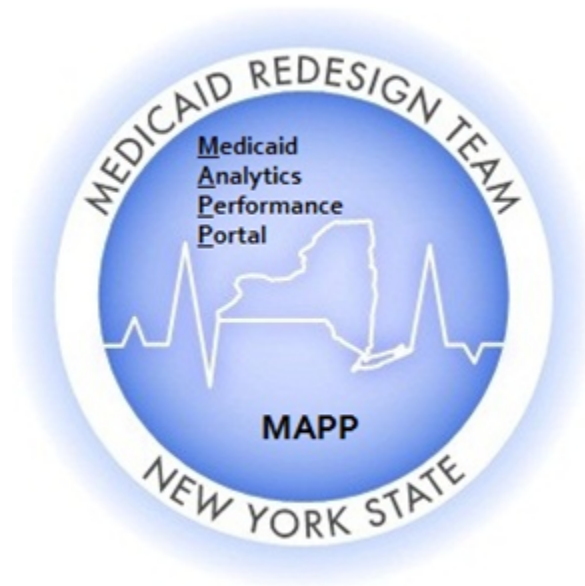


New York State Department Of Health Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Ellis Hospital



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

TABLE OF CONTENTS:

Index..... 4
Section 1 – Executive Summary..... 5
 Section 1.0..... 5
 Section 1.1..... 5
Section 2 – Governance..... 11
 Section 2.0..... 11
 Section 2.1..... 11
 Section 2.2..... 14
 Section 2.3..... 16
 Section 2.4..... 17
 Section 2.5..... 17
 Section 2.6..... 18
 Section 2.7..... 20
Section 3 – Community Needs Assessment..... 21
 Section 3.0..... 21
 Section 3.1..... 22
 Section 3.2..... 23
 Section 3.3..... 24
 Section 3.4..... 25
 Section 3.5..... 27
 Section 3.6..... 29
 Section 3.7..... 31
 Section 3.8..... 37
Section 4 – PPS DSRIP Projects..... 44
 Section 4.0..... 44
Section 5 – PPS Workforce Strategy..... 45
 Section 5.0..... 45
 Section 5.1..... 45
 Section 5.2..... 47
 Section 5.3..... 49
 Section 5.4..... 50
 Section 5.5..... 51
 Section 5.6..... 52
 Section 5.7..... 52
 Section 5.8..... 53
Section 6 – Data Sharing, Confidentiality & Rapid Cycle Evaluation..... 54
 Section 6.0..... 54
 Section 6.1..... 54
 Section 6.2..... 55
Section 7 – PPS Cultural Competency/Health Literacy..... 57
 Section 7.0..... 57
 Section 7.1..... 57
 Section 7.2..... 58
 Section 7.3..... 59
Section 8 – DSRIP Budget & Flow of Funds..... 61
 Section 8.0..... 61
 Section 8.1..... 61
 Section 8.2..... 62
 Section 8.3..... 62
Section 9 – Financial Sustainability Plan..... 64



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Section 9.0.....	64
Section 9.1.....	64
Section 9.2.....	65
Section 9.3.....	66
Section 9.4.....	67
Section 10 – Bonus Points.....	69
Section 10.0.....	69
Section 10.1.....	69
Section 11 – Attestation.....	71



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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: 3_SEC000_Ellis DSRIP Financial Stability Narrative and Spreadsheets.pdf Description of File <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">Scan of Ellis Hospital Signed Financial Stress Test Narrative and Spreadsheets</div> File Uploaded By: smingler File Uploaded On: 12/17/2014 02:34 PM
--

You can use the links above or in the navigation bar to navigate within the application. Section 4 **will not be unlocked** until the Community Needs Assessment in Section 3 is completed.

Section 11 will allow you to certify your application. **Once the application is certified, it will be locked.**

If you have locked your application in error and need to make additional edits, or have encountered any problems or questions about the online Application, please contact: DSRIPAPP@health.ny.gov

Last Updated By: smingler Last Updated On: 12/22/2014 09:49 AM

Certified By: jc418041 Certified On: 12/22/2014 12:11 PM Lead Representative: James W Connolly	Unlocked By: Unlocked On:
--	------------------------------



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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	Better population health via system transformation, clinical/nonclinical improvement, PH management	<p>Since the 1960s Medicare and Medicaid have financially rewarded providers by volume. However, the reward should be population health; health value not health intervention volume. That transformation has been difficult to fully achieve. DSRIP provides a process with incentives to "move the volume to value dial."</p> <p>The data regarding the use of hospitals and EDs in the Ellis PPS region show that a new approach is needed. Clinical expertise is essential but not in isolation. Non-clinical follow up can help maintain members' wellness. The PPS has designed DSRIP projects to achieve the goal of improving population health through integrated delivery and integration of mental health and substance abuse services. With primary care as the lead, the PPS will provide services that teach good health habits, support peoples' frailties, provide post-discharge support after hospital interventions and leverage patient registries. All projects will be connected through an interoperable IT system.</p>
2	Promote community level collaboration (in three groups: behavioral, medical, CBOs)	<p>The integration of behavioral health within the PPS has not been fully achieved. The emergence of substance abuse as a major health issue has additionally challenged the PPS. A large majority of the PPS' super-utilizers have some combinations of physical, mental health and substance abuse issues.</p> <p>The PPS' objective is to meet various health needs with approaches by building linkages with physical medicine, behavioral health and CBOs based on the individual person's needs, appropriate for that individual. The approach will not be successful without a community-wide approach. Linking PPS hospitals with timely hand-offs to existent and new/expanded BH programs is essential. DSRIP provides and formally incorporates CBOs as part of a person's health plan, as health solutions are often based on CBO services.</p> <p>DSRIP has created a vehicle to address the impact poverty, housing and cultural influences have on health and the relationship of trust each individual has with healthcare.</p>
3	Quality driven, life-enhancing, cost effective care delivery ("right care, right place, right time")	<p>At a listening session with ED professionals, many expressed frustration that while most ED care given is needed, it all too often was not "right" regarding time and place. Further it often was not linked to the right follow up. The PPS has chosen DSRIP projects to address this issue in the ED</p>



