***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.

The Board will approve and enforce a written policy for addressing the management and, as necessary, sanctioning of a poor performing Partner Organization. Progressive sanctions will be determined by the Executive Committee for a Partner with repeated or egregious failure to cooperate with PPS policies or Project implementation.

Sanctions will be implemented only after a Partner Organization has been engaged by CNYCC leadership. Such engagement may involve analysis, education, Peer Support, and subject to Board approval, the expenditure of funds to assist Partner performance improvement. Poor performing Partners will be required to submit performance improvement plans acceptable to the Executive Committee.

Given repeated or egregious failure by a Partner Organization, sanctions may be recommended by the Board Committee (Clinical, Compliance, IT/ Data, or Finance, as appropriate). The Executive Committee will consider the Committee recommendations and make a final determination.

Consistent with the sanctions process, CYNCC may consult DOH in specific circumstances with potentially significant impact on continuity of care for Medicaid beneficiaries, impairment of PPS performance, or patient safety

***Oversight 4:**

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

CNYCC will publicize information about DSRIP Projects and the Partners on its interactive website. This information will invite feedback and suggestions regarding Providers, whether laudatory or critical. Anonymous feedback will be easily collected via the website.

CNYCC will publicize its anonymous hotline by which an individual may raise concerns or complaints without fear of reprisal.

CNYCC will establish routine and ongoing liaison with FQHCs to identify issues, concerns and suggestions from Medicaid members, including those who serve on FQHC Boards of Directors.

The stakeholder engagement process will be ongoing with information regarding individual providers reported through the Performance Improvement process.

Regional PACs (R-PACs) will be open to Medicaid beneficiaries and advocates, and notice will appear on CNYCC's website.

***Oversight 5:**

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

If a Provider is removed from the network, notification of removal will be posted on the CNYCC's interactive website.

CNYCC will announce the removal of a Partner by a poster to be displayed for Medicaid beneficiaries and advocates in the locations of CNYCC Partners in the geographic area (R-PAC) of the removed Provider.

Other notices, both written and verbal, will be made to all CNYCC Partners and PAC Members.

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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.

JSI was hired to conduct the CNA. A steering committee met periodically to: 1) facilitate information flow to the R-PACs and governing body, 2) ensure a comprehensive, efficient, and responsive CNA, and 3) identify priorities, service gaps, and other key findings.

Quantitative and qualitative data was collected from primary and secondary sources. Quantitative data was collected from federal, state, and local sources and organized by DSRIP Domain. County-and sub-county level data was collected longitudinally and mapped using GIS software to identify geographic "hotspots" and trends overtime. Upstate and NYS data was collected to facilitate comparative analysis and to identify health disparities. Health and community resource inventories were developed to assess capacity and to identify assets and potential partners. A range of qualitative information was gathered from internet searches, interviews, focus groups, and community meetings to inform an understanding of the community context, underlying determinants of health, service gaps, consumer care seeking behaviors, and barriers to care.

EMA was contracted with to conduct stakeholder engagement activities. In total JSI and EMA conducted 98 interviews across the service area with service providers and other stakeholders spanning the full continuum of care as well as consumers of services. Also, 28 consumer focus groups with 202 participants and over 26 community meetings were conducted with over 1000 participants.

Detailed county-level reports were made available to stakeholders and used to engage the community. Information was presented to the RPACs to vet findings and obtain important feedback. The CNA Steering Committee held a retreat near the culmination of the CNA to identify leading needs, health priorities, service gaps, hotspots, and challenges that were applied to inform project/partner selection and DSRIP planning. A final written report was developed to report the CNA's results.

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

Quantitative data was collected from public sources through federal/state portals. Data was also collected from local sources through provider/consumer surveys and inventories. Sources included:
Federal:
- Census Bureau
- CDC
- Bureau of Primary Health Care
- SAMHSA

NYS:

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- Vital Statistics
- E-BRFSS
- County Prevention Agenda Data
- SPARCS
- Medicaid Data
- County Health Assessment Indicators
- Medicaid Beneficiaries Chronic Disease Admissions/ER Visit Reports
- Medicaid DSRIP Dashboards
- Adult/Pediatric Prevention Quality Indicators
- Potentially Preventable ER Visits

Regional/Local:
- Resource Inventories: A provider survey was conducted capturing information from 1656 health/community service providers on service scope, capacity and population served.
- Consumer survey: A consumer survey was conducted capturing information from 571 low income residents on healthcare access, barriers to care, and quality.

Qualitative information on community need, access to care, service gaps/barriers, causes of inappropriate utilization, and quality was captured from consumers/residents and other organizational stakeholders through:
-98 interviews with service providers and other stakeholders spanning the full continuum of care as well as consumers of services.
-26 community meetings with over 1000 stakeholders including health/social/community service providers, public health officials, community advocates, and other programmatic stakeholders.
- 28 focus groups with residents/consumers from the low income target population with 202 participants.

Information from already published assessments was also compiled, including:
- County Health Department and Hospital Community Needs/Benefit Assessments
- Central NY Primary Care Safety Net Assessment. JSI with funding from the Health Foundation of Western and Central NY, conducted a primary care safety net assessment in 2013/14, which assessed the strength/capacity of the regions primary care system.

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	11	11
2	Ambulatory surgical centers	13	13
3	Urgent care centers	18	18
4	Health Homes	10	10
5	Federally qualified health centers	6	5
6	Primary care providers including private, clinics, hospital based including residency programs	738	722
7	Specialty medical providers including private, clinics, hospital based including residency programs	1538	1422

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
8	Dental providers including public and private	551	266
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	98	96
10	Behavioral health resources (including future 1915i providers)	280	276
11	Specialty medical programs such as eating disorders program, autism spectrum early	8	8
12	diagnosis/early intervention	6	6
13	Skilled nursing homes, assisted living facilities	45	43
14	Home care services	18	18
15	Laboratory and radiology services including home care and community access	113	111
16	Specialty developmental disability services	65	60
17	Specialty services providers such as vision care and DME	243	242
18	Pharmacies	847	822
19	Local Health Departments	6	5
20	Managed care organizations	3	2
21	Foster Children Agencies	10	10
22	Area Health Education Centers (AHECs)	2	2

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

***Infrastructure 2:**

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

Hospitals: Hospitals in the region have a 2,640 bed capacity, which translates to 2.5 beds/1,000 residents, compared to 2.6 beds statewide. County rates range from 3.4 to 1.1. Regionally, the occupancy rate is 67.3% compared to 68.5% statewide. County rates range from 76.9% to 40.3%. Quantitative and qualitative data suggests that regionally there is a slight overcapacity in beds but the rates are consistent with state rates. CNYCC partners must take action to reduce bed capacity overtime in thoughtful and proactive ways in response to reductions in inappropriate utilization.

Outpatient Primary Care: It is estimated that a core network of primary care (PC) practices provide quality, PCMH service to ~30% of the low income target population. The remaining ~ 70% of the target population either does not have access to PC services or faces major barriers to quality care. Roughly 50% of the target population receives intermittent, poorly coordinated services from the Hospital ER or a large amorphous network of PC practices that do not serve the target population and are of questionable quality. Approximately 15% of the target population receives no PC services. Hotspotting shows that shortages are more extreme in rural areas. CNYCC partners must strengthen capacity of the core PC network and the adoption of PCMH principles. CNYCC must also broaden the pool of private, PCMH-certified providers that serve the target population and work with hospitals to ensure proper follow-up and engagement after ER/inpatient discharge.

Behavioral Health: Behavioral Health services are well distributed throughout the region but there are major shortages for all segments of those in need, particularly for substance abusers and the mentally ill. Screening services also need to be enhanced. CNYCC partners must take broad steps to expand and strengthen capacity at all levels, particularly at the outpatient level by integrating behavioral health and PC services, improving services for those in crisis, and building overall behavioral health infrastructure.

Post-Acute: 45 nursing homes operate in the service and have a capacity of 7,279 beds. But beds are not well distributed in the region. DSRIP project activities will create new demand for post-acute services, which will require operational changes and additional capacity as patients shift from hospitals to less intensive settings. CNYCC partners must take immediate action to ensure that its operations are responsive to this need and make incremental increases in capacity overtime.

Care Management: Medicaid Health Homes and a network other service providers who serve the chronically ill provide the bulk of care management services along. Quantitative and qualitative data suggests there are current and future shortages of care management

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services as DSRIP initiatives expand outreach and engagement efforts to prevent inappropriate utilization. CNYCC must take immediate steps to build this capacity.

Section 3.3 - Community Resources Supporting PPS Approach:

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

***Resources 1:**
Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Resource Types.

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	106	100
2	Food banks, community gardens, farmer's markets	186	172
3	Clothing, furniture banks	43	42
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	30	30
5	Community outreach agencies	148	146
6	Transportation services	45	2
7	Religious service organizations	850	80
8	Not for profit health and welfare agencies	546	400
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	106	25
10	Peer and Family Mental Health Advocacy Organizations	11	11
11	Self-advocacy and family support organizations and programs for individuals with disabilities	15	13
12	Youth development programs	65	63
13	Libraries with open access computers	76	0
14	Community service organizations	675	400
15	Education	23	0
16	Local public health programs	6	5
17	Local governmental social service programs	6	1
18	Community based health education programs including for health professions/students	220	201
19	Family Support and training	41	41
20	NAMI	3	0
21	Individual Employment Support Services	43	41
22	Peer Supports (Recovery Coaches)	21	18
23	Alternatives to Incarceration	9	5
24	Ryan White Programs	1	1
25	HIV Prevention/Outreach and Social Service Programs	20	18

***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.

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Local Public Health/Social Service (#s 16-17): These agencies are anchors in the community and are critical assets, particularly for low income residents. No modifications are necessary but considerable efforts should be made to include them and ensure that all of the functions listed above are tapped to the full extent possible.

Individual, family, and peer support programs, including social service, health/welfare, and clothing/furniture banks (#s 3, 8, 10, 11, 19-21): A key theme from the CNA's qualitative findings was the impact of poverty, unemployment, and cost barriers. Most participants cited the need to strengthen welfare, social service, and other support programs that help to ensure that basic needs are met. Efforts need to be made to strengthen these organizations as well as include these organizations with respect to DSRIP outreach.

Services and supports for children/adults with special needs, developmental disabilities, behavioral health, physical, emotional, or other disabilities (#s 4, 9,10, 11, 22-25): A key theme from the CNA's qualitative findings was the needs and barriers experienced by those with special needs, disabilities, or who are otherwise vulnerable. While there are no absolute gaps in these areas, efforts need to made to expand/strengthen capacity, particularly for those with disabilities and behavioral health issues.

Food banks, community gardens, farmers markets, youth development, and community health education (#s 2, 12, 18): According to the CNA, there are shortages of these resources. Given the burden of chronic disease, CNYCC needs to expand service capacity and the involvement of programs that promote healthy eating/active living and that conduct health education in these areas.

Transportation (#6): Lack of transportation, particularly in more rural areas, was a major theme from the CNA's qualitative findings. Transportation shortages impact patients' ability to get to appointments and follow care plans as well the workforce's ability to get to work. CNYCC must promote efforts that address transportation barriers either directly within project plans or indirectly as part of broader PCMH strategies.

Housing (#1): A key finding from the CNA's qualitative findings was the need for housing supports and care management programs designed specifically for those who are homeless or who live in unstable housing situations. These programs target the high utilizing cohort and are help to ensure that stable housing is an integral part of their care transition plans. CNYCC needs to explore how its projects can integrate housing supports.

Religious, community service, outreach organizations and libraries (#s 5, 7, 13, 14): There are no absolute gaps in these resources but CNYCC should ensure that these organizations are integrally involved to identify, educate, and engage those who are chronically ill or otherwise at-risk in appropriate care.

Education (#15): Institutions of higher education are critical assets with respect to workforce development. No absolute gaps exist but efforts need to be made to promote their involvement in training and re-training the current health and community service workforce.

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 service area is a mix of urban, quasi-urban, and rural areas with a total population of 1,002,605. There is dramatic variation in population density at the county level, ranging from 21/sq. mi to 599/sq. mi; most of the counties fall well below the Upstate NY rate (239 people/sq. mi). Lewis County is extremely rural with a population of 27,062. Onondaga County is more urbanized with a population of 466,179. The population distribution by age is skewed towards older adults, as younger segments have left the area, typically in search of better employment. Oneida and Cayuga have the highest proportion of older adults (65+) (16.3% and 15.5% respectively). Three of the counties (Onondaga, Lewis, and Oswego) have larger under 18 populations compared to Upstate NY. With respect to gender, the distribution mirrors the State distribution. However, data from the Bureau of Primary Health Care shows that men are less engaged in PC care but have higher rates of chronic conditions.

***Demographics 2:**

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

Regionally, the population is predominantly White (88.4%); in 4 of 6 counties Whites comprise more than 90% of the population. But this has been changing. Between 2000 and 2010, there were major increases by race/ethnicity, particularly in Syracuse and Utica. In 2000, 64% in Syracuse and 79% of the population in Utica reported as White. By 2010, the % of the population that reported as White declined to 56% in Syracuse and 69% in Utica. The fastest growing segment during this time was the Hispanic/Latino segment. There are also large and growing immigrant/refugee populations in Syracuse and Utica who struggle with access, health literacy, and language. Regionally, 5.3% of residents are foreign-born; Syracuse and Utica have the highest proportions at 11.1% and 17.6% respectively. The largest immigrant/refugee populations are from Bosnia, Somalia, Thailand, Burma, Central America, and Iraq. These individuals face major language and cultural barriers that hinder access to care.

***Demographics 3:**

Income levels:

The average median household income for the service area is $51,254, and the figures ranges from $53,593 in Onondaga County to $45,187 in Lewis County. Regionally, the low-income population (i.e. < 200% FPL) comprises 31.6% of the total population. Throughout the region, the county averages for people living below 200% FPL range from 28.9% in Madison to 36.3% in Oswego. Incomes are lowest in urban and very rural areas and highest in quasi-urban and suburban areas. The highest numbers and highest density of those living in low income households are in Syracuse, Utica, Oswego, and Auburn. The cities of Syracuse and Utica have the lowest median household incomes at $31,459 and $31,408 respectively and in a number of the most urbanized neighborhoods, the low income population comprises more than 70% of the population.

***Demographics 4:**

Poverty levels:

Living in poverty or in a low-income household is one of the leading factors associated with vulnerability, as those who are in these income brackets face economic barriers to care and tend to have stress in their individual or family lives that limit access to care. In the six-county CNY region, the low-income population (i.e. those living below 200% of the federal poverty level) comprised 31.6% of the total population using a 5-year estimate from 2008-2012. Looking specifically at rates of poverty, once again Syracuse and Utica stand out at 33.6% and 30.1% respectively, compared to the regional rate of 14.8%.

***Demographics 5:**

Disability levels:

In 2013, 2.9% (29,116 residents) of the region's population received Supplemental Security Income due to being blind or disabled, which mirrored the state percentage. Onondaga had the largest number of residents who were blind or disabled (13,710) but Oneida County had the highest proportion (3.5%) as a percentage of total population. The percent of Medicaid recipients who are dually eligible was higher than the state in all of the counties in the region. Lewis, Oneida, and Madison Counties had the highest percentages (19.6%, 18.0%, and 17.7% respectively). The dually eligible population is split between seniors on Medicare who have long term care support through Medicaid and persons with developmental and other disabilities. According to CNA qualitative findings, those with developmental disabilities or disabilities due to mental illness are particularly at-risk as they lack access to needed services and social supports, such as primary and specialty care, housing and transportation.

***Demographics 6:**

Education levels:

In 2012, approximately 11.9% of the region's population had less than a high school diploma compared to 11.1% for Upstate NY and 15.1% for the State overall. Four of the 6 counties had lower proportions of the total population with less than a high school diploma. The percentages for Syracuse and Utica were nearly double the Upstate and NYS percentages, 19.6% and 21.0% respectively. The percentage of the population with a college education or more, was considerably lower than the state percentage of 33.2% across all 6 of the region's counties. Percentages ranged from 13.6% in Lewis to 33.1% in Onondaga and the regional average was 26.5%. Limited health literacy, both not being aware of what services are available as well as not understanding how to utilize them were identified as contributors to unnecessary ED visits and higher in-patient rates. These problems are exacerbated for immigrant populations as they face the added burden of language and cultural barriers.

***Demographics 7:**

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Employment levels:

In 2013, approximately 7.6% of the region's population was unemployed compared to 7.7% for Upstate NY. Four of the 6 counties had equal or higher rates of unemployment than the Upstate average. The unemployment rates for Syracuse and Utica were 40% higher than the Upstate rate, 11.4% and 12.7% respectively. Unemployment and lack of high wage jobs is one of the leading barriers to access. As manufacturing has left the area over the past years the service industry has become the dominant sector. This transformation has meant an increase in part time and low wage work as well as a decrease in employer-based insurance. A major theme from the qualitative findings was high rates of poverty, lack of employment, and lack of transportation and affordable housing. Limited health literacy, which is associated with educational attainment, was identified as a contributor to inappropriate hospital utilization. These problems are worse for immigrants as they face language/cultural barriers.

***Demographics 8:**

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

In 2012, there were approximately 3,707 inmates incarcerated within the region's prisons. There were an additional approximately 1,975 inmates incarcerated in County jails in the region for a total of 5,682 incarcerated people. In the region there were also 45 nursing home institutions with approximately 6,435 beds and 59 residential mental health facilities with approximately 3,000 beds.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
8_SEC034_3.b.i Question 4c.docx	12/20/2014 09:19:51 AM	3.b.i Question 4c
8_SEC034_CNYCC Stakeholder Engagement Report.pdf	12/18/2014 02:01:18 PM	CNYCC Stakeholder Engagement Report
8_SEC034_CNYCC Data Analysis Summary Memo.pdf	12/18/2014 02:00:03 PM	CNYCC Data Analysis Summary

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:

Heart disease, cancer, respiratory disease, and stroke are the leading causes of death in the CNYCC service area overall. By race/ethnicity there is considerable variation. For Whites, Blacks, and Hispanics the two leading causes mirror the overall population but there is variation in the 3rd, 4th, and 5th leading causes. These slots include respiratory disease, unintentional injury, pneumonia, and diabetes in various sequences. Most notably diabetes is the third largest cause of death for African Americans/Blacks. The leading causes of premature death are similar to those of mortality overall. The first and second leading causes of premature death in the region are cancer and heart disease. Unintentional injuries, respiratory disease, and diabetes are ranked respectively. Data by race/ethnicity is not available. On a county basis, cancer and heart disease are the leading cause of premature death across all counties, but there is variation with respect to the 3rd, 4th, and 5th causes. Unintentional injuries, respiratory disease, diabetes, and suicide factor in. Except in a few cases the rates of these conditions across all 6 counties are higher than the Upstate rate.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

NYS' Medicaid Chronic Health Conditions, Inpatient/ED Utilization dataset was used to identify the most significant drivers of hospital use. This data corroborates findings from BRFSS that shows the major impact of chronic medical/behavioral health issues. Depression and hypertension were at the root of most admissions followed by diabetes, asthma, and drug abuse. In 2012, 13% of beneficiaries (30,885) in the region were categorized with hypertension, 12% (30,413) with depression, 7% with diabetes (15,732), 6% with asthma (14,517), and 5% with drug abuse (11,943). These diagnoses accounted for a total of 66,381 hospital admissions. The remaining causes of admission

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were a mix of chronic medical and behavioral health conditions. A review of ED data led to similar conclusions. Depression and hypertension were at the root of most ED visits. The remaining causes were a mix of chronic medical and behavioral conditions. The top 5 most prevalent conditions seen in the ED accounted for 166,155 ER visits. It is important to note that the data shows that behavioral health issues are more widely diagnosed than chronic medical conditions.

***Challenges 3:**

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

To assess inappropriate hospital inpatient and emergency department utilization, PQI, PDI, and PPV data was analyzed. A review of the region's PQI data shows four of the six counties have higher rates of PQI conditions than the NYS average. County data ranges from 2,267 admissions per 100,000 for Oneida County to 1,651 admissions per 100,000 in Lewis. The State average is 1,784. Further the rates are disproportionately higher in the more rural areas, although there are relatively high rates in pockets throughout the region. A review of the region's PDI data does not lead to the same conclusions. With respect to the PDIs, the county rates are generally lower than the statewide average, with only 1 of the 6 counties having higher rates. Finally, a review of the region's PPV data shows a dramatic overutilization of the emergency department particular in the more rural areas. With respect to PPV rates, 5 or the 6 counties have rates that are higher than the State average.

***Challenges 4:**

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

With respect to the prevalence of the leading chronic medical conditions (e.g., diabetes, asthma, heart disease, and hypertension), data shows that the rates among adults in the service area are higher than for adults statewide. This is particularly true in Cayuga and Oswego, which had higher rates than the state across all four of these medical conditions. The State's E-BRFSS data also shows the impact of behavioral health (e.g., depression and alcohol abuse). The county rates for these conditions are considerably higher than the State and Upstate averages. The rates are particularly high in Cayuga, Oneida, Onondaga, and Oswego. The prevalence of these conditions indicates that need for greater outreach, health education, primary care engagement and care management efforts across the region. HIV/AIDS and other sexually transmitted diseases are a major community health issue in Syracuse and Utica, which have the highest rates in the region. However, rates across the region are generally lower. Consideration was given to selecting the HIV/AIDS project but given that it was not widespread regional issue, CNYCC opted to prioritize other issues.

***Challenges 5:**

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

The indicators with respect to the leading maternal and child health issues (e.g., infant mortality, prenatal care, adolescent births, and low birth weight) are generally better throughout the CNYCC service area with the exception of Oneida and Cayuga Counties. In Oneida County in 2012, 13.1% of all births were preterm, compared to a state percentage 10.8%. The percent of preterm births for African Americans/Blacks was 75% higher than White, non-Hispanic populations and for Hispanics it was 45% higher. This strong data throughout much of the region obscures the reality that many residents face difficulties in accessing care. Prenatal care services are located mainly in the population centers. Several "outpost" clinics in the far rural areas have closed due to finances and there are few private providers in these areas. The State PCAP (Prenatal Care Assistance Program) provides support to fill the gaps in Medicaid coverage; however, some of the county prenatal clinics that were a part of the program have closed. These clinics are particularly important for teens who are pregnant.

***Challenges 6:**

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

The percentage of adults in the service area that are overweight/obese range of from 56% to 68%, and 4 of the 6 counties in the service area have higher percentages than the Upstate average (60%). These findings are consistent with respect to current smokers, heavy drinkers (alcohol), those who do not eat appropriate quantities of fruits/vegetables, and those who do not get enough physical activity. Across the board, adults in the service area fare worse than adults in the Upstate region on these risk factors. When looking at these risk factors, African Americans and Hispanics fare worse than their non-Hispanic, White counterparts. Qualitative information from the assessment interviews, focus groups, and meetings corroborates these findings as nearly all those involved cited obesity, poor nutrition, lack of physical exercise, and alcohol abuse as leading health issues. These issues are the leading risk factors associated with the major chronic medical/behavioral health condition, which further reinforces the need for need for community outreach, awareness, primary care

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engagement, and health education efforts related to good lifestyle choices and healthy eating/active living.

***Challenges 7:**
Any other challenges:

Not applicable

Section 3.6 – Healthcare Provider and Community Resources Identified Gaps:

Description:
Please describe the PPS' capacity compared to community needs, in the response please address the following.

***Gaps 1:**
Identify the health and behavioral health service gaps and/or excess capacity that exist in the community, **specifically outlining excess hospital and nursing home beds**.

Shortages of Primary Care Medical and Behavioral Health Services: Ambulatory care services, especially primary care and behavioral health services, must be strengthened and capacity expanded in order to address high rates of chronic disease, improve overall health status, increase quality, and reduce costs, including the cost of inappropriate hospital utilization. The CNA identified very high rates of chronic conditions and preventable hospital inpatient (PQIs) and emergency department (PPVs) utilization when compared to Upstate NY and NYS averages. These rates were particularly high and pervasive in the more rural areas in the northern and eastern portion of the CNYCC service area. Key informant interviews also consistently highlighted shortages in primary medical and behavioral health as two of the leading health care challenges, particularly in more rural areas. Interviewees also highlighted the need for strengthening operations with respect to PCMH, care coordination, services integration, care management, and the use of evidence-based practice. Key informant interviewees and meeting participants went on to say that these gaps are largely due to a shortage of PCMH providers and perhaps more importantly providers who are committed to serving Medicaid insured and uninsured segments of the population on a regular basis. There is a need to promote PCMH, care management, improved communication, and stronger partner engagement across the region.

It is important to note that the CNA has not identified a shortage of hospital or nursing home service capacity. With respect to hospital bed capacity, occupancy rates mirror the states. Efforts will need to be made starting in year 1 to respond to decreases in bed capacity due to reductions in inappropriate utilization but for now capacity seems to be appropriate. With respect to post-acute, nursing home capacity, a slight shortage is predicted in the next year or two but this shortage could increase as patients move from the hospital setting to less intensive, post-acute settings as a result of DSRIP efforts.

The high rates of morbidity and mortality, particularly with respect to chronic medical and behavioral health conditions, highlight the need for more intense chronic disease management activities, particularly in the areas of heart disease, hypertension, diabetes, depression, and anxiety/stress. It is also critical to incorporate efforts that address the underlying risk factors for these conditions, such as obesity, poor nutrition, lack of fitness/activity, tobacco use, and alcohol abuse.

***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.

High prevalence rates for chronic medical and behavioral health conditions along with high PQI and PPV rates: Low income populations throughout the service area struggle with chronic medical / behavioral health conditions and have high rates of inappropriate hospital use, which underscores the need to: 1) Strengthen / expand access to quality primary care services, 2) Promote patient-centered medical home principles in new and existing practices, 3) Strengthen primary care operational capacity (e.g., reduction of no-show rates, improved patient flow, streamlined referral/follow-up systems, etc.), 4) Promote integrated primary care / behavioral health service models, 5) Develop ED diversion programs, and 6) Develop palliative care programs that identify those at-risk of becoming super-utilizers.

Approximately 35% of the region's low income population either use hospital EDs for primary care or do not access regular primary care: The lack of appropriate primary care engagement, particularly for people with chronic illness or risk factors, highlights the need for health

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education, outreach, and primary care engagement efforts to reduce the number of low income residents in the service area who use hospital emergency departments for their usual source of primary are or who do not access regular primary care services.

Major theme across qualitative data findings was the lack of coordination of care and the fragmentation of services, particularly after discharge from the hospital: Most practice sites lack the time, resources, and understanding to train providers to fully use their medical record systems to identify those at-risk, manage follow-up, communicate with other providers, and coordinate care.

Need for primary care provider recruitment and retention efforts, especially in rural areas: Primary care provider recruitment and retention efforts will be essential if CNYCC is to expand, stabilize and strengthen the primary care capacity. These efforts require a regional approach drawing on regional, state and national workforce agencies. These agencies have endowed pools of funds to support signing bonuses, provided technical assistance with respect to benefit package design and recruitment, and have developed community forums to share information regarding identified candidates.