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

#	Goal	Reason For Goal
		<p>and all levels of care provided. Eventually the PPS must be able to show MCOs that its service is both high quality and cost effective. The PPS believes nothing will impact this more than addressing this issue. Linking MH services while the person is in the ER as opposed to providing a contact number; considering palliative care as a routine part of primary care; engaging the unengaged in their health care; connecting a person with post hospital services including a home visit; connecting with CBOs as appropriate, are some of the PPS' plans. The Ellis PPS believes that these approaches are not only thrifty but represent good care practices.</p>
4	Culturally sensitive person centered care-promotes health literacy, self-care, understanding choices	<p>The effectiveness of person-centered care is understood within the PPS. The work of Jeffery Brenner in Camden NJ made it clear that working with people as they want and need is not only appropriate but it is cost effective. DSRIP discussions led the PPS to ask what can be done to respond to the community on their terms. This became an objective that drove project selection and implementation plane. The Ellis PPS envisions training "high contact" staff regarding ethnic, cultural and linguistic sensitivities. Hopefully positions like Patient Engagement Specialists will use these skills to build community trust one person at a time. That trust will be a key to achieving the PPS goals of enrollment of the uninsured, increased participation in routine health care and expanding health literacy. Entering a home to discuss asthma, tobacco or advanced directives requires mutual respect built on trust in the workers of the PPS.</p>

***Formulation:**

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

The potential of DSRIP was obvious to the providers that were already engaged in creating an ACO. With this common interest a delegated governance model was decided upon to lead the DSRIP program. Weighted voting will be based on attribution. In addition to the three hospital systems and their extensive down-stream programs, the two Federally Qualified Health Centers and two major primary/multi-specialty care provider partnerships were invited to join the governing body. The importance of primary care to the success of the DSRIP goals drove this decision. These providers will constitute the ownership of the newly initiated LLC. In addition, three community stakeholders will complete the membership of the governing body.

The Project Advisory Committee will have access to and representation on the governing body.

The governing body will be responsible for hiring, empowering and providing leadership to the DSRIP CEO who will hire and supervise the management staff. The operational staff will work directly for the PPS members. Committees will be created to coordinate policies and procedures and evaluate performance metrics.

***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.

In 5 years, it is expected that the population of the PPS' service area, particularly those served by the Medicaid program, will experience an integrated system of care across the continuum that is significantly different than the current fragmented one. These new partnerships among health care providers and social service agencies will ensure that Medicaid members receive high quality care that is specific to individual needs both medically and socially. A greater involvement of case managers and care navigators will ensure that high-need individuals receive coordinated care at an earlier stage resulting in healthier individuals and lower health care costs.

It is expected that there will be an EMR system that is fully integrated within the members of the Ellis PPS that has "push and pull" capabilities.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

PPS primary care practices will be PCMH level 3 participation at 100% using 2014 standards.

Further, the PPS expects that CBOs will be critical partners to the ability of DSRIP to meet its goals.

In conclusion, the Ellis PPS hopes to have a fully integrated, person-centered care system.

***Regulatory Relief:**

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

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

- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the waiver request, including a description of how the waiver would facilitate implementation of the identified project and why the regulation might otherwise impede the ability of the PPS to implement such project;
- Identify what, if any, alternatives the PPS considered prior to requesting regulatory relief; and
- Provide information to support why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) 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	Ancillary withdrawal in 822.4 and 822.5 clinics - project 3.a.iv	<p>- The Ellis PPS requests a waiver regarding the regulations governing the provision of ancillary withdrawal in 822.4 and 822.5 clinics and the ability to offer voluntary ambulatory detoxification services.</p> <p>- This waiver is being requested to facilitate the implementation of Project 3.a.iv, Development of Withdrawal Management Capabilities. The waiver will support the ability of existing withdrawal management providers (Part 816 programs) to operate ambulatory detox programs.</p> <p>- Currently, only Part 822.4 and Part 822.5 outpatient OASAS providers can operate ambulatory detox programs connected to their existing outpatient clinic programs. The waiver, if granted, would allow existing Part 816 inpatient detox units to offer ambulatory detox programs leveraging existing staff and expertise, and creating access for members 24/7. In addition, it would help eliminate the need to transfer patients from a Part 822-4 or 822-5 clinic to a Part 816 program for acute management of withdrawal when the patient presents with severe withdrawal or have used substances within the last 24 hours. If the Part 816 program can provide the ambulatory detox, there is a greater continuity of care.</p> <p>- If the waiver is granted Part 816 providers would offer ancillary withdrawal services as an additional level of care to the medically managed and medical supervised withdrawal services they currently offer. Ancillary withdrawal services would be provided consistent with existing OASAS regulations and guidance documents.</p> <p>- The waiver would allow existing inpatient detox programs the ability to provide ambulatory detox services to members presenting for symptom relief in the emergency departments and newly developed ED Triage services. This "no wrong door" approach would expedite the referral of patients to the most appropriate and least restrictive level of care reducing</p>



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

#	Regulatory Relief(RR)	RR Response
		<p>wait times for services with a goal of seamless transitions. As it currently stands, OASAS indicates that Part 822-4 and 822-5 providers should be familiar with Part 816.5 (C) (1) – "Procedures for the clinical evaluation and management of alcohol and/or other substance specific withdrawal syndromes, to include the use of standardized withdrawal evaluation instruments,(including, but not limited to, Clinical Institute Withdrawal Assessment [CIWA] or Clinical Opiate Withdrawal Scale [COWS], if available.)". Part 816 providers already have this knowledge, so it does not pose a risk to patient safety.</p>
2	<p>Reimbursement for collaborative team meetings - project 4.a.iii</p>	<ul style="list-style-type: none"> - The Ellis PPS requests a waiver in the form of a State Plan amendment (in Section 599.14), which currently does not provide reimbursement for collaborative team meetings. - This waiver will facilitate the implementation of Project 4.a.iii, Strengthen Mental Health and Substance Abuse Infrastructure across Systems. The change would enable providers from multiple clinical disciplines to be reimbursed for team meetings for comprehensive care planning (which is currently not billable). These team meetings are an important component proposed within the plans of Project 4.a.iii. - The PPS requests this waiver because section 599.14. This stands in the way of integrating behavioral health and primary care since the two disciplines need to talk but, while the talk is allowed, the professional staff is not willing to do so for free. Integrating Behavioral Health and other health disciplines creates the opportunity to effectively collaborate. The current system is to schedule separate appointments on separate times and likely places and share notes (at best). The Ellis PPS expects to combine these services by location and need the change in regulations would maximize the benefit. - If the waiver is granted, multidisciplinary providers would be reimbursed for team meetings. The change would make the patient easier to engage in the dual health needs by creating a unified approach toward care. This presents no risk to the patient; rather, since getting many patients with BH issues to attend appointments is difficult, if patients need to be included in meetings between providers, combining meetings/appointments by location and hopefully time will improve their health and increase their safety.
3	<p>Title 18 NYCRR, 540.6 - project 2.a.i</p>	<p>This request pertains to Project 2.a.i, Integrated Delivery System- it seeks to establish an exception to the 90 day time limitation for Medicaid billing. All too often the delays in doctors' turn-around of written orders go past the 90 limit: due to the limits of physician turn around in signing orders, there are often patients treated with verbal physician orders but not signed orders, many of these patients end up in cases approaching 90 days from admission and leave the agency without a mechanism for payment and at risk of limiting or eliminating patient access to care. This is especially acute in the urban clinic settings.</p> <p>The waiver is necessary simply to insure payment for services rendered in a market place where the cost/reimbursement ration is very tight. As the Office of Health Insurance has recognized, this issue is outside of the control of the Home Care agency. This negatively affects patient access to care as agreed upon in concept by the Department of Health.</p> <p>An extension to 180 days for timely billing of Home Care claims is requested. The Ellis PPS see no impact on safety.</p>
4	<p>Coordinate the assessments needed as patients move within and Integrated Delivery System - 2.a.i</p>	<p>The regulations that the PPS seeks waivers on to facilitate the project 2.a.i, Integrated Delivery System, are: CHHA assessments Title 10 NYCRR Part 763.3 and 42 CFR 484. 55 (federal); Plan of Care: Title 18 NYCRR section 540, Title 10 NYCRR 763.6, 42 CFR 484.18 (federal); Physician Orders: Title 10 NYCRR 766.4, Title 10 NYCRR 763.7.</p> <p>These regulations are duplicative of MLTC requirements.</p> <p>The IDS should be integrated to the degree that its assessments are not</p>

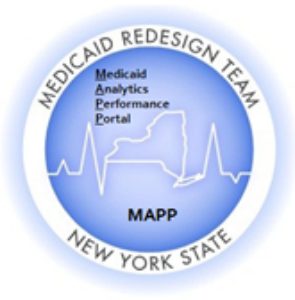


**New York State Department Of Health
Delivery System Reform Incentive Payment Project**

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

#	Regulatory Relief(RR)	RR Response
		<p>duplicative and such a system would have efficient, necessary and timely changes in a care plan. The ease of service changes within the IDS plan of care should not be hindered by duplicative assessments.</p> <p>This waiver will assist in reach project goals by making the process more efficient. It will help build relationship of confidence with a singular care coordinator who is not leading a patient through unnecessary burdensome steps, it will make for faster decisions and it will save system resources Using the MLTC UAS system, is consistent with the direction of the NYS Medicaid program.</p> <p>The Ellis PPS can see that coordinated assessments could speed needed services, eliminating risk to patients.</p>
5	Title 10 NYCRR, 415.26 and 400.11 - project 2.a.i	<p>The waiver of these regulations would facilitate the implementation of project 2.a.i, Integrated Delivery System. The PPS seeks to allow a Nursing Home to admit someone without requiring a PRI and Screen, to enable more rapid admission.</p> <p>The movements of patients within the PPS should be timely yet considered. Care planning within an IDS for a patient based on the right care, in the right place at the right time should not be delayed due to a PRI or a Screen. The purpose of these forms has changed over time but their use now is to ensure that an improper placement doesn't take place; that responsibility will be passed to the IDS, making these forms redundant.</p> <p>Also in rural or border communities where the local hospital is out of state (Hoosick Falls as an example in this DSRIP region), arranging for a person trained to conduct these evaluations can delay admission.</p> <p>This waiver will allow the PPS to base admission planning on the IDS systems</p> <p>By allowing this change for only patients enrolled in the supervising IDS, eliminate risk.</p>
6	Create regulatory language to expand SNF services - project 2.a.i	<p>This waiver would facilitate the implementation of Project 2.a.i, Integrated Delivery System. Various references in the NYS Residential Health Care Code are made regarding allowed and covered services. Many services are not specifically prohibited, but there is no language specifically allowing them (such as chemotherapy services, hyperbaric services for wound care.) An IDS should plan and coordinate services across service lines. Often the reason an SNF resident is admitted to a hospital is based on strict understandings of the limits of SNF care. These limits should be flexible in a changing health system.</p> <p>Avoiding Hospital admissions can be achieved by reconsidering limits on SNF care.</p> <p>A committee of providers and regulators should consider expansion of SNF services and the require audits by the SNF quality programs.</p> <p>The MLTCs would need to approve and properly compensate all providers. Patient risk would be controlled by training and quality control.</p>
7	State Licensure Threshold policies - project 3.a.i	<ul style="list-style-type: none"> - The regulation that the Ellis PPS would like waived pertains to the present State Licensure Threshold policies in the Regulatory Flexibility document. - This waiver is being requested to facilitate the implementation of Project 3.a.i, Integration of Primary Care and Behavioral Health Services. Physical location at the same address and use of shared space for primary care and behavioral health services is currently prohibited because of this regulation. The main component of the plans for project 3.a.i is to co-locate PC into BH services and vice versa. - Ellis PPS is requesting this waiver in order to facilitate the integration of primary care into currently licensed OMH and OASAS provider spaces. - An alternative the PPS considered is to allow each licensed facility to share space. In many cases an Article 28 provider will be providing primary care in an OMH or OASAS licensed space. - Allowing use of shared space for Primary and BH/OASAS services will