***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.

Evidenced-based Care Management, Coordination, and Transition Initiatives: Care management (CM) and care coordination activities focused on those with emerging or already complex chronic conditions are critical to addressing DSRIP goals. The most significant contributors to poor health status and inappropriate utilization are lack of: outpatient and CM capacity; evidenced-based care; early detection; coordination, and effective transitional services. In order to address these issues, CNYCC plans to promote population health management strategies across sectors, specifically aimed at identifying current and future high utilizers, screening for BH, promoting PC engagement, and linking those at-risk to evidence-based care. The CNYCC also plans to expand/strengthen its PC and BH networks by developing new capacity in FQHC, hospital, community clinics, and private practice settings; promoting PCMH, and integrating BH/specialty care within PC. Additionally, CNYCC plans to ensure smooth transitions from hospital settings by embedding CM, navigators, and BH specialists in inpatient and ER settings. Finally, CNYCC will promote coordination and appropriate follow-up across community settings (e.g., post-acute, PC, home, BH, and specialty care). A robust HIT infrastructure that promotes proactive CM and information exchange is integral to all of these activities.

Enhance transportation and Housing Programs for high-need populations: There is a marked lack of public transportation particularly outside of Syracuse. This fact combined with high poverty rates means that many people face substantial barriers to access. This impacts patient's ability to get to appointment and follow care plans. CNYCC plans a multi-pronged strategy aimed at enhancing regional transportation infrastructure, promoting PCMH principles that address transportation, and developing targeted transportation services. CNA findings also highlighted the need for CM programs designed specifically for those who are homeless or live in unstable housing. Stable housing must be an integral part of care plans for high utilizers to ensure effective care transition. These efforts will be integrated within the BH infrastructure and stabilization projects. CNYCC will also partner with housing entities, ensure proper integration of services, and identify funding streams to build additional housing capacity.

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).

Stakeholder engagement activities with service providers, city/town officials, community leaders, and many other types of stakeholders were a critical part of the CNA and occurred primarily through key informant interviews and community meetings. In total the CNA talked with a geographically representative group of 108 non-consumer stakeholders through key informant interviews. These interviews were organized on a county basis and included a core set of informants that were the same across all counties (e.g., public health/social service departments, community hospitals, FQHCs, BH and social service providers,) and a more fluid group of additional stakeholders. In

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addition to these interviews, 26 Community meetings were held throughout the CNA and DSRIP application processes and in total included more than 1,000 representatives from: public health, service, advocacy, social service, business, academic, and philanthropic organizations as well as Medicaid beneficiaries, community residents, and other community leaders. These interviews and meetings were to vet preliminary findings and to gather information on community context, community health status, at-risk population segments, service gaps, and barriers to care.

Consumer engagement activities were conducted with low income Medicaid insured and uninsured residents throughout the region. These activities ranged from structured focus groups to guided listening sessions to individual interviews with consumers. Discussions with consumers were guided by formal protocols that encouraged discussion on care seeking behaviors, root causes of inappropriate utilization, access barriers, care coordination, and experience locating services.

In addition, drafts of CNA results were disseminated to PAC members and posted on the web for review and comment.

***Community 2:**

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

Twenty-eight focus groups were conducted as part of the CNA. Participants in these activities were predominantly Medicaid beneficiaries but many were uninsured or dually insured by Medicare and Medicaid. In all over 202 individuals from all six of the counties in the CNYCC service area provided input on their experiences with the health care system as well as on barriers to care, root causes of inappropriate utilization, and other care seeking behaviors. Focus group participants were recruited by CNA staff with the support of key partner agencies in each County. Key partners included public health departments, health and community service providers, and other community organizations. The focus groups were geographically distributed throughout the service area to increase access to participants and ensure diverse perspectives. Agencies recruited participants by reaching out to their patients or program participants as well as by identifying people in various community venues where low income populations tend to reside or congregate.

***Community 3:**

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

-Core findings from these consumer engagement activities included:
-Limited access to outpatient primary care, behavioral health, and dental services
-Lack of access to health education and preventive services
-Lack of access to chronic disease management services
-Lack of communication between health care providers
-Lack of access to palliative care and hospice services
-Shortage of primary care and urgent care clinics leading to improper use of ED
-Poor discharge planning in hospitals
-Major transportation barriers, particularly for low income populations in rural areas
-Fragmentation of services for those who are mentally ill or have substance abuse issues
-Major barriers experienced by refugee and recent immigrants
-Barriers related to cost of health care services (co-pays/deductibles, transportation, medication, lost work opportunities)
-Large burden of substance abuse (e.g., alcohol, heroin and opioids)
-Lack of employment and training services
-Lack of affordable housing
-Need for programs related to healthy eating and active living

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.

[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Cayuga County Office of Mental Health	Mental Health Center provides psychiatric services to the residents of Cayuga County. Programs are driven	Identified by PPS as a key Partner. Provides critical mental health

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		by consumer need and are delivered in a team approach. Services include outpatient treatment, emergency, psychosocial and rehabilitation services, consultation and community education.	services to the Medicaid population in the PPS service area.
2	Auburn Housing Authority	Programs include public housing, project based housing, low income housing tax credit, market rate housing, and Section 8 housing choice voucher.	Identified by PPS as a key Partner. Important community resource for the Medicaid population in the PPS service area.
3	Hillside Children's Center	A part of Hillside Family of Agencies. Hillside Children's Center is a provider of care for youth and families with a wide range of emotional, behavioral, or life-circumstance challenges. HCC offers mental health, child welfare, juvenile justice, special education, safety net, and developmental disabilities services to children and families throughout Central and Western New York. Comprehensive pediatric, psychiatric, and medical consultation and coordination services are also provided.	Identified by the PPS as a key partner. Provides critical pediatric and mental health services to children with special health care needs in the PPS community.
4	East Hill Family Medical, Inc.	Community Health Center that provides adult medicine, family planning, pediatric, dental, office based surgical, behavioral health, and education services.	Identified by the PPS as a key partner. Identified by the PPS as a key partner. Provides critical medical, behavioral and dental health services for the Medicaid and rural population throughout the PPS region.
5	Cayuga County Office for Aging	Cayuga County Office for the aging is your trusted source for information and assistance for seniors and their families.	Identified by the PPS as a key partner. Support transitional care and social services in the PPS community including home health and family support.
6	Unity House of Cayuga County	Unity House of Cayuga County, Inc. provides transitional and permanent housing, respite care, and rehabilitative and employment services for individuals with mental health illnesses, developmental disabilities, and/or chemical dependencies from which they are recovering. A nonprofit 501(c)(3) organization founded in 1977, Unity House partners with these individuals to develop their personal skills and potential, enabling them to live more full and independent lives.	Identified by the PPS as a key partner. Provides critical medical, behavioral and dental health services for the Medicaid and rural population throughout the PPS region.
7	Finger Lakes Community Health Center	Finger Lakes Community Health, founded in 1989, is a Federally Qualified Health Center and a provider of health care for agricultural workers. Expanded services provide comprehensive health care for everyone, with numerous centers in the region. Providing health services, along with community outreach and advocacy, education about preventive care, certified medical interpreters who help patients with transportation, housing assistance, financial advocacy, free lunch programs, bilingual Insurance Enrollers who can assist patients with insurance forms, Medicaid, and Child Health Plus Enrollment, and patient navigators who help guide patients through the healthcare system, including obtaining health insurance and referrals, making appointments, following-up, and ensuring you feel comfortable throughout every step of the healthcare process.	Identified by the PPS as a key partner. Provides critical medical, behavioral and dental health services for the Medicaid and rural population throughout the PPS region.
8	Cayuga County Health Department	Promotes and protects the health and well-being of	Identified by the PPS as a key

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		the individuals, families and the community. Committed to improving health, preventing disease and providing essential health services within community.	partner. Critical resource for accessing care, providing services, and promoting health in Cayuga County.
9	Lewis County Public Health Agency	Prepare and educate the people of Lewis County to ensure their health and safety. Offer preventative services, Cancer services programs, and programs for children with special needs.	Identified by the PPS as a key partner. Critical resource for accessing care, providing services, and promoting health in Lewis County.
10	Lewis County Office for the Aging	Lewis County Office for the Aging provides services to all Lewis County seniors in need through advocacy and the development of a service delivery system at the local level. The Office for the Aging works with federal, state, local officials; elderly constituents; service providers; and the private/volunteer sector to coordinate existing services and stimulate new ones.	Identified by the PPS as a key partner. Identified by the PPS as a key partner. Support transitional care and social services in the PPS community including home health and family support.
11	Lewis County General Hospital	Inpatient medical provider with over 100 professional health care providers in various specialties. Also offers home health and hospice services.	Identified by the PPS as a key partner. Identified by the PPS as a key partner. Support transitional care and social services in the PPS community including home health and family support.
12	Madison County Health Department	The Madison County Department of Health promotes and protects the health the community through assessment, education, and by ensuring necessary services. Provided services include children with special healthcare needs early intervention, community health, environmental health, and health education and promotion.	Identified by the PPS as a key partner. Critical resource for accessing care, providing services, and promoting health in Madison County.
13	Madison County Rural Health Council	The Madison County Rural Health Council, Inc. (MCRHC) was established in April 2013 by a consortium of organizations representing the largest providers of health and social services in the county. Through the MCRHC local providers are better able to coordinate the county-wide alignment of health care resources, expertise and services, and evidence based practices to meet health needs in our communities.	Identified by the PPS as a key partner. Provides important coordination, monitoring, and support to a wide range of health and community resources in Madison County.
14	Madison County Department of Mental Hygiene	Provides resources to individuals in Madison County with intellectual delays, as well as problems with mental illness and/or alcohol and substance abuse. Services include advocacy, counseling, daycare/evaluation, family support services, health services, mental health services, parent training services, referral, respite, service coordination, therapies, transition, and transportation.	Identified by the PPS as a key partner. Provides critical mental health services to the Medicaid population in the PPS service area.
15	Oneida Healthcare	Oneida Healthcare (OHC) is a 101-bed acute care hospital and short-term rehab facility licensed by the State of New York and operated by Oneida Health Systems, Inc., a New York not-for-profit corporation. Oneida Healthcare serves an area comprised of approximately 24 communities in Madison and western Oneida counties with a population of about 80,000. In addition to a full range of acute care hospital services and Long/Short Term Care Skilled Nursing Services, Oneida Healthcare operates	Identified by the PPS as a key partner. Major inpatient and outpatient healthcare provider serving the PPS population.

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		primary health centers, a maternal health clinic, four outreach laboratory draw stations, a Physical Therapy Center, Sleep Study and Pulmonary Function Testing, Neurology Services, Orthopedic Specialists, and ENT Specialists	
16	Oneida Healthcare- Extended Care Facility	The Extended Care Facility (ECF) at Oneida Healthcare is a skilled nursing facility also offering live-in, long-term and short-term rehabilitation that can give patients the intensive occupational, physical and speech Therapy they need to regain their independence.	Identified by the PPS as a key partner. Provide critical transitional care, medical services and rehabilitation services to patients in the PPS community.
17	Community Hospital Clinic	Family Health Care Center affiliated with the Community Memorial Hospital in Madison County. Offers primary care, pediatrics, and specialty services; cardiology, general surgery, and neurology.	Identified by the PPS as a key partner. Major outpatient healthcare provider serving the PPS population.
18	Community Action Partnership, Madison County	Community Action Partnership (CAP) for Madison County is one of over 1,100 Community Action Agencies (CAA's) across the U.S. and one of 52 in New York State. CAA's are nonprofit private and public organizations established under the Economic Opportunity Act of 1964 implemented to fight America's War on Poverty. Each Community Action Agency is a grassroots organization designed to meet the ever-changing needs of the local population.	Identified by the PPS as a key partner. Important community resource for the Medicaid population in the PPS service area.
19	Barr Dental, Madison County	Dental provider in Madison County.	Identified by the PPS as a key partner. Important dental provider to the PPS population.
20	Oneida Health Department	Promotes and protects the health and well-being of the individuals, families and the community. Committed to improving health, preventing disease and providing essential health services within community. Programs and services offered include cancer services program, children with special healthcare needs, clinic, early intervention, emergency preparedness, environmental health, health education and information, injury prevention, maternal and child health, WIC.	Identified by the PPS as a key partner. Critical resource for accessing care, providing services, and promoting health in Oneida County.
21	Oneida County Department of Mental Health	The Oneida County Department of Mental Health provides the planning, monitoring and reviewing of services for individuals with mental illness. The Department focuses on direct participation in committee work and continuous interaction in an array of services that include case management, crisis services, vocational-educational services, peer advocacy, clinics and clubs, emergency services, continuing day treatment, compeer, drop-in center, representative payee, discharge planning, legal services, individual case reviews, residential services, incident review/risk management, forensic services, and transportation.	Identified by the PPS as a key partner. Provides critical mental health services to the Medicaid population in the PPS service area.
22	Mohawk Valley Resource Center for Refugees	Since being founded in 1981 MVRCR has resettled more than 15,000 individuals to the City of Utica. Services offered include immigration and citizenship, interpretation and translation, cultural competency, adult learning, job placement, refugee resettlement, and community programs.	Identified by the PPS as a key partner. Critical community resource for the refugee population in the PPS service area.
23	Regional Primary Care Network	Regional Primary Care Network (RPCN) is a network	Identified by the PPS as a key