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

#	Regulatory Relief(RR)	RR Response
		effectively create a "no wrong door" access point for this vulnerable population. The waiver will support access, affordability, and quality care to a population that is difficult to manage and treat effectively in a coordinated or integrated manner. The issue here historically for NYS OHSM has been one of shared space leading to the potential for capturing space costs multiple times and providers potentially being reimbursed multiple times for the same space usage. There are no patient safety concerns in this request, only that of having the benefit of using a space that the patient is already comfortable with in hopes of increasing adherence.
8	10 NY CRR 864.9 - project 3.a.i	<ul style="list-style-type: none"> - The regulation that the Ellis PPS would like waived is 10 NY CRR 864.9. Presently, Article 28 Hospital Outpatient Departments and Diagnostic & Treatment Centers (D&TCs) providers are limited to one threshold visit being billed per patient per day, regardless of the number of clinical interventions being completed on that day in that single site of care. - This waiver is being requested to facilitate the implementation of Project 3.a.i, Integration of Primary Care and Behavioral Health Services. Delivery of Primary Care and Behavioral Health services in the same setting will undoubtedly lead to services from each discipline being provided to a patient on the same day in order to maximize the integration of Physical and Behavioral Health services. - The Ellis PPS believes that to support the integration of care, D&TCs will need to be adequately reimbursed to cover costs. - An alternative the PPS considered is to allow D&TCs to bill for multiple services on the same day, or develop a primary care capitation plan to provide an alternative rate methodology. - Allowing D&TCs to bill for more than one service on the same day will be beneficial to this vulnerable population. The ability to address the behavioral health and somatic issues in a patient in a single visit is the cornerstone to integrated care. Assessing the BH aspects of one's chronic medical condition requires much more time to allow for the appropriate clinician to complete the assessment and the medical provider to address the somatic concerns in a coordinated manner. Asking the patient to make multiple visits in a week's time to address the comprehensive needs of his/her clinical condition is not efficient, unfriendly to the patient and not likely to foster care integration. The waiver will support access, affordability, and quality care to a population that is difficult to manage and treat effectively.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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:

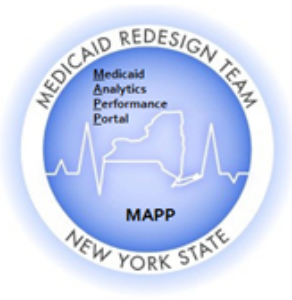
Description:

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.

Delegated Governance Model. The Ellis PPS proposes to implement a delegated governance model through the formation of a limited liability company (for now, "NewCo, LLC") for the purpose of operating a DSRIP PPS in the Counties of Rensselaer, Albany, Schenectady, Saratoga, Montgomery and Fulton. The DSRIP application for these counties will be submitted by Ellis Hospital, the lead applicant. NewCo, LLC is expected to be formed before March 1, 2015, and will contract with the State Department of Health as the DSRIP PPS. It is expected that the governing body of NewCo, LLC will consist of (but not necessarily be not limited to) representatives of the 7 key organizations in the Ellis Hospital DSRIP application: Ellis Hospital, St. Peter's Health Partners, St. Mary's Healthcare (Amsterdam), Whitney M. Young Jr. Health Center, Hometown Health Centers, Capital Care Medical Group, and Community Care Physicians (the 7 Key Members). The first 3 are safety net hospitals (or in the case of St. Peter's Health Partners, a healthcare system that includes safety net hospitals); the next two are FQHCs which qualify as safety net clinics; and the last two are multi-specialty physician groups. The 7 Key Members decided upon this model after review of KPMG's "How To' Guide – Governance" and after consideration of



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

alternative models including the Collaborative Contracting model. After careful discussion, a clear consensus emerged that housing the PPS in a separate legal entity would constitute the simplest and clearest approach to organizing this complex collaborative effort. It would also provide familiar and intelligible means to address issues of representation and decision-making regarding clinical matters, financial matters and IT matters.

Embodying the skills, knowledge, experience and vision of the region's leading healthcare institutions, NewCo, LLC will be well positioned to design, implement and oversee the steady progression of a coalition of participating partners into a well-integrated and highly functioning network that will meet the needs of the region's communities in a more effective, coordinated and responsive fashion. NewCo, LLC will combine the creative energy of a new venture with the stability and sustainability of established regional healthcare leaders. This governance design is conducive to DSRIP implementation and success.

The following actions are reserved to the NewCo, LLC board and require a vote of 75% of all the membership interest:

- Appointment of CEO of the company;
- Any amendment of the Articles of Organization;
- The sale, lease, exchange or other disposition of substantially all of the assets of the company;
- The merger or consolidation of the company with another entity;
- The dissolution of the company;
- The admission of any new Member;
- The adoption or amendment of any methodology for the allocation of DSRIP funds;
- Removal of a Manager or Member (excluding replacement of a Manager by a Member).

The governance structure and processes outlined here have the backing of the leaders of the respective organizations, as well as the members of the PPS governance committee drawn from various disciplines within each of the 7 Key Members.

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:	3_SEC021_\\efs\users\ELLIS\sminglerd\1115 Waiver\Application\Final Sections\Ellis PPS Governance Structure Chart Final.docx
Description of File	Ellis PPS Organization Chart
File Uploaded By:	smingler
File Uploaded On:	12/19/2014 09:40 AM

***Structure 2:**

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

Effective governance requires a common objective, fair representation among the principal stakeholders, and clear rules for arriving at decisions. Through the project application development process, the key organizations have already identified a shared objective: to create an integrated delivery system that will improve care and reduce unneeded hospitalization among Medicaid patients and the broader population. The Delegated Governance Model structure described above will ensure fair representation through the PPS, LLC governing body and clear rules for making decisions. Senior Leadership will be recruited, as needed, for such roles as Chief Executive Officer, Chief Information Officer, Chief Medical Officer and Chief Financial Officer.

An LLC operating agreement will facilitate both cooperation and decision-making by specifying, among other matters:

- The composition of the governing body, their terms and the appointment and removal process
- Actions that require majority vote; actions that require supermajority votes
- Governing board committees, including Finance and Audit, Clinical and Data/IT
- A process for adding and removing Participating Members/Managers
- A process for deciding upon distributions
- A process for securing capital contributions
- Compliance (including antitrust compliance) requirements



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

Page 13 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

NewCo, LLC envisions a management structure, with adequate dedicated and experienced staff, that will provide for central, coordinated oversight of this integrated delivery system, and pursue the stated objectives of DSRIP.

The governing body will be a single entity with various committees. The governing body will be comprised of representatives from each lead organization, independent providers who are not employed by any member, and a Project Advisory Committee member appointed by that Committee. The committees will be comprised of participating physicians, community leaders and social service representatives.

***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.

Most of the 7 Key Members of NewCo, LLC have current direct experience in the establishment of a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed establishment of a Medicare MSSP ACO through the creation of the new Innovative Health Alliance of New York, LLC (IHANY). IHANY meets federal requirements for a MSSP ACO, including adoption of clinical standards, a compliance program and a process distribution of shared savings.