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		of FQHCs that provide family medicine, pediatrics, family planning, prenatal care, dental, laboratory, behavioral/mental health, substance abuse, case management, patient education, translation/interpretation, and community education service for everyone, regardless of financial, cultural, or social barriers.	partner. Provide critical medical and social services to patients throughout the PPS community.
24	NAMI Hope	The National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need.	Identified by the PPS as a key partner. Provides critical mental health services to the Medicaid population in the PPS service area.
25	Planned Parenthood Mohawk Hudson	Planned Parenthood is health care provider, educator, and advocate. Delivers vital reproductive health care, sex education, and information.	Identified by the PPS as a key partner. Provides critical family planning services to the Medicaid population in the PPS service area.
26	The Neighborhood Center	The agency provides a full range of outreach, preventative, developmental and therapeutic human services for nearly 20,000 people in the Central New York, a majority are children and their families.	Identified by the PPS as a key partner. Important community resource for the Medicaid population in the PPS service area.
27	Mohawk Valley Housing and Homelessness Coalition	Help to find residents of Oneida, Herkimer, and Madison counties safe, decent, affordable homes that supports their physical and behavioral health, their social well-being, and their economic independence by sustaining an inclusive, community wide, system-level planning, program development and program integration process that targets public and private, local, state, and federal resources to the areas of greatest need.	Identified by the PPS as a key partner. Important community resource for the Medicaid population in the PPS service area.
28	Upstate Cerebral Palsy	Upstate Cerebral Palsy is the premier provider of direct-care services and programs for individuals who are physically, developmentally, or mentally challenged and their families. Upstate Cerebral Palsy currently has 74 locations throughout central New York. As direct-care and education centers, these include medical, clinical and therapeutic personnel, teachers, social service staff, maintenance, clerical and general support staff.	Identified by the PPS as a key partner. Provides critical health services to people with developmental disabilities in the PPS service area.
29	Visiting Nurse Association of Utica and Oneida	The Visiting Nurse Association (VNA) of Utica and Oneida County is a certified home health agency and also provides a certified long-term home health care program approved by the New York State Department of Health.	Identified by the PPS as a key partner. Provide critical transitional care, medical services and rehabilitation services to patients in the PPS community.
30	Patient Family Advocates, Oneida	Provides advocacy and family support in Oneida County and the surrounding communities.	Identified by the PPS as a key partner. Provide critical transitional care, medical services and rehabilitation services to patients in the PPS community.
31	Mohawk Valley Perinatal Network	Provide a number of services including child care, human services, health care, financial services, health insurance, mental health, and domestic violence support to inform, educate and support families and professionals.	Identified by the PPS as a key partner. Provide critical health and social services to the Medicaid population in the PPS service Area.
32	St. Camillus Residential Health Care	St. Camillus is a not-for-profit healthcare facility	Identified by the PPS as a key

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#	Organization	Brief Description	Rationale
	Facility	featuring comprehensive inpatient and outpatient services including sub-acute and brain injury rehabilitation programs; continuing care (nursing home); outpatient rehabilitation, home healthcare; medical transport and a variety of other support services.	partner. Provides critical in-patient medical services, out-patient medical services, transitional care, and rehabilitation services to patients in the PPS community.
33	Liberty Resources	Liberty Resources, Inc., headquartered in Syracuse, New York, is one of Central New York's most diversified and trusted human service agencies. Founded in 1978 by a concerned group of citizens who wished to develop community based services in Madison County, Liberty Resources continues to expand its geographic reach and scope of services. Providing residential and non-residential services to individuals and families, our present array of services include Mental Health; Mental Retardation and Developmental Disabilities; services for individuals living with HIV/AIDS, families and youth involved in the child welfare system, domestic violence services; services to persons in recovery; and diversified case management services.	Identified by the PPS as a key partner. Important community human services resource for the Medicaid population in the PPS service area.
34	REACH CNY, Inc.	REACH CNY is a non-profit education and advocacy organization located in Central New York.	Identified by the PPS as a key partner. Important community resource for the Medicaid population in the PPS service area.
35	Crouse Hospital	A private, not-for-profit hospital, Crouse is licensed for 506 acute-care beds and 57 bassinets and serves more than 23,000 inpatients, 66,000 emergency services patients and more than 250,000 outpatients a year from a 15-county area in Central and Northern New York.	Identified by the PPS as a key partner. Major inpatient and outpatient healthcare provider serving the PPS population.
36	Onondaga Case Management Services	Provides case management, and peer and family support to adults and children residing in Onondaga County. SPOA Coordinator for Onondaga County	Identified by the PPS as a key partner. Important community resource for the PPS population in Onondaga County.
37	St. Joseph's Hospital	St. Joseph Healthcare is a regional, full-service healthcare system with a 208-bed facility that combines the latest technologies with personalized medicine. Offer in-patient, out-patient, and specialty services.	Identified by the PPS as a key partner. Major inpatient and outpatient healthcare provider serving the PPS population.
38	Onondaga Department of Mental Health	Offers prevention, treatment and rehabilitation services lessen the personal and community impact of mental illness, chemical dependency and developmental disorders on children, adolescents and adults.	Identified by the PPS as a key partner. Provides critical mental health services to the Medicaid population in the PPS service area.
39	Franciscan Health Support Services, LLC	Since 1985 Franciscan Companies, an affiliate of St. Joseph's Hospital Health Center, has operated a network of healthcare services to allow people to live home and live well. Services include sleep and breathing, lifeline, home medical equipment, home health care, medication management, and embracing age.	Identified by the PPS as a key partner. Provide critical transitional care and home health medical services to patients in the PPS community.
40	Loretto Health & Rehabilitation Center	The Loretto Health and Rehabilitation Center is comprised of the Cunningham building, a 10-floor, 450-bed long term care skilled nursing facility, and Fahey Rehab, a 90-bed short term residential rehabilitation program - the largest in Central New	Identified by the PPS as a key partner. Provide critical transitional care, medical services and rehabilitation services to patients in the PPS community.

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		York. The Loretto Health and Rehabilitation Center is able to offer specialized services that are not often found in smaller nursing homes because of its size.	
41	CNY Services, Inc.	Serves persons with mental health and substance abuse issues through outpatient treatment, housing, financial management, forensic mental health and employment programs. CNYS also offers Medicaid Services Coordination for children and adults.	Identified by the PPS as a key partner. Provides critical mental health services and community services to the Medicaid population in the PPS service area.
42	The Salvation Army Syracuse Area Services	Offer a broad variety of innovative programs that serve everyone from infants to seniors, our services touch the lives of more than 41,000 Onondaga County residents each year.	Identified by the PPS as a key partner. Important community resource for the Medicaid population in the PPS service area.
43	Onondaga Department of Health	The Onondaga County Health Department promotes and protects the health the community through assessment, education, and by ensuring necessary services. Provided services include children with special healthcare needs early intervention, community health, environmental health, and health education and promotion.	Identified by the PPS as a key partner. Critical resource for accessing care, providing services, and promoting health in Onondaga County.
44	Oswego County Health Department	The Oswego County Department of Health promotes and protects the health the community through assessment, education, and by ensuring necessary services. Provided services include children with special healthcare needs early intervention, community health, environmental health, and health education and promotion.	Identified by the PPS as a key partner. Critical resource for accessing care, providing services, and promoting health in Oswego County.
45	Oswego Hospital	164-bed acute care community hospital with ER, imaging center, surgery center, maternity center, and intensive care unit. Oswego Hospital has more than 160 on-staff physicians in more than 25 specialties and is part of the Oswego Health system.	Identified by the PPS as a key partner. Major inpatient healthcare provider serving the PPS population.
46	Oswego County Opportunities, Inc.	Oswego County Opportunities is a private, nonprofit human service agency serving 30,000 people each year through more than 50 programs providing assistance for the homeless, educational services, health care for the whole family, independence for the disabled, meals for the elderly, disabled, & youth, safety for the abused, support for youth, and transportation for all.	Identified by the PPS as a key partner. Important community resource and health services provider for the Medicaid population in the PPS service area.
47	Northern Oswego County Health Services	Northern Oswego County Health Services, Inc. (NOCHSI) is a patient-centered network of health care practices providing Oswego and surrounding county residents with a variety of comprehensive health care and related services. The network is operated by a private, federally funded non-profit organization governed by a volunteer Board of Directors.	Identified by the PPS as a key partner. Identified by the PPS as a key partner. Provides critical medical, behavioral and dental health services for the Medicaid and rural population throughout the PPS region.
48	Oswego County Mental Hygiene Division	The division develops community resources, programs, and services for the mental hygiene needs of Oswego County citizens, including prevention, intervention, treatment, crisis, and support programs to assure continuity of community mental hygiene services.	Identified by the PPS as a key partner. Provides critical mental health services to the Medicaid population in the PPS service area.
49	Catholic Charities of Oswego County	Catholic Charities of Oswego County has evolved into a midsize human service agency providing many valuable programs and services to children, families, and individuals. These wide ranging programs touch	Identified by the PPS as a key partner. Provides important community and social service resources for the Medicaid population

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[CNY DSRIP Performing Provider System] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		the lives of thousands of people in communities throughout Oswego County. Services include children and family services, children's mental health programs, CYO, Adult mental health, step by step wellness program, emergency services, thrift store, and food bank.	in the PPS service area.

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.

[CNY DSRIP Performing Provider System] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Increase in services addressing issues related to poverty	Five of six included counties have poverty rates (% less than 100%FPL) greater than the Upstate NY average. All six have higher proportion of population <200%FPL than Upstate NY.	-US Bureau of Census, American Community Survey, 5-year averages, 2008-2012 -2013 Central New York Consumer Access Survey -Key informant interviews, community meetings, and focus groups
2	Improved services addressing lifestyle behaviors that contribute to chronic disease	Between a 32% and 41% of children are overweight or obese. Among adults, obesity rates are higher than the Upstate NY average in five of six counties. Inadequate consumption of fruits and vegetables and sedentary behavior is more prevalent in five of six counties than the Upstate NY average.	-Expanded BRFSS July 2008 - June 2009; BRFSS County-Specific Prevention Agenda Reports -Key informant interviews, community meetings, and focus groups
3	Need for health education and awareness activities for all segment of the low income population	High rates of obesity, tobacco use, poor nutrition, limited physical activity, risky drinking, and other risk factors lead to chronic illness and are evidence of the need for health education and awareness campaigns across sectors	-Expanded BRFSS July 2008 - June 2009; BRFSS County-Specific Prevention Agenda Reports -Key informant interviews, community meetings, and

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[CNY DSRIP Performing Provider System] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			focus groups
4	Increased health literacy for foreign born and recent immigrants	Health literacy is a major barrier for large proportions of the population, particularly for low income foreign born and recent immigrants/refugees. This issues impact individuals and families ability to access services and navigate the system as well as patient's ability to communicate with their providers.	-Key informant interviews, community meetings, and focus groups
5	Improved transportation systems and options	Public transportation only exists in urban areas, where the majority of resources are. Rural counties lack transportation options. Public transportation that does exist in urban areas are limited. Lack of transportation makes is difficult to access preventive and routine health services, to follow through on discharge, obtain medications, among other challenges.	-2013 Central New York Consumer Access Survey -Key informant interviews, listening sessions, focus groups with consumers
6	Increased consumer engagement	Primary care sites struggle to engage consumers, even in areas with unmet need	-2013 Primary Care Safety Net Assessment funded by the Health Foundation of Western and Central New York -2013 Central New York Consumer Access Survey -Key informant interviews, community meetings, and focus groups
7	Increased access to primary care providers	There are a large number of primary care Health Professional Shortage Area and Medically Underserved Areas (HPSA/MUAs) designated in the CNYCC, including entire counties. Key informants reiterated this finding of shortages of PCPs. Additionally, for primary care providers that do exist there is a substantial strain on resources – a fact that was noted by FQHC survey respondents to the CNYCC Partner Organizational Survey. All six counties have a much lower rate of FTE primary care providers per 100,000 compared to the state. There are 8 FQHCs in the region, operating a robust, well-distributed network of sites. However, penetration into the low-income areas remains low in Cayuga and Madison. There were 215 PCMH organizations in the CNYCC region, with approximately 70% of those being in Onondaga County.	-2013 Primary Care Safety Net Assessment -HPSA/MUA designations HRSA, Key informant interviews, Partner Survey, HRSA, Area Health Resources Files (AHRF), 2012 -UDS Mapper -"The Evolution of Patient-Centered Medical Homes in NYS: Current Status and Trends as of September 2012." UHF. 2012.
8	Increased access to mental health providers	There are a large number of primary care and mental health HPSA/MUAs designated in the CNYCC, including entire counties. Key informants also highlighted the lack of behavioral and mental providers. All six counties had a lower rate of psychiatrists per 100,000 compared to the state.	-HPSA/MUA /Populations designations from HRSA, Key informant interviews; AHRF 2012
9	Increased access to care management	High rates of chronic medical and behavioral conditions, limited engagement in primary care, high	-Expanded BRFSS July 2008 - June 2009

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[CNY DSRIP Performing Provider System] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		rates of inappropriate utilizations, and high rates of behavior risk factors are evidence of the need for expanded and strengthened care management issues	-PPR, PQI and PPV Data from NYS DOH -Key informant interviews, community meetings, and focus groups -Medicaid Beneficiary Chronic Health Conditions, Inpatient and Emergency Room Utilization (Accessed from Health Data NY) -2013 Primary Care Safety Net Assessment
10	Improved care transitions and coordination of services	Informants consistently noted that there is a lack of communication between providers, resulting in poor transitions of care after patients have been discharged from the hospital.	-PPR, PQI and PPV Data from NYS DOH -Key informant interviews, community meetings, and focus groups
11	Increased access to chronic disease management programs	In all included counties, cancer and heart disease are the first and second leading causes of death, respectively. Unintentional injury, chronic lower respiratory disease, diabetes, suicide, and stroke are also in the top five, although there is variation across counties.	-NYS Department of Health, Leading Causes of Premature Death (Death before age 75), 2010-2012 -Key informant interviews, community meetings, and focus groups
12	Increased access to community mental health services to reduce utilization of hospital & ED services	All six counties had a higher proportion of adults with heavy drinking in the past month than the state. Four counties had a higher proportion of adults with poor mental health reported in the prior month. Oswego is a hot spot for mental health issues. 4 of 6 counties had higher PQI rates than the State average and 6 of 6 counties had higher PPV rates. The leading cause of hospitalization (18,650 admissions) and ED use (51,432 visits) in the CNYCC service area is depression. Drug abuse and chronic stress/anxiety is the third and sixth leading cause of hospitalization, and the third and fifth leading cause of ED use, respectively.	-EBRFSS July 2008 - June 2009; BRFSS County Prevention Agenda Reports -2013 CNY Consumer Access Survey -Key informant interviews, community meetings, and focus groups -PPR, PQI and PPV Data from NYSDOH -Medicaid Beneficiary Chronic Health Conditions, Inpatient & ER Utilization
13	Increased access to primary care services to reduce utilization of hospital and ED services	All six counties had a higher proportion of adults with high blood pressure than the state average. Five of six counties had higher rates of asthma. The second leading cause of hospitalization (15,827 admissions) and ED use (36,279 visits) in the CNYCC service area is hypertension. Diabetes and Asthma are the fourth and fifth leading cause of hospitalization, and the sixth and fourth leading cause for ED use, respectively.	--Expanded BRFSS July 2008 - June 2009 -PPR, PQI and PPV Data from NYS DOH -2013 Central New York Consumer Access Survey -Key informant interviews, community meetings, and focus groups -Medicaid Beneficiary Chronic Health Conditions, Inpatient and

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[CNY DSRIP Performing Provider System] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			Emergency Room Utilization
14	Increased access to dental providers	Compared to primary care and mental health HPSA/MUAs, there are fewer designated dental shortage areas, although this is contrary to the key informant interviews which highlighted dental shortages. Only Onondaga had a rate of dental providers per 100,000 anywhere close to the state average; the other five counties had significantly lower rates of dentists.	-HPSA/MUA designations from HRSA, Key informant interviews; AHRF 2012 -Key informant interviews, community meetings, and focus groups
15	Increased availability of affordable housing	Homelessness is an issue, especially in urban hubs like Syracuse and Utica. Persons who are homeless use the EDs for shelter, food, showers, and clean clothes. The lack of housing as an issue is exacerbated by increasing heroin and opiate use. Lack of housing makes it challenging to follow through on discharge plans, resulting in a cycle of readmissions to EDs.	-Key informant interviews, community meetings, and focus groups
16	Increased access to post-acute care capacity overtime	Currently post-acute, nursing home capacity is right sized with a very slight shortage but capacity is not well distributed and as inappropriate hospital utilization declines there will be a need for additional capacity as patients transfer to less acute settings	-Health Facility Certification Information (Accessed from Health Data NY)
17	Increased access to services in rural areas	Rural nature of service area and low population densities creates major barriers due to transportation and service delivery In general, the resources identified across categories (hospital, primary care, behavioral health, dental, post-acute, and community-based) were located in the more urban areas, leaving rural areas with limited access to the available resources.	-US Bureau of Census, American Community Survey, 5-year averages, 2008-2012 - PPS Partner Survey
18	Increased access to refugee support services in Syracuse and Utica	Syracuse and Utica hubs have large immigrant, refugee and minority populations. There is less education, higher unemployment in these areas. Poverty is also concentrated in these areas – % in poverty is at least double the CNYCC regional average.	-US Bureau of Census, American Community Survey, 5-year averages, 2008-2012
19	Increased access to opportunities for physical activity	Five of six (all but Onondaga) counties have a lower rate of recreation and fitness facility establishments per 100,000 than the state average. Further, all six counties have a lower percent of the population that lives within one-half mile from a park.	-US Census Bureau, County Business Patterns: 2012. Data analysis by CARES -Key informant interviews, community meetings, and focus groups -CDC Healthy Community Design Initiative and Geospatial Research Analysis and Services Program. Accessed from Environmental Public Health Tracking Network, 2010.
20	Increased access to healthy foods	All six counties have fewer grocery stores per	-US Census Bureau,

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[CNY DSRIP Performing Provider System] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		100,000 than the state, probably due to the rural geography of the region. Further, four of six counties have a higher proportion of the population that are low-income and have low access (live more than one mile from) to a large grocery store.	County Business Patterns: 2012. Additional data analysis by CARES -2010 US Dept. of Agriculture Food Environment Atlas Data as of November, 2012
21	Improved maternal and child health services in hotspots	Although CNYCC service area is generally better off than the Upstate average with respect to maternal and infant health outcomes, there are selected areas of need. With the exception of infant mortality, Oneida performs relatively worse than other included counties on all indicators including lack of prenatal care, percent of women breastfeeding, c-section, and proportion of births that are preterm and low birth weight	-CHAI 2011 -BRFSS 2009
22	Increased access to PC services in rural areas to reduce preventable hospitalizations and ED use	Four of six counties had higher overall composite Prevention Quality Indicator (PQI) rates than the New York State average. Rural areas have high rates of potentially preventable ER visits and a high proportion of Medicaid beneficiaries with an ED visit.	-All Payer Potentially Preventable Emergency Visit (PPV) Rates by Patient Zip Code (SPARCS) (Accessed from Health Data NY)
23	Increased access to health care resources	Critical partners – those that have already self-identified as a PPS partner – have been identified in six categories: hospital, primary care safety net, behavioral health, dental, post-acute, and community-based. Additionally, other potential partners have been identified to fill in gaps to maximize the effectiveness of services provided.	-2014 Survey of Health Care and Community Resources -Key informant interviews, community meetings, and focus groups -See source list of resources.
24	Increased social supports for Medicaid and dual eligible populations	Five of six counties have Medicaid rates higher than upstate average; more than 1 in 5 residents in Oswego and Onondaga are Medicaid beneficiaries. Further, in five of six counties dual eligible make up a greater proportion of Medicaid beneficiaries than the NY state average.	-New York Department of Health, Medicaid Enrollees and Expenditures by County 2012
25	Employment opportunities for younger populations encouraging them to stay in CNY	Four of six counties with higher than state % population 65+. Industries closing, leaving older, poorer population behind.	-US Bureau of Census, American Community Survey, 5-year averages, 2008-2012

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
8_SEC038_CNYCC CNA Final Compressed.pdf	12/19/2014 12:10:20 PM	CNYCC Community Needs Assessment

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

DSRIP PPS Organizational Application

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **CNY PPS (Upstate) _Section4_Text_12-20-14 DSRIP Project Plan Application.docx**

Description of File

CNYCC Project Plan Application Narrative

File Uploaded By: cjaconsk

File Uploaded On: 12/22/2014 06:24 AM

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

Currently Uploaded File: **CNY PPS (Upstate) _Section4_ScopeAndScale_Speed and Scale.xlsx**

Description of File

Scale and speed

File Uploaded By: cjaconsk

File Uploaded On: 12/22/2014 06:40 AM

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

***Strategy 1:**
In the response, please include

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

CNYCC partners have over 28,000 employees. CNYCC is a highly unionized workforce, with 69% of all hospital workers represented. Given its large scope and geography, impact upon the CNYCC workforce as a whole is minimized with certain partners, such as hospitals, primary care, and behavioral health providers feeling the most impact. Numerical estimates provided are directional estimates, calculated on the overall workforce. They are subject to change as more comprehensive workforce planning is underway. The impact of DSRIP on existing workers will be largely captured through staff retraining and to a lesser degree, redeployment, with no anticipated reductions to the workforce. Based on training needs emanating from the 11 projects and the CNA (e.g. cultural competency) a significant percentage of the workforce (55%) will require some form of retraining. The majority of these workers (98%) will retain their existing positions while

adjusting to new methods of care delivery. Training needs will vary depending on the current competencies of organizations and their workforce, from changes in care protocols or workflow processes to the acquisition of skills and capabilities in support of the 11 projects.

CNYCC anticipates growth in the need for Health Home care managers, case managers, transition coaches, and patient navigators. CNYCC expects staff such as RNs have the highest potential for redeployment based on their position relative to: 1) changes in patient volume; 2) greater emphasis on primary care; 3) patient education; 4) patient navigation; and 5) direct patient care. It is also anticipated that a higher percentage of preventative services may be performed by non-clinicians and roles that combine clinical and administrative duties such as medical office assistants. There will also be new functions requiring skills in HIT, HIE, QI, and population health analytics.

In terms of reductions, CNYCC utilized both qualitative and quantitative measures to evaluate the impact of prospective DSRIP-related bed reductions on the workforce across the network. Quantitatively, CNYCC utilized a methodology which accounted for: 1) the overall impact of a 25% reduction in preventable hospital visits; 2) allocation of reduced visits/admissions based on county utilization/market share; 3) reduction in visits/admissions in total across participating inpatient facilities and by individual facility; 4) comparison of average patient hours per day or ED visit to the total; and 5) comparison of average length of stay to the total of reduced admissions. Qualitatively, interviews were conducted with project leads, hospital staff, labor representatives, and other healthcare providers.

In total, the reduction of inpatient admissions appeared significant. However, once this number was evaluated by facility it did not indicate a significant reduction in inpatient daily census. CNYCC anticipates that reductions to the workforce will be managed almost exclusively through attrition and, if necessary, reduction of contractual arrangements (e.g. temporary staff, Travel RN's, etc.).

The reduction in ED visits will have a more significant impact on workforce. However, CNYCC projects that as unnecessary ED visits are reduced outpatient demand will grow. Any negative effect to the workforce that cannot be managed through attrition or reduction of contractual services will be minimized through redeployment. While redeployment is a preferred strategy for allowing staff who may be negatively impacted to remain within the bounds of CNYCC, existing collective bargaining agreements and other restrictions may not permit redeployment of staff across some CNYCC partners. Approximately 275 positions will be created as a result of DSRIP-related activity. To the extent possible, retraining and redeployment strategies will be used to fill these positions.

***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.

Based on analysis of inpatient and ED visit reduction modeling data, CNYCC does not anticipate reductions to the workforce that cannot be managed through attrition or reduction of contract services. Given that a large percentage of the CNYCC workforce (i.e. 69% of hospital workers alone) are represented by organized labor, CNYCC expects that redeployments, when possible, are unlikely to result in reductions in wages and benefits. While numbers of retraining are high, the number of retrained employees who will retain their current position is also expected to be high. Given these factors, CNYCC is monitoring and planning for the following workforce impacts: 1) substantial retraining efforts, which may result in overload and confusion; and 2) resistance to change. CNYCC will work with AHEC as part of the comprehensive workforce plan to: 1) Identify training needs and compare to existing training capacity; 2) Create an organized training plan which utilizes a variety of methods to ensure training is conducted in a manner conducive to learning and retention; 3) Engage, plan, and work with union, educational, and training partners to identify solutions to training capacity gaps; including online education for a diverse workforce across many providers in a broad geography; and 4) Engage, plan, and work with union and training partners to overcome resistance to change.

Based on available data and confirmed by the results of the CNA there are 38 Health Professional Shortage Areas (HPSAs) which exist in the geographic region of the PPS, half of which are for primary care. The need for primary care exists in both urban and rural communities, but is especially pronounced in the cities of Utica and Syracuse which are home to comparatively larger minority and refugee populations. Additionally, mental health population-to-provider ratios are unbalanced across all counties, including three counties where the entire population is within the HPSA (Madison, Lewis and Oswego).

These persistent shortages are a significant contributor to the barriers to care identified in the CNA and will likely persist without the

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activities undertaken in the DSRIP program, including the ability to pursue regulatory waivers. These shortages are of serious concern and with the relatively short timeline for achieving DSRIP goals, CNYCC will focus on mobilizing the existing workforce, with priority given to capacity building measures such as: decreasing no-shows; refining patient flow; developing primary care pods; and creating interdisciplinary teams. Primary recruitment efforts will focus on non-physician practitioners, as well as recruiting and training for emerging job categories such as care coordinators, case managers, peer educators, and patient navigators. Regulatory relief, to enable non-physician practitioners to practice at the top of their license, will be sought. CNYCC will continue to work with its partners at SUNY Upstate Medical University and St. Joseph's Hospital to maximize recruitment of primary care physicians through R-MED and Rural Residency programs and support changes in the University admissions process designed to increase admissions from rural and under-represented areas of NYS. CNYCC will work to leverage funding and recruitment opportunities through programs such as National Health Service Corps, Doctors Across New York, etc. In addition, CNYCC will work with AHEC and other local, regional, and state education and workforce development entities to increase awareness of shortage areas and to maximize efforts to create a pipeline approach to fulfillment.

***Strategy 3:**

In the table below, please identify the percentage of existing employees who will require re-training, the percentage of employees that will be redeployed, and the percentage of new employees expected to be hired. A specific project may have various levels of impact on the workforce; as a result, the PPS will be expected to complete a more comprehensive assessment on the impact to the workforce on a project by project basis in the immediate future as a Domain 1 process milestone for payment.

Workforce Implication	Percent of Employees Impacted
Redeployment	1%
Retrain	55%
New Hire	1%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

The goal of CNYCC is to minimize any adverse impact to the workforce as roles are aligned within the existing workforce to meet project needs. CNYCC anticipates that the majority of retraining (98%) will be for employees who retain the same job title/function but require mandatory training with respect to new processes or protocols. CNYCC expects a small amount of retraining to be for individuals who may be advancing to new roles and/or employment opportunities (1%) and for whom retraining will be voluntary. Finally, CNYCC expects a small number of redeployments which will require retraining (1%). In selecting redeployments for retraining, CNYCC will seek volunteers as a first option. In those instances where employees are covered by a collective bargaining agreement, the process outlined in that agreement for training shall be followed. The appropriate HR office(s) will be consulted regarding the selection of employees for retraining, as well as the policies and agreements to be followed in terms of retraining. CNYCC will work with AHEC to ensure available job openings within the PPS partner organizations are well identified and communicated to HR, staff, and union representatives to maximize continued employment options and ensure the best possible fit for these employees.

CNYCC anticipates a minimum of five levels of retraining will be required. These include:
-Level 1: Staff who require orientation to integrated delivery systems of care. By far the largest category of training, this is also expected to be conducted through a mass informational campaign including a variety of print, online, and other self-directed approaches.
-Level 2: Staff with the technical expertise, but who require orientation to a new environment, department, or protocol. Examples include: cultural competency, patient centered model, screening for behavioral health vs. medical condition, etc. Level 2 training is expected to be less than or equal to 40 hours.