A Clinical Integration Committee will be established as a standing committee of NewCo, LLC. Through that committee NewCo, LLC will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to ensure a process for standardization of clinical best practices. The committee will be responsible for establishing operating standards and clinical guidelines, which includes Behavioral Health (BH) and Substance Use Disorders (SUD), to be used in the care of Medicaid members and others served by the PPS, focusing first on the project areas.

The Clinical Integration Committee will also assume responsibility for determining whether the PPS participating partners are complying with NewCo, LLC's operating standards and clinical guidelines. In instances of noncompliance, the Committee will impose a corrective action plan on a participating partner, and require successful implementation of the Corrective Action Plan as a condition for full distribution of DSRIP funding.

The Clinical Integration Committee will also create a network annual quality improvement plan, prioritizing areas where the PPS overall could improve its performance against its own clinical standards.

***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.

The PPS' DSRIP application is submitted by the lead applicant Ellis Hospital. NewCo, LLC will be formed before March 1, 2015 and will be the contracting party in the contract with the NYS DOH as the DSRIP PPS. The development of an operating agreement will set forth the structure and processes required to effectively govern the articulated integrated delivery system (IDS) vision of the PPS.

Agreement on the formation of a collaborative LLC is a significant milestone on the road to an IDS. It shows the commitment of the 7 Key Members to creating that system and reveals a common vision of a key feature of the IDS. Most of the 7 Key Members of NewCo, LLC have direct experience in establishing a new, transformative, risk-based, region-wide, healthcare infrastructure, having just completed a Medicare MSSP ACO through the creation of the new Innovative Health Alliance of New York, LLC (IHANY). IHANY meets federal requirements for a MSSP ACO, including adoption of clinical standards, a compliance program and a process distribution of shared savings, all components of a high performing IDS. Given the overlap of the geography (the MSSP and DSRIP projects cover the same 6 counties), partner membership and purpose, the PPS intends to explore ways to leverage the 2 projects by sharing applicable infrastructure.

The IDS will provide clinical integration across the PPS and require all Primary Care Practices to be PCMH Level 3 by end of Demonstration Year 3. Primary care, Specialists and Care Managers will be recruited to extend hours and access at PCPs. Care will be coordinated among members by implementing IT connectivity with RHIO.

NewCo, LLC will improve Care Triage in EDs by embedding patient navigators within all hospital EDs to help patients establish primary care and identify community support.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

NewCo, LLC will integrate primary care and behavioral health by providing PC in one BH clinic in each of the 4 urban settings. BH will be provided in targeted PC locations.

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.

It is expected that its governing body will consist of (but not necessarily be not limited to) representatives of the 7 Key Members.

Governing body committees will include both governing body members and others who can contribute special expertise to the committee's function. For instance, the Clinical Integration Committee will include physicians and other health care professionals who may not serve on the governing body.

The composition of the governing body will include two representatives from each of the 7 member organizations, two independent providers who are not employed by any member and a member of the Project Advisory Committee (PAC) appointed by the PAC. The governing body will not be commensurate with capital contribution to NewCo, LLC.

The specific members, roles and responsibilities of NewCo, LLC governing body will be as is set forth in the operating agreement.

***Process 2:**

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

As part of the project application development process, the emerging PPS formed a 20 member governance committee composed of members from the PPS Steering Committee representing key healthcare sectors including acute care, health homes, behavioral health services, FQHCs and visiting nurse organizations. Additional members of the committee included expert consultants and legal resources, in addition to in-house legal counsel experienced with the establishment of transformative, risk-based, region-wide healthcare infrastructure.

In exploring an appropriately representative PPS governing body composition, the committee utilized a consensus decision making model and focused primarily on partners' respective attribution levels, operational and financial impacts resulting from shifts in patient flow, contingencies for capital requirements and strategic considerations.

***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.

The Ellis PPS has openly communicated its vision with all partners, inviting participation in developing the planning and project applications. The composition of the Project Advisory Committee has been drawn from the ranks of acute care centers, public health agencies, labor unions, physician practices, managed care organizations, FQHCs, health homes, organizations with particular expertise in behavioral health, substance abuse, asthma and smoking cessation, long term care, and palliative care-all operating within the region's 6 county footprint. Representatives from local Community Based Organizations (CBOs) have also been important participants in the PAC and with project development, thus opening lines of communication between the providers and community with governing body/Steering Committee members who led project planning. This same balanced and representative approach was extended to the formation of the PPS governance body.

***Process 4:**

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



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

based organizations.

All seven organizations involved have significant continuums of care with CBOs. These organizations share information to a centralized repository where the data can be analyzed and the patients are most effectively managed by the members' organizations. Ellis has been the leader of Care Central, a community collaborative and health home of more than 60 partners that coordinates healthcare and social services among its high risk population. Care Central has various agreements with payers to manage the health of the identified population.

***Process 5:**

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

The governing body shall consist of no more than 17 Managers. Each Member of the PPS shall appoint up to 2 Managers, one of whom shall be a clinician. PPS Members will elect 2 independent providers who practice in the region who are not employed by any Member, and one the PAC shall designate as an individual to serve as a manager. PPS members collectively will hold an 85% voting interest to be apportioned among the members based upon their Membership Interest. The elected representatives shall each have a 5% voting interest. Quorum for the transaction of business is established by 75% of the voting interests present at the meeting. Decisions, except those designated as member-reserved powers, are made with a simple majority vote of those representatives present. Member-reserved decisions will include (i) addition of new members; (ii) amendment of Articles of Organization; (iii) disposition of substantially all company assets; (iv) merger or consolidation; (v) dissolution; (vi) amendment of the Operating Agreement; (vii) adoption or amendment of any methodology for allocation of DSRIP funds, removal of a Manager/Member, appointment of CEO of company and require a vote of 75% of all members.

***Process 6:**

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

Effective March 1, 2015, when NewCo, LLC is established, a structure will be identified for the resolution of conflicts. Each member organization will be involved in all conflict mitigations to ensure thoroughness and transparency among partners. All conflicts will be brought to the governing body to hearing and recommended action. These issues will be identified during the regularly scheduled committee meetings.

***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.

Governing body decisions will be reflected in: Minutes, available to the governing body Managers; Policies, which will be distributed to all the parties to whom the policies apply; other transmittals as necessary.

It will be ensured that all governing body Managers have access to Board Effect, a web-based product that facilitates access to governing body materials.

The PAC will be updated on no less than a quarterly basis of appropriate governing body determinations, and relevant information will then in turn be shared with the respective project teams.

***Process 8:**

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

The PPS engagement strategy included monthly PAC meetings, interactive project planning sessions, stakeholder meetings, a PPS website to enable flow of information to the general public, 6 listening sessions, 8 focus groups and a survey to 18,000 community members. The PAC will continue to meet on a quarterly basis and the broader stakeholder community/general population will be kept up to date on PPS developments, population health trends and advancements through the website, an annual community forum and newsletter.

NewCo, LLC will create a physician engagement model focused on education and continuous communication. Education sessions for physicians will have details on the structure of NewCo, LLC, population health and patient base management with info gathered from



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

clinical integration.

Participating providers and community clinical leaders will have collaborative learning and planning sessions, developed with approval of the Board of Managers and Clinical Integration Committee.

Section 2.3 - Project Advisory Committee:

Description:

Describe the formation of the Project Advisory Committee of the PPS. In the response, please address the following:

***Committee 1:**

Describe how the Project Advisory Committee (PAC) was formed, the timing of when it was formed and its membership.

Initially, the Ellis PPS formed a 14 member Steering Committee to complete the planning grant application. That committee was comprised of representatives from the 7 Key Members.

The Steering Committee developed an inventory of key community resources including subject matter experts associated with each project. The committee then, after careful deliberation, arrived at consensus on required additions in expanding the committee to form a 37 member PAC in September 2014. The composition of the resulting PAC is drawn from the ranks of acute care centers, public health agencies, labor unions, physician practices, managed care organizations, federally qualified health centers, health homes, as well as organizations with particular expertise in behavioral health, substance abuse, asthma and smoking cessation, long term care, and palliative care that all operate within the PPS' six county footprint. Representatives from local Community Based Organizations (CBOs) have also been important participants in the PAC and with project development, thus opening lines of communication between the providers and community with governing body/Steering Committee members who led project planning.

The PAC has convened monthly during the planning period and will continue to meet on no less than a quarterly basis throughout the DSRIP project implementation.

***Committee 2:**

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

The PAC presently operates as an internal advisory entity including representation by PAC members on project specific planning and implementation teams.

Moving forward, the PAC will be involved in the development of the operational plan for the respective projects, and then engaged in the implementation and oversight of the project plan, including a member of the PAC serving on the governing body. Through its participation, the PAC will continue to provide voices of expertise through various health care entities and CBO engagement through the PAC will particularly support in ensuring considerations of cultural competency throughout all PPS project implementation.

***Committee 3:**

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

The evolving nature of Ellis PPS has been an open process inclusive of the PAC, whose guidance and feedback has been continuously solicited through weekly project committee meetings and monthly PAC meetings. PAC members were enlisted to help drive attendance and participation at 6 different listening sessions, 8 focus groups, as well as surveys that went out to over 18,000 community members, all of which generated intelligence which was integrated into the PPS' Community Needs Assessment.

***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.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

The Steering Committee developed an inventory of key community resources including subject matter experts associated with each project. The committee then, after careful deliberation, arrived at consensus on required additions in expanding the committee to form a 37 member PAC whose composition is drawn from the ranks of acute care centers, public health agencies, labor unions, physician practices, managed care organizations, federally qualified health centers, health homes, as well as organizations with particular expertise in behavioral health, substance abuse, asthma and smoking cessation, long term care and palliative care, and CBOs that all operate within the PPS' 6 county footprint.

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.

Colleen Susko –Director Corporate Compliance and Audit, of Ellis Medicine, is the designated Compliance Official. Ms. Susko will report directly to the governing body. She will also provide periodic updates to the NewCo, LLC CEO.

*Compliance 2:

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

As a foundation, each PPS Provider will be responsible for maintaining their own compliance program which complies with the Federal and State regulations. These provider programs will serve as compliance monitors for the PPS. An enterprise-wide risk assessment for the PPS as a whole (updated when needed, or at least annually) will be conducted to identify any compliance concerns related to PPS operations and performance. During this assessment, data will be gathered from the PPS governing body and its operational leaders, the Office of Medicaid Inspector General work plan and general industry compliance risks. There will be scheduled audits in the areas specifically identified in the risk assessment. In addition, the Ellis PPS will have an anonymous hotline that can be used by all employees and the public in order to report any compliance issue(s) that may arise.

*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.

Compliance training will begin with an overview presentation of the compliance program to the governing body. Compliance training will be provided, as needed, on risk areas of the PPS. This training will be supplemental to the compliance training provider by each individual provider. The training specific to the PPS is under development. The training with the separate providers currently exists.

*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.

Community members, Medicaid beneficiaries and uninsured community members will be able to file a compliance complaint at any time. An anonymous, 24/7 hotline will be established for complaints to be filed. All complaints will be directed to Colleen Susko, Director of Corporate Compliance and Audit at Ellis Medicine. Complaints will be shared with representatives from all member organizations. Once the complaint has been addressed and resolved, the appropriate parties will follow up with the individual who voiced the complaint to close the process. All complaints will be reviewed by an independent, third-party following resolution.

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:



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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

The existing Finance Committee, currently directing the development of the financial components related to the PPS projects and completion of the application, will be formally established as part of the operating agreement and shall be responsible for all financial management functions for NewCo, LLC. This will include advising the governing body in such areas as systems for claims processing, budgeting, bookkeeping and practitioner reimbursement as well as assisting the audit committee with internal and external audits. The Finance Committee's main responsibility will be to oversee the budgets and reporting of projects as it relates to the distribution of DSRIP funds including review of the financial stability of partners in the PPS and as further described in Sections 8 and 9 of this application. The committee will assume oversight on all value based provider contracts both new and expanded contracts by the end of the project. The Finance Committee's process will develop and analyze financial and operational data reported by PPS partners and projects. Regular summary reports will be developed and provided to the governing body for input and approval then shared with PPS partners.