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-Level 3: Staff who require training in new processes or methods due to system redesign. Examples of training include: Integrated Delivery System protocols and processes; revised practice guidelines, triage protocols, etc. Level 3 training is expected to be more than 40 hours but less than 80 hours.
-Level 4: Staff who require training in new or advanced roles. Ex: PAM training for the Patient Activation Measure team; Specific prevention and follow up strategies/protocols for disease management. Level 4 training may be cumulatively more than 80 hours, but less than 400 hours.
-Level 5: Staff who have little or no knowledge of their new role and require training in new skills. This may include certificate based training (i.e. care coordination or transition coach training), but may also include college level course work. Level 4 training is expected to range from 100 to over 1000 hours.

The comprehensive workforce strategy due March 1, 2015, will include a thorough analysis of the retraining needs of the existing workforce to support DSRIP project goals. CNYCC will work with the HR offices of partner employers, AHEC, union representatives, and other community partners to identify, compare, and contrast: specific training needs by project and position, existing training capacity, and resulting gaps. Shared resources for training will be maximized prior to the creation of new training options. CNYCC anticipates training will be provided by a variety of partners and vendors based on specific expertise and offerings available. CNYCC further anticipate a variety of training methods (i.e. instructor led, web-based, etc.) will be utilized.

***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.

CNYCC anticipates that the majority of retraining (98%) will be for employees who retain the same job title/function. However, CNYCC acknowledges that system transformation will lead to greater employment opportunity within the outpatient setting where some employees are historically paid less. Given that a high percentage of CNYCC workers (69% of hospital workers alone) are represented by organized labor, risk of negative impact to wages/benefits is considered low. Assessment of specific salary impact on retraining/redeployment of existing employees will be included in the comprehensive workforce plan. In those instances where retraining/redeployment will result in less than 95% of present salary/wage, the employers within CNYCC will work with their HR departments, utilizing existing policies, procedures, and agreements to govern these issues. CNYCC will work with AHEC to ensure available job openings within all PPS partners are well identified and communicated to all involved so as to maximize continued employment options and ensure the best possible fit.

***Retraining 3:**

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

Retraining will be used to its maximum advantage to ensure, that to the extent possible, existing workers will not be disadvantaged. The employer partners of CNYCC will abide by all relevant HR policies, as well as the collective bargaining agreements in place, with respect to refusal of retraining/redeployment options. Depending on the particular circumstances of re-deployment, some partner employers may not be able to redeploy employees. CNYCC will work with AHEC and the partner HR offices to provide career guidance to assist in career transition or placement.

***Retraining 4:**

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

Within CNYCC, hospital partners alone have over 8,000 employees represented by unions. Union representatives will play a key role is assisting CNYCC with the transformational change DSRIP requires. Thus far, CNYCC has worked with the following labor organizations: SEIU1199, CSEA, and UUP. Labor representatives have been active participants in CNYCC PAC meetings, in qualitative interviews, and in the public comment period regarding the DSRIP process. As CNYCC moves forward with the comprehensive workforce strategy plan, it will work with AHEC to engage labor representation in a variety of formats (i.e. meetings, conference calls, and online forums) regarding the impact of retraining on union members and to identify training options through union training funds, such as 1199SEIU Training and Upgrading Fund, for the benefit of union members. Additionally, CNYCC and AHEC will formulate both a Workforce Steering Committee and a larger Advisory Group based on the existing AHEC Regional Advisory Councils for regional health workforce development. CNYCC will work to ensure appropriate union representation in these forums for reviewing and recommending retraining options for the workers.

***Retraining 5:**

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

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	70%
Partial Placement	30%

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.

The goal of CNYCC is to minimize any adverse impact to the health workforce as roles are aligned within the existing capacity of partner organizations to meet project needs. Successful transformation of the workforce to adapt to the new environment of healthcare delivery will create new employment opportunities for qualified workers. Retraining will be used to allow existing workers to retain their current positions whenever possible. In cases when this is not possible, redeployment is considered a viable strategy for allowing existing employees the opportunity to remain with their employer of origin in a similar and equitable role. If no similar and equitable role exists with the employer of origin, the employee will be provided with guidance and resources through the HR department of their current employer, including available openings with other CNYCC partners. CNYCC recognizes that both collective bargaining agreements and certain laws will prohibit or impact the degree to which redeployments are possible. In all cases, collective bargaining agreements and state and federal laws will be honored.

While, these are early, directional estimates, CNYCC anticipates the number of redeployments to be fairly small at less than 1% of the overall CNYCC workforce. The comprehensive workforce strategy due March 1, 2015, will include a thorough analysis of those positions vulnerable to redeployment as a result of DSRIP project goals. As part of the comprehensive workforce strategy, CNYCC will: 1) Identify what healthcare occupations, as well as the specific tasks associated with each occupation, will be required to carry out the various Projects, in what number, and at what stage of Project completion; 2) Further refine the resulting trends in market utilization that may have an impact on existing workers over the course of project completion; 3) Identify and refine the number and types of workers at risk for redeployment; 4) Identify the skills and talent currently available in the PPS labor pool; and 5) Plan and execute possible movement into approved vacancies. CNYCC and AHEC will work to maximize awareness and availability of employment vacancies through Health Workforce NY, an online database with a social media platform that allows the exchange of data in real time regarding available openings, and training opportunities.

The role of CNYCC will be to provide data, analytics, information, and resources to its employer partners. Ultimately, it serves primarily an advisory role. The details of managing individual staff redeployments will be subject to the personnel policies and collective bargaining agreements currently in force at the member institutions. CNYCC recognizes that some collective bargaining agreements place restrictions on 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.

CNYCC anticipates the number of redeployments to be minimal, representing less than 1% of the overall CNYCC workforce. Yet, CNYCC acknowledges system transformation will, over time, lead to greater employment in an outpatient setting where employees are traditionally paid less. In the short term, however, the risk to existing employees for decreases in wages/benefits through redeployment is considered low. This is due to: 1) the high percentage of employees protected by collective bargaining agreements (69% of all hospital staff within CNYCC); and 2) certain collective bargaining agreements place restrictions on involuntary redeployment. Assessment of salary impact for those facing redeployment will be part of the comprehensive workforce plan. In those cases where redeployment will result in less than 95% of present salary/wage, the employer partners will work with their HR departments, utilizing existing policies, procedures, and agreements to facilitate these issues. For those interested in redeployment, CNYCC will work with AHEC to ensure available job openings within all PPS partners are well identified and communicated to maximize continued employment options.

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***Redeployment 3:**

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

Despite the many positive changes to the health workforce, CNYCC recognizes that, for some, redeployment may not be voluntary in nature. In these instances, individual employer partners within CNYCC will work with their HR departments, utilizing existing policies and procedures to facilitate redeployment to the extent possible. Additionally, in those instances where redeployment is not by choice and employees are covered by a collective bargaining agreement, the existing agreements will be honored. CNYCC will work with AHEC to ensure available employment opportunities are well identified and communicated to HR offices and staff to maximize continued employment options and ensure the best possible fit for these employees.

***Redeployment 4:**

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

Within CNYCC, hospital partners alone have over 8,000 employees represented by unions. Union representatives will play a key role is assisting CNYCC with the transformational change DSRIP requires. Thus far, CNYCC has worked with the following labor organizations: SEIU1199, CSEA and UUP. Labor representatives have been active participants in CNYCC PAC meetings, in qualitative interviews, and in the public comment period regarding the DSRIP process. As CNYCC moves forward with the comprehensive workforce strategy plan, it will engage labor representation in a variety of formats (i.e. face-to-face meetings, conference calls, and online forums) regarding the impact of potential redeployment on union members and to identify available resources for union members facing redeployment. Additionally, CNYCC and AHEC will formulate both a Workforce Steering Committee and a larger Workforce Advisory Group based on the existing AHEC Regional Advisory Councils for regional health workforce development. CNYCC and AHEC will work to ensure union representation in these forums for reviewing and recommending options for the healthcare workers who may be affected by redeployment.

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.

The DSRIP Projects will create exciting new employment opportunities in healthcare in the region. CNYCC expects partner institutions will need to fill approximately 275 positions to meet the needs of the community through system redesign. Growth is anticipated in the following areas:
-Primary care physicians and psychiatrists: Recruitment in this area is essential to support both the Care Transitions Intervention Model, the Integration of Palliative Care in the Medical Home, and the Behavioral Health Community Crisis Stabilization project.
-Physician Assistants, Nurse Practitioners, and other physician extenders of primary care: Given historical difficulty in physician recruitment, CNYCC is focusing efforts on non-physician providers. Over 20 physician extenders will be required to support project goals.
-RN's : Despite a transition to community-based care, the need for Registered Nurses remains strong with 28 required to support a variety of projects.
-LMSW: A total of 19 positions will be required to cover partner hospitals with ED Care Triage and Care Transitions as CNYCC works to effect overall DSRIP goals. Two additional positions will be required to support the Strengthen Mental Health Systems project.
-Care Transition Coaches: Twelve positions will be needed across the PPS in order to reduce 30-day readmissions for chronic health conditions.
-Health Home Care Managers: CNYCC anticipates the need for 110 Health Home Care Managers to support both the Health Home At-Risk Intervention Program and ED Care Triage.
-Peer Mentors: will be utilized to support Behavioral Health Community Crisis Stabilization.
-RN PAM Trainers: RN's will be trained in PAM to assist in engaging the uninsured and low/non-utilizing population.
-Mobile Crisis Outreach Workers: Eighteen will be needed to support the Behavioral Health Community Crisis Stabilization Services project. These workers may come from a variety of educational backgrounds such as: nursing, social work, licensed mental health counseling (LMHC), etc.
-Behavioral Health providers: This may be a combination of Psychologist, NP's, LMHC, LMSW, etc. A total of 30 will be needed to help

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integrate primary care with behavioral health services.
-Patient Navigators: Will be needed to support the ED Care Triage project for at risk populations.
-Administrative: A variety of administrative support, oversight, executive leadership, quality control and data analytic positions are anticipated to help organize and implement the projects, as well as measure quality and performance outcomes through data measures.

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

Position	Approximate Number of New Hires
Administrative	10
Physician	4
Social Workers	21
IT Staff	1
Nurse Practitioners	21
Other	219

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	9,892,500	9,821,250	9,821,250	9,821,250	9,821,250	49,177,500
Redeployment	500,000	500,000	500,000	500,000	500,000	2,500,000
Recruiting	2,250,000	2,250,000	750,000	750,000	750,000	6,750,000
Other	275,000	200,000	200,000	200,000	200,000	1,075,000

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.

As part of the overall workforce strategy, CNYCC intends to leverage all available resources in response to the identified recruitment, training and redeployment needs of the DSRIP Projects and the broader PPS. CNYCC has engaged the Northern and Central Area Health Education Centers as the workforce vendor to develop the workforce strategy, including assessment, strategic planning, and stakeholder engagement.

Specifically, CNYCC and AHEC will dedicate staff to: 1) Identify and acquire resources available through existing State programs (i.e. Doctors Across NY, Physician Loan Repayment, Primary Service Corp, etc.) to help fill identified needs; 2) Inventory existing training offerings for the purpose of identifying gaps between existing capacity and the workforce strategy; 3) Identify existing State programs and best practices for increasing training capacity to meet identified gaps (i.e. SUNY RP2, articulation agreements outside the region with local clinical placements, etc.); and 4) Identify and coordinate grant applications for existing State programs (i.e. Health Workforce Retraining Initiative, WIA funding for entry level healthcare workers, etc.).

CNYCC will communicate future workforce needs to the AHECs for the purposes of recruiting youth and adults into the pipeline. CNYCC will utilize Health Workforce NY, an online database with social media platform that allows the exchange of data in real time regarding available openings and training opportunities to communicate with partners and to: advance, track, and measure recruitment, clinical placement, and continuing education efforts. CNYCC will also work with AHEC and other community partners in health workforce development to identify and implement solutions for those positions that are difficult to recruit, train, or retain and may present difficulties for development of an integrated workforce.

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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.

CNYCC engaged stakeholders during the planning process primarily through meetings of the PAC and key informant interviews. CNYCC efforts included education and dialogue via a presentation by the Center for Health Workforce Studies School of Public Health at SUNY Albany in a workforce session at a PAC meeting, as well as assessment through interviews to understand the challenges and opportunities from the perspective of organizations, providers, staff and patients. The addition of AHEC as a workforce vendor in November leveraged their ongoing engagement of partners in healthcare employment and education, many of whom are represented in CNYCC, through the Regional Advisory Council. This Council has met regularly over the last two years and is charged with identifying current and emerging workforce needs. More targeted discussions regarding the workforce implications of the selected projects were conducted by AHEC with CNYCC project leads, partners, and consultants.

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

Based on the partner organizations of CNYCC, a significant portion of the healthcare workforce of the PPS is represented by the following labor groups: SEIU 1199, PEF, CSEA, CWA, UUP, NYSNA, UFCW, AFSCME and PBANYS. Individuals from SEIU 1199, UUP and CSEA have participated in PAC meetings or standing PPS-wide conference calls, while all have received CNYCC communications. The key informant interviews included an SEIU 1199 representative and the human resources staff at Upstate University Hospital, which includes unions comprising just over 5,000 employees. Representatives from the following labor groups (SEIU 1199, PEF, CSEA, CWA, UUP, NYSNA, UFCW, and AFSCME) were invited to review and provide feedback on a draft of the workforce strategy in advance of submission.

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

Engagement of frontline workers has occurred through in-person and email communication with PAC members, as well as key informant interviews. CNYCC membership requires the designation of organizational representatives to participate in the PAC. For those organizations with workforce members in a union, the PAC representative is selected by the union. PAC representatives are the primary points of contact for organizations. The PAC is an advisory body to the Board of Directors that offers recommendations on initiatives and promotes participation among members and their workforce. CNYCC will communicate regularly with the R-PACs which will meet monthly and receive minutes and information regarding project plans, budgets, performance, compliance, and funds distribution. The PAC will also serve as the source for nominees to the Board of Directors and PAC members populate Board committees that recommend policies and report results to the Board. In addition, the comprehensive workforce strategy will include a communications plan that utilizes a variety of methods (i.e. online, print, social media, etc.) to inform and engage frontline workers with respect to system change.