*Organization 2:

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

The key finance functions will include all those generally included in a finance department of a health care provider, but with a much larger and integrated communication system. These functions will include budgeting and monitoring of the PPS projects, financial stability reviews of the Members on an ongoing basis, assisting in the development of billing and collecting tools and insuring a strong internal control over revenue and expenditures. The budgeting and monitoring of the PPS projects will include the review, monitoring and reporting of project costs, such as workforce hiring, training and redeployment, new costs incurred, revenue analysis, incentive payments proposed and implemented in addition to other elements critical to financial stability of the PPS and its Members. The committee will collect, analyze and report financial results on a regular basis assuring they are accurate and timely. The Finance Committee will report their findings and provide recommendations to the governing body on a regular basis. Another major function of the committee will be the assistance to the audit committee providing data and support for their respective function within the PPS.

*Organization 3:

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

An independent Audit/Compliance Committee will be established as part of the PPS governing body. This committee will determine the planned use of the internal and external auditors based on generally accepted accounting principles and practices. The A/C Committee will be responsible for recommending internal and external auditors to the Board of Trustees. They will work with data prepared and provided by the Finance Committee and the management of the PPS to develop independent reports on the overall financial condition of the PPS and the distribution and use of DSRIP funds. The A/C Committee will develop a process and timing of internal and external audits. They will report the results of these audits directly to the governing body of the PPS. The Finance Committee will have the opportunity to provide a management response to these audits and provide these responses as part of the final audit report presented to the governing body. The A/C Committee will be responsible for reviewing such issues as conflict of interest that may occur and the overall adherence to Medicaid compliance policies and procedures established by the PPS governing body.

*Organization 4:

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

The A/C Committee will establish and oversee the compliance program of the PPS and ensure that it meets the standards spelled out in NYS Social Services Law 363-d. The PPS partners are already participating in the Medicaid program and have compliance programs meeting of these requirements. The A/C Committee will be responsible for the integration of the overall compliance program of the PPS, incorporating many of the existing program components of the individual Members. This will provide for a similar program across the PPS membership and efficiently develop the compliance policy by building on what already exists. The compliance program developed and implemented will include written policies and procedures, training and education of all affected employees, communication lines to the A/C Committee, disciplinary policies to encourage good faith participation, a system for routine identification of compliance risk areas and a system for responding to compliance issues as they are raised. The A/C committee will regularly report to the governing body and have the ability to engage an independent party to review and audit the compliance program.

Section 2.6 – Oversight:

Description:



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

A Clinical Integration Committee will be established as a standing committee of NewCo, LLC. Through that committee, NewCo, LLC will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to insure a process for standardization of clinical best practices. The Clinical Integration Committee will also assume responsibility for determining whether the PPS Participating partners are complying with NewCo, LLC's operating standards and clinical guidelines, including: Clinical outcomes; Compliance with clinical process standards; Beneficiary experience and Citizenship.

In instances of noncompliance, the Committee will impose a corrective action plan on a Participating Provider and require successful implementation of the Corrective Action Plan as a condition for full distribution of DSRIP funding.

The Clinical Integration Committee is also responsible for creating a network annual quality improvement plan, which prioritizes areas where the PPS overall could improve its performance against its own clinical standards and guidelines, including Behavioral Health and Substance Use Disorders.

***Oversight 2:**

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

The Ellis PPS will establish performance expectations and monitor performance. Specifically, the PPS will: establish benchmarks for performance expectations; include target benchmarks and performance expectations in the contracts with all participating partners and vendors; monitor and evaluate on a regular basis (e.g. monthly) PPS Participating partners' compliance with PPS operating standards and clinical guidelines; in conjunction with the Clinical Integration Committee, develop a corrective action plan in the event a Participating partner is performing at a level that is significantly below target benchmarks or performance expectations; timely reports on progress consistent with the terms of the corrective action plan will be provided to the Clinical Integration Committee to monitor improvement activities; and the Clinical Integration Committee and PPS Medical Director shall work collaboratively with the participating partner until the performance improvement opportunity is corrected or otherwise addressed.

***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 PPS will establish the following Policy/Procedure:

I. Procedural Rights. Any participating Member who is the subject of a Potential Adverse Action shall be afforded the procedural safeguards set forth in this Policy

II. Notice of Request for Hearing and Waiver. The PPS Medical Director shall give written notice to the affected participating partner of any Potential Adverse Action Trigger or Summary Suspension.

III. Notice of Hearing. The PPS Medical Director will schedule and arrange for a hearing and shall notify the participating partner.

IV. Hearing Committee

A. Committee. The hearing shall be conducted by a Hearing Committee, which shall be composed of at least five (5) members: four (4) physicians shall be appointed by the PPS Medical Director from any of PPS's other committees, and one (1) shall be appointed by the Participating partner from any of PPS's other committees. The remainder of any additional members of the Hearing Committee shall be appointed by the PPS Medical Director. The Committee will choose the Chair of the Hearing Committee.

B. Qualifications. No member of the Hearing Committee appointed by the PPS Medical Director shall be in direct economic competition with the Participating partner involved.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

V. Conduct of Hearing. The hearing shall be conducted in accordance with an established policy which will set forth rules covering Committee Presence, Participating partner Presence, Responsibilities of Parties, Witness Fees, Procedure and Evidence, Burden of Proof, Hearing Officer, Deliberations, Recesses and Adjournment.

VI. Written Report. The Hearing Committee shall make a written report and recommendations to the PPS Board. A copy of the Report shall be promptly sent to the participating partner.

A. Board Action on Hearing Committee Report. The Board shall be the final decision-maker with respect to all recommended Adverse Actions and Summary Suspensions.

*Oversight 4:

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

Community members, Medicaid beneficiaries and uninsured community members will have various tools and methods to provide feedback to providers and with NewCo, LLC. A website that encourages comments for participants will be created and a process will be enabled to disseminate the comments to the appropriate contact. Additionally, all parties will have a follow-up regarding the feedback. An anonymous, 24/7 hotline will also enable beneficiaries to reach NewCo, LLC by phone and provide feedback. NewCo, LLC will work with its patient satisfaction vendors to develop a survey tool that is sent to beneficiaries following an outpatient office visit. Additionally, NewCo, LLC will utilize follow-up phone calls with patients to ensure all of their questions are answered and there is an easy method for feedback.