***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.

Moving forward, CNYCC plans to continue and expand stakeholder and engagement efforts with the support of the Northern and Central Area Health Education Centers (AHEC). A Workforce Steering Committee will be established and this committee will report to a Workforce Advisory Committee. Currently, the AHECs conduct Regional Advisory Committees (RACs) throughout the region to determine workforce needs. Many current members of the RACs are partners in CNYCC. To make most efficient use of this existing structure, the AHECs will work with CNYCC to evaluate the membership of its Regional Advisory Councils to ensure it reflects key PPS stakeholders needed at the table to support the development and implementation of the comprehensive workforce strategy. It is anticipated that additional union and worker representation will be required.

Section 5.8 - Domain 1 Workforce Process Measures:

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

- 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.

The Information Technology and Data Governance Committee (ITDGC) will set policy regarding data sharing and confidentiality. Existing consent policies for the local RHIO will be maintained to ensure continued patient confidentiality and protection. Any new data sharing and confidentiality policies enacted to account for access to additional consolidated data sources (e.g. population health management platforms) will follow this model and will adhere to guidelines given by NYS, HIPAA, and Federal Policy for the protection of human subjects. Any new or updated policies will be incorporated into Business Associate Agreements established between the CNYCC and its partner. The ITDGC will also define role based security protocols and their associated data accessibility for all sources of aggregated patient information. Participating providers will be required to utilize EMR's and modes of exchange that are compliant with all existing HIPPA and security protocols.

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

CNYCC partners will be required to accept and sign Business Associate Agreements that will: 1) bind them to all of the provisions of the DEAA established between the CNYCC and NYS; 2) comply with the security standards for the protection of electronic protected health information in 45 CFR part 164, Subpart C; 3) ensure the enforcement of these policies and procedures within their organizations. Established HIPAA policy and/or training requirements by individual partner organizations will be evaluated and supplemented with DSRIP specific considerations where appropriate and as agreed upon by the Information Technology and Data Governance Committee. Partner organizations without established security and HIPAA policies or training curriculums will be required to adopt them and compliance to these standards will be a mandatory requirement to participate in the CNYCC.

***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.

Data exchange will be facilitated through an iterative process that will maximize current community assets, as well as introduce new,

robust capabilities. Point-to-point communications will be enhanced through expanded use of Direct protocols, a HIPAA compliant mode of exchange adopted by EMR vendors as part of MU stage 2. This real time mode of exchange was developed to facilitate safe transitions of care and is widely utilized across CNYCC with 71% of eligible providers on the SureScripts network compared to 21% for the rest of NYS. The development of community wide documentation standards by the Clinical Governance Committee will maximize the efficacy of this exchange. Web-based, secure messaging portals that support Direct will be made available to partners without EMRs, or whose current EMRs are not MU certified.

Connections to the local SHIN-NY/RHIO infrastructure will be expanded to include additional bi-direction, real-time, and near real-time data transmission from and to eligible providers. Admit-Discharge-Transfer (ADT) notifications, lab reports and clinical documentation will be "pushed" from the RHIO in real-time to providers with compatible systems where desired and appropriate, otherwise data will be pulled upon demand from the existing portal.

By DY 3, data sharing will be bolstered by the implementation of a population health management platform that will combine data from the RHIO, discrete clinical data from partner EMRs, and data from relevant sources (e.g. claims). This platform will also allow for the creation and real-time maintenance of shared care plans that can follow the patient throughout the continuum.

To ensure patient privacy the Information Technology and Data Governance Committee will leverage and maintain the existing patient consent ("opt out") process in place for the RHIO, in addition to overseeing the development of rule and role based security protocols for access to any consolidated data sources (RHIO/PHM platform).

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.

CNYCC will form a Business Analytics Unit (BAU) responsible for business intelligence and analytics that will be overseen by the Performance Improvement Director. In conjunction with the Chief Medical Officer, the BAU will report clinical and financial performance monthly to the Clinical and Financial Governance Board Committees. Clinical performance data will be summarized in the form of scorecards that aggregate quality/outcome metrics (Domains 2-4) by provider, organization and region. Process metrics from Domain 1, as well as implementation milestones will be reported by organization and project. These committees will ultimately be responsible for the interpretation of the reported outcomes including the development of plans of corrective action to address identified performance lags, or missed goals. These findings will be disseminated to the board, shared with CNYCC partners and carried out by CNYCC operations.

***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.

The Clinical Governance Committee will be responsible for monthly oversight of partner and provider performance as defined by the domain 2-4 metrics. Initially, claims driven partner/provider metrics will be within the MAPP Performance Measurement Portal, while clinical data driven metrics will be reported by individual partners/providers from their local EMRs. With the establishment of a comprehensive population health management platform, the CNYCC will be able to consolidated standardized clinical and administrative data from all eligible partners in order to: 1) centralize reporting functions; 2) perform advanced population health analytics including

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clinical and financial risk stratification; 3) develop patient registries to track the populations at-risk; 4) coordinate care across the continuum. All available sources of information will be utilized by the Clinical Governance Committee to evaluate project effectiveness and inform the development of evidence-based care pathways.

***RCE 3:**

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

The Clinical and Financial Governance Committees will ultimately be responsible for the interpretation and application of the results produced by the CNYCC rapid cycle evaluation (RCE) process. Oversight of these committees by a representative, elected Board of Directors as well as CNYCC operations will ensure fair and equitable treatment of all partners and participating providers. The scorecards utilized by the BAU will be posted to the members only portion of the CNYCC website, that was developed during planning activities. Once available, the population health management platform will be utilized to publish performance data, allowing authorized users access via a secure portal. Access will be limited based on user permissions and retrieval requests for all reports will be logged. The Business Analytics Unit will be available to assist in the interpretation and application of results, using statistical analysis and comparison of outcomes to expected performance.

***RCE 4:**

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

The monthly review of performance data aggregated by provider, organization, region and project will ensure that areas for improvement and areas of success will be quickly and easily identified, which will allow the PPS to promote best practices and process across all partners. The Clinical and Financial Governance Committees responsible for this oversight will ensure that accountability across the PPS is upheld. Non/under performing partners will be subject to investigation by CNYCC operations and peer partners to identify underlying issues. Interventions will be enacted where appropriate and may include training, work with the Regional Project Advisory Committees (R-PAC) and the commitment of additional CNYCC resources. Combined, these factors will ensure that the CNYCC as a whole will be driven by consistent, objective and measureable data that will ensure the effective and appropriate utilization of resources by the collaborative.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

This section is broken into the following subsections:
- 7.1 Approach To Achieving Cultural Competence
- 7.2 Approach To Improving Health Literacy
- 7.3 Domain 1 - Cultural Competency / Health Literacy Milestones

Scoring Process:

This section is worth 15% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 7.1 is worth 50% of the total points available for Section 7.
- 7.2 is worth 50% of the total points available for Section 7.
- 7.3 is not valued in points but contains information about Domain 1 milestones related to these topics which must be read and acknowledged before continuing.

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

***Competency 1:**
Describe the identified and/or known cultural competency challenges which the PPS must address to ensure success.

The PPS serves a region where socioeconomic and demographic changes have not been adequately accounted for in the organization, infrastructure and delivery systems of health care providers, leading to cultural competency challenges. The population of the PPS region is increasingly older and more diverse, reflected in the aging of baby boomers, the departure of younger generations due to limited economic opportunity, and the growing immigrant and refugee population.

The population of the region is predominantly White (86.9%), followed by African American/Black (7.0%) and persons of Hispanic/Latino descent (3.6%). During the period 2000-2010 increases were seen in the relative size of racial and ethnic minority populations. This is particularly relevant in urban areas which include communities where the concentration of racial or ethnic minorities is as high as 70-80%. The cities of Syracuse and Utica, in particular, are home to large and growing immigrant and refugee populations based on the work of local resettlement agencies. Across the region, 5.6% of residents are foreign-born, with the highest percentages in Syracuse (11.1%) and Utica (17.6%), hailing from Bosnia, Somalia, Thailand, Burma, Central America, and Iraq.

In addition to changing demographics of age, race and ethnicity, nearly a third of the population is experiencing poverty (31.6% living below 200% of the federal poverty level). Unemployment ranges from 7.2 %– 10% across the region, although the highest rates are found in rural counties (Oswego and Lewis) and urban centers (Syracuse and Utica).

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While the CNYCC region appears to be fairly homogenous in terms of race, important cultural differences exist, born by age, ethnicity, economics, language, education, and geography to which the organization and delivery of healthcare must be responsive.

***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.

CNYCC's strategic plan to support the development of a culturally competent health care organization and system of care will be a multilevel and continuous process, via assessment, training and hiring practices. At the organizational level, partners will be required to complete a functional assessment of their organizational cultural competency on an annual basis to monitor their performance or compliance with internal standards or guidelines, and in support of QI activities. The ongoing monitoring of demographics, population health, community assets and needs by CNYCC will be an additional resource against which partner organizations can measure the degree to which they are responding to identified needs, for example interpretation services based on the number and size of foreign-born residents in their region.

With regard to staff development, the CNYCC will provide training modules to partner organizations designed to educate and assess staff and other frontline workers on the attitudes, knowledge and skills necessary for delivering culturally competent services. The availability of these resources will be shared via meetings and multi-media platforms (website, webinar, and e-newsletter) aimed at both organizational management and front-line employees. Partner organizations will be required to track and report on their respective training activities on an annual basis. In addition, Partner organizations will be encouraged to employee workers, such as community health workers, representative of the cultures of the community when appropriate.

In addition, CNYCC will disseminate identified best practices and resources related to cultural competency across the collaborative, via meetings and member communications, and through the website and social media. Delivering culturally and linguistically appropriate care at all levels of the health care delivery system is important for the potential it holds to improve access, quality, and ultimately, health outcomes.

***Competency 3:**

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

CNYCC's CNA process included the identification of community-based agencies to support outreach and education efforts in local communities, such as refugee and immigrant resettlement agencies and cultural organizations. PPS efforts will be bidirectional, in that the PPS will look to leverage relationships with community based organizations (CBOs) in order to understand the context in which people live, engage CBOs in the development of intra-organization training and procedures to meet the comprehension and language needs of local communities, disseminate best practices identified in PPS partner organizations, as well as identifying and supporting opportunities to promote cultural competency within and across care settings.

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.

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- 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.

CNYCC will promote health literacy in the regional health care system through partnerships with community based organizations, stakeholders, and providers to build the skills of providers and the population served.

CNYCC will develop a health literacy plan during implementation planning (January-March 2015) utilizing the "National Action Plan to Improve Health Literacy" (US Department of Health and Human Services).
CNYCC's plan will address the "Ten Attributes of Health Literate Health Care Organizations" (IOM, June 2012) which includes: 1) ensuring leadership makes health literacy integral to its mission, structure, and operations; 2) integrating health literacy into strategic and operational planning, quality improvement, goals, and measures; 3) preparing the workforce to address health literacy issues and monitoring progress; 4) providing easy access to health information and services and helping to find the way in facilities; 5) addressing health literacy in high-risk situations; 6) communicating clearly available health services and cost; 7) including members of groups served in the design, implementation, and evaluation of health information and services 8) meeting the needs of audiences with a range of health literacy skills while avoiding stigmatization 9) using health literacy strategies in oral communication; and 10) designing and distributing print, audiovisual, and social media content that is easy to understand and act on.

CNYCC will contract with a variety of CBOs such as refugee and immigrant resettlement agencies and literacy organizations to achieve and maintain health literacy and to ensure patients understand information and services and use them to make appropriate decisions about their health. Specifics will be determined during implementation planning . CNYCC will engage medically trained interpreters familiar with clinical terminology and provider protocols. CNYCC will arrange for face-to-face access to interpreters whenever possible and engage interpreters from outside the patient's immediate family, to reduce emotional factors. If culturally appropriate, the CNYCC will arrange for interpreters to be of the same gender as the patient served.

Additionally, CNYCC will contract with CBOs such as a literacy program to test the readability of patient education materials. CNYCC recognizes that many patients don't understand written words and will provide training to providers and utilize other communication techniques such as pictures, computer screens, and other visual media. The PPS will make health information accessible to everyone regardless of background, education, or literacy level. CNYCC will test messaging and get feedback from members of the intended user groups prior to designing communication and educational materials. The PPS will also work with community-based organizations to ensure that health information is relevant to the intended users' social and cultural contexts. The cnycares.org website will see the addition of an online repository of multilingual materials, resources and services, such as interpretation and translation, for both providers and consumers.

CNYCC will also develop guidance and training for partner organizations regarding the integration of health literacy into the policies, materials and training and assessments of their organizational structure. This information will be culled from various sources during implementation plan from academic and gray literature, as well as best practices at a regional level.

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.

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☑ 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 Funds Flow Framework is constructed to account for: implementation costs, revenue loss, bonus payments, services not sufficiently covered by Medicaid, and debt service coverage (e.g., to repay Members financing the start-up). The framework recognizes that certain categories, such as centralized project implementation costs are fixed (or less variable) and as such they will be prioritized (carved out) in the funds flow to achieve sustainability.

The anticipated DSRIP funding by category is based upon the initial project specific budgets. To incentivize providers to work towards achieving DSRIP project metrics, payment allocation to providers are directly linked to each project's performance, while bonus payments require achieving a minimum performance with higher payments for superior performance. The framework will cap funding at 5% for non-Safety Net Providers.

Each project defines specific metrics. Providers participating in a project will have equal access to bonus pools, presuming they achieve a threshold of project metrics specific to their provider type. Additional bonuses will be awarded for the achievement of metrics vital for the realization of core DSRIP milestones.

The framework implicitly addresses provider differences in the other categories as funding for project investments (implementation costs, costs for services not covered by Medicaid) will be allocated proportionate to costs (Provider types investing more in project implementation receive a higher share of funds allocated to project investments). Considerations for revenue loss will be dependent upon the provider's portion of the overall PPS-wide DSRIP utilization reduction (Provider types with higher utilization reduction will receive more funds).

Providers participating in the DSRIP projects have contributed to the development of the Funds Flow Framework. The Finance Committee with input from the PAC recommends funds flow changes to the elected Board of Directors. The Board (comprised of Hospital, FQHC, and

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Community Partner representatives) has the final authority with a 2/3 supermajority to approve the funds flow methodology, including: incentive alignment, performance measurement, and fund distributions. The Board will oversee the disbursement of contingency funds which will cover multiple items, including aiding underperforming projects or geographic areas (Regional PACs) to improve performance on DSRIP metrics. The broad representation of providers and clinical specialties on the Board will help build cooperation to meet DSRIP project goals and build a collaborative organization among participating providers.

CNYCC's contingency fund pool will afford flexibility, allowing the PPS to apply resources for problem solving and unanticipated changes. It will include resources for underperforming Projects and work with distressed Partners.

Allocation methodologies assure funds apply to Projects in proportion to system benefits while assuring support for Partners making changes to meet goals. The allocation supports investment variation by Project and by Partner. CNYCC cannot guarantee full support for Partner investments or full compensation for DSRIP-related revenue loss. However, the methodology for funding these categories will be transparent, will use objective measures, and will apply fairly to Partners regardless of licensure, size, or location. Bonus awards will require a minimum Partner performance against Project-specific metrics with a greater amount available for superior performance. Bonus thresholds will progressively increase over the years to encourage and reward Provider development consistent with PPS goals.

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	20%
2	Revenue Loss	5%
3	Internal PPS Provider Bonus Payments	75%
	Total Percentage:	100%

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

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

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

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☑ 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.

CNYCC conducted a survey of Partners to get an initial assessment of financial stability. Each organization was asked to identify its risk for financial failure in the next 12 months. None of the 1,656 responders indicated such a risk.

CNYCC will expand its information on Partner financial risk through a three-stage process: 1) Identify indicators of financial challenge using third party sources: CNYCC will convene a CFO Peer Support team to identify third-party indicators such as IAAF awards, VAP funding, 990 filings, etc. Using such information, the Peer Support team will identify select Partners for confidential, follow-up discussions. 2) Develop partnership agreements: CNYCC will enter agreements with Partner Organizations that delineate PPS-Partner responsibilities. This will include a Partner's responsibility to disclose financial information when its performance is below threshold levels (e.g., key financial ratios below minimum values). A CFO Peer Support Group will be engaged to consider such disclosures and recommend follow-up action. 3) Monitoring scorecard performance: A Partner's performance on a DSRIP Project scorecard may indicate financial risk, based on CNYCC's analytical and educational resources. Monthly scorecards will be used for Projects, for Partners and for Regional PACSs (R-PACs), and indicators of financial risk will be referred to CFO Peer Support, as indicated.

***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.

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FFS payment methodologies are entrenched within the CNY region, and the current delivery system reflects this.

DSRIP will affect utilization (and therefore, FFS revenue) for some (e.g., hospitals, SNFs), while increasing demand for others (e.g., primary care, behavioral health). Some service demand may not be reimbursed under current methodologies, and some community support services may not be covered.

On the cost side, DSRIP Projects will require capital and staff expenses, and the ability of PPS Partners to accommodate such investments varies. Financially challenged organizations will be hard pressed to budget dollars for new initiatives and to absorb marginal revenue declines from traditional FFS patients.

Based on PPR, PQI, and PPV data in the 6 county region, CNYCC expects the negative workforce impacts of lower utilization to be effectively managed through attrition. The greater challenge will be accommodating new primary care and behavioral health demand, given these constraints: the size and location of ambulatory facilities, the regulatory and CON process, the scarcity of professionals and difficulties in recruiting to the region.

DSRIP presents an opportunity for organizations, even financially challenged ones, that understand and plan for service transformation and changes in payment methodologies. Transformation of the health care system may necessitate market-restructuring which may include the need for organizations to right-size or re-purpose their systems of care. DSRIP incentives and PPS support can inform and assist such efforts. Further, CNYCC will foster community-wide understanding and Peer Support through its Regional PACs (R-PACs) as local Partners work together in advancing Projects, measuring impacts, and making adjustments.

Organizations must appreciate that DSRIP will not improve status quo situations that are inconsistent with system reform and DSRIP Project goals. Financially challenged institutions may be reluctant to disclose the extent of their distress, but CNYCC presents a unique opportunity for them to collaborate on meaningful goals to assist (if not assure) transition to the post-FFS payment environment.

Through Funds Flow, CNYCC has specific plans to support implementation costs and to reward Partner success in bonus payments. In the early years, CNYCC funding will be proportionately more generous for infrastructure and Project investments. In later years, Funds Flow will shift to greater rewards for Partner success. CNYCC's Funds Flow will be available to mitigate lost revenue due to utilization changes. Additionally, CNYCC plans for Set-Aside funds that can help financially challenged Partners through resourced learning and transitional support.

At application time, the CNYCC DSRIP valuation remains imprecise, and PPS infrastructure and project budgets remain in initial drafts. Based on current information and assumptions, it is unclear if DSRIP funds can adequately support or reward the individual and collective investments the PPS and the region require.

Beyond the DSRIP valuation and funding mechanics, however, CNYCC has moral authority through its network role and DOH relationship. This authority will become greater as CNYCC gains experience and achieves success, and CNYCC has the potential to support Partner changes through grant applications and supportive business relationships that will provide additional value for Partners.

With all its tools, CNYCC will act establish, support, and build an effective Partner network CNYCC, understanding the ultimate purpose is to better serve Medicaid and low-income uninsured populations and develop the network to be sustained beyond DSRIP. Should a Partner -- for financial reasons or otherwise -- withdraw from CNYCC, the PPS would identify alternative steps to assure proper system function and continued progress.

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.

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CNYCC's path to financial stability begins with its co-leads (Members), each of which has relationships with Partner Organizations. CNYCC believes trust among Partners and a fair governance structure provide the basis for stability and progress. With PAC input, the Members developed a governance model reliant upon PAC representatives for Board positions and Committee membership. The Board structure balances the interests of Hospital and Community Partners, supports transparency, and requires consensus (2/3 supermajority) for key decisions. The Regional PACs (R-PACs) assure focus and support in addressing local needs within the region.

CNYCC Members have Reserved Powers, providing fail-safe support for the PPS. Three co-leads will provide working capital, assuring CNYCC is properly organized and resourced in advance of DY1. They are positioned to provide additional financing, as may be required in subsequent years, further assuring PPS stability.

Through the Funds Flow process (described previously), CNYCC will use Set-Aside Funds to support PPS operations, including debt service. The Set-Aside includes Reserves for capital infusions for underperforming Projects or R-PACs. Reserves will allow CNYCC to positively intervene where Projects or Partners are challenged. In addition, CNYCC supports 11 Projects, proportionate to the full potential of each. Support is through Project Investments (~ 60%), support for Partner Revenue Loss (~ 16%), and Bonus payments for high performing Partners (~ 24%).

CNYCC is organized to provide professional and support staff to monitor Project and Partner effectiveness with ongoing reports to R-PACS and Board Committees. This will identify weaknesses to be addressed through CNYCC's Process Improvement process or, as necessary, the Board sanctioning process (described previously).

Finally, CNYCC is a provider network unlike previous relationships among Partners. It can provide Peer Support for challenged Partners, focusing collective attention on areas with underperforming or at-risk services, as well as support for regional solutions in consultation with DOH.

***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.

CNYCC seeks to transform the service system for the Medicaid population by supporting network effectiveness and service accessibility. CNYCC has multiple tools to work with fragile safety net providers:

- Funds flow investments that assist Partner-specific Projects in adapting to change;
- Funds flow that temporarily compensates for Revenue Loss associated with DSRIP changes;
- Set-Aside (reserve) funds allowing CNYCC to assist Partners where they may be challenged;
- CNYCC's moral leadership within the integrated delivery model, focused at the sub-regional level (Regional PACs); and
- Peer Support involving education, training, problem-solving, and other potential assistance.

Using Funds Flow tools as well as Peer Support, CNYCC will work with fragile safety net providers to support sustainability as Partners within the network. In some cases, sustainability may best be served by Provider reconfiguration or affiliation with a stronger Partner. In working with fragile safety net Providers, CNYCC expects to support service sustainability through its professional staff, its resource tools, and it network leadership.

***Path 3:**

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

CNYCC will use DSRIP incentives to align services and improve care coordination, identify opportunities for value-based contracting, and develop network systems and expertise.

By establishing a comprehensive population health management platform (DY3), CNYCC will be able to consolidate standardized clinical and administrative data from eligible partners to: (1) centralize reporting functions; (2) perform advanced population health analytics including clinical and financial risk stratification; (3) develop patient registries to track the populations at-risk and; (4) coordinate care across the continuum. Continued use of this platform after DY5 will assure outcomes continue to be monitored and coordinated care delivery remains in place.

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The impact on utilization and insurance costs offers potential for value-based contracts with MCOs, based on interim DSRIP achievements. Respecting anti-trust limitations and consistent with COPA, CNYCC will support Provider education and contracting readiness during DSRIP while preparing for the post-FFS environment after DY5.

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.

CNYCC shares NYSDOH's vision for value-based payment methodologies involving MCOs in the post-DSRIP years. This means CNYCC is much more than a regional mechanism for achieving DSRIP incentives. CNYCC must mature as a network in preparing Partners for the post-FFS environment. CNYCC will do so by:
- Aligning Partners in working effectively together toward measurable targets in a transformational care model;
- Meeting monthly with MCOs on utilization trends, performance, and payment reforms (consistent with 2.a.i.);
- Educating Partners to opportunities for negotiating pay-for-performance contracts with MCOs in advance of DY5 by taking advantage of Project improvements in population health and reductions in preventable admissions and ED visits; and
- Developing CNYCC's infrastructure, professional expertise and resources to perform network functions for at-risk contracting on behalf of its Partners post-DY5.

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

Payment transformation promises to free Providers from a business model focused on production, replacing it with one that rewards population health management. CNYCC's network will encourage Partners to devote resources in developing the population health model, preparing to move beyond FFS transactions only. CNYCC will provide safety net Providers with the structure, learning systems, expertise and processes for building a new business focus and will reward them as they do so.

CNYCC will assist Partners in two ways: through technical support and leadership assistance.

Technical support includes:
- Educating a Partner in changes that prepare for the post-FFS environment
- Providing support for Project implementation and transitional Revenue Loss
- Rewarding success through Bonus payments
- Helping overcome resistance to change through Peer Support and PPS expertise

Leadership assistance includes:
- Helping Partners understand how to avail themselves of value-based contracting with Medicaid MCOs, based their success in DSRIP Projects that reduce utilization and improve outcomes (e.g. P4P, shared savings, and potentially sub-capitation)
- Assisting Partners that are considering substantive changes to address scale inefficiencies, service mix changes, medical staff performance, etc.
- Providing Peer Support to address potential reconfiguration or affiliation with a stronger Partner.
- Developing the PPS infrastructure for ACO-like functions by DY5

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.

The four CNYCC lead entities along with PPS partners collectively represent significant capabilities and experience in the implementation of evidence based population health management strategies including:
-Emergency Department (ED) Utilization Management: Implementation of ED-based Patient Navigators reduced non urgent ED utilizations from 23.6% in 2011 to 18.5% through April 2014.
-PCMH Certification: Attainment of PCMH Level 3 2014 Certification in two clinics, and lower levels of certification in 4 additional clinics amongst the lead entities.
-Health Home (HH) Development: Outcome-driven care coordination reduced emergency utilizations in HH enrollees by 11% in 2014.
-Data Analytics and HIT/EHR System Development: Experience in system-wide EHR platform integration and predictive analytics to support population health management.
-SNF Transfer Avoidance: Development of medical protocols and collaboration between EDs and SNF's reduced SNF admissions from 54.1% in 2012 to 50.0% in 2013
-Redesign of Hospital Inpatient Case Management (CM): Relocated RN CMs to PCP/outpatient services and altered the skill mix of hospital based CM to 50% RN CM and 50% discharge planners to improve care transitions.
-Frequently Admitted Patient Program: identified and addressed social determinants of frequently admitted patients with behavioral health diagnoses resulting in a 54% reduction in preventable admissions.

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.

The CNYCC has contracted with the Northern and CNY Area Health Education Centers (AHECs) to carry out the PPS' workforce strategy. Since 1998, AHECs have worked diligently to recruit, train, and retain the health workforce. In NY, AHECs have engaged 200,000 students in healthcare recruitment efforts, provided training for 30,000 health professions students, and provided retraining and continuing education to 137,000 workers. AHECs have achieved these outcomes through 1) development of cutting-edge technologies for delivery of health workforce services in recruitment, training and continuing education, and; 2) development of strong networks of community partners in education and healthcare. This combined strategy of collaboration, innovative and flexible delivery systems has made AHECs a leader in identifying current and future healthcare workforce needs, and marshalling resources and community partners to fill current and emerging gaps.

NAHEC and CNYAHEC have worked successfully with both the NYS Departments of Health and Labor to retrain and redeploy healthcare workers affected by restructuring changes. Relevant awards include: Strategies to Assist Workers Impacted by Berger Commission Actions; Displaced Healthcare Worker Program; and the Emerging and Transitional Worker Training Program. Of particular note, CNYAHEC and NAHEC assisted one of the North Country's largest employers with transformational organizational change as it transitioned its traditional long term care operation to a modern assisted living facility. Coordinating and facilitating training for employee change was a significant component of the project. To date, the local AHECs have managed over $16 million in Federal, State, and private dollars and served over 55,000 individuals.

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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 CNY DSRIP Performing Provider System that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: UNIVERSITY HSP SUNY HLTH SC
Secondary Lead Provider Name:

Lead Representative:	Shawna Craigmile-sciacca
Submission Date:	12/22/2014 09:22 AM

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