*Oversight 5:

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

The member organizations will share claims data using population health software, Verisk. Using this claims data, and a master list of beneficiaries enrolled in NewCo, LLC, provider participation and their enrolled patients will be continuously reviewed. NewCo, LLC will establish a management structure to review the Medicaid beneficiaries who are enrolled and provide continuous outreach, including automated letters that are mailed to patients when the provider is no longer enrolled. This letter will explain that the provider is no longer a member of NewCo, LLC and detail changes (if any) to their Medicaid coverage. Additionally, all signage and notices announcing the providers' involvement in NewCo, LLC will be removed immediately from the office location.

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



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

Page 21 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

Description:

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

*Overview 1:

Describe the process and methodology used to complete the CNA.

The HCDI/Ellis PPS CNA was completed in two phases. During Phase 1, existing data were analyzed, preliminary analyses of SPARCS data performed, and small area maps developed for Ellis PPS review. Results were presented to the Ellis PPS Steering Committee and via Webinar to a broader audience of Ellis PPS providers/stakeholders. Results included summary of County and Hospital CHA/CHIP/CSPs; analysis of 148 county-specific health indicators and PQI, PDI, PPV, and PPR rates; multivariate analyses of SPARCS Medicaid Inpatient and ED encounters, and mapping of key indicators. Ellis PPS "Proposed Projects" were categorized as: having sufficient evidence of need; not yet having sufficient evidence to continue; or other projects where evidence of need was found, but not identified as a "proposed project". Phase 2 involved collection of additional information to clarify the specific DSRIP projects and target geographic areas for project start-up. Ellis PPS providers and stakeholders formed Sub-Committees to assist with this effort. Ellis PPS assisted in the creation of the provider/CBO lists for the provider survey, key informant interviews, and provider/CBO listening sessions; and with the identification of beneficiaries for the consumer survey, community listening sessions, and focus groups. Sub-committee discussions helped focus questions for the listening sessions and focus groups. The web-based provider (n=184) and consumer (n=120) surveys; key informant interviews; 8 focus groups (3 chronic disease; 5 behavioral health and/or substance abuse); 3 Provider/CBO, and 5 Community/CBO listening sessions, were conducted in October-November 2014. Ellis PPS Sub-Committees worked closely with HCDI on project-specific analytic requests utilizing SPARCS data, especially the "high utilizer" sub-population analysis, and additional small-area geographic analyses. Ellis PPS and HCDI reviewed the all information to couple identified need with the appropriate DSRIP projects.

*Overview 2:

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

Sources of primary data included: provider survey; consumer survey; focus groups; listening sessions; and key informant interviews. Demographic data sources included US Bureau of Census's: Population Estimates; 2000 and 2010 Census (DP-1; P-42); ACS 5 year estimates (DP-2; DP-3; S-1703); and 2011 Small Area Health Insurance Estimates. The NYSDOH data included: Vital Statistics of NYS-2012; and DSRIP Dashboard B-8, Medicaid Enrollment by Member County. Prevention Agenda County/Hospital Plans came from their individual websites. Data sources for general population health status included the following from NYSDOH: Prevention Agenda Dashboard; Community Health Indicator Reports; County Health Assessment Indicators; County Health Indicators by Race/Ethnicity; Leading Causes of Death in NYS; EBRFSS Reports; Environmental Public Health Tracker-Birth Defects. Non-DOH source used was County Health Rankings (RWJ Foundation). Avoidable hospitalization/ED data sources included: Health Data NY for "All-Payer" PQI, PDI, PPV and PPR events by county, Zip Code or hospital; and Avoidable Hospitalization Chart Book; PQI, PDI, PPV, and PPR data sets for Medicaid recipients by county and Zip Code for Medicaid population. Medicaid hospitalization ,ED data sources, and Clinical Metrics included: Clinical Metrics Chart Book; Medicaid Chronic Conditions, Inpatient Admissions and ER Visits by county and Zip Code data sets; and DSRIP Dashboards B2-B5, B7- B8, C1-C6. Provider information sources included: Ellis PPS provider listing; Salient Provider and Member Work Books; DSRIP Managed Care Provider data; and DSRIP Dashboards B1, B6. PCMH providers were identified via NCQU



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Patient-Centered Medical Recognition website. CBO's were identified through web searches and partner referrals. Certified health care facilities were identified from NYDDOH data files, NPI database, and HRSA data file. Hospital/nursing home data were from NYSDOH website and Health Data, Nursing Home Weekly Bed Census.

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	15	13
2	Ambulatory surgical centers	4	2
3	Urgent care centers	7	3
4	Health Homes	16	14
5	Federally qualified health centers	7	2
6	Primary care providers including private, clinics, hospital based including residency programs	896	506
7	Specialty medical providers including private, clinics, hospital based including residency programs	1311	381
8	Dental providers including public and private	443	54
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	1638	286
10	Behavioral health resources (including future 1915i providers)	212	95
11	Specialty medical programs such as eating disorders program, autism spectrum early	7	3
12	diagnosis/early intervention	9	5
13	Skilled nursing homes, assisted living facilities	23	27
14	Home care services	196	28
15	Laboratory and radiology services including home care and community access	50	12
16	Specialty developmental disability services	0	0
17	Specialty services providers such as vision care and DME	0	0
18	Pharmacies	224	22
19	Local Health Departments	6	2
20	Managed care organizations	8	2
21	Foster Children Agencies	0	0
22	Area Health Education Centers (AHECs)	1	1
23	Hospice	3	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.

The Ellis PPS has capacity constraints resulting in insufficient resources in outpatient and community- settings, limiting the ability to schedule timely follow-up appointments, which could result in readmission. In response, In order to align provider resources with the



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

needs of the community the PPS will employ best practice recruitment and retention strategies to maximize placement of primary care, behavioral health, and dental providers in the communities with greatest gaps as determined by the CNA. The PPS will also extend primary care capacity by 10-15 hours a week on average while also incorporating open-access scheduling within PCP sites to address qualitative data findings suggesting that much of ED use is due to lack of access to a PCP during necessary hours. In addition to using best practices for recruitment and retention to bolster the number of primary care, behavioral health, and dental providers, the PPS will also endeavor to leverage their prior PCMH experience to ensure that the PPS reaches 100% NCQA Level 3 certifications. To reinforce and implement other initiative, a strong force of care managers will also be necessary, and the PPS intends on satisfying that need through recruit of these positions within its health homes, primary care practices and community based organizations.

For facilities and facility capacities, there will no reduction within the earlier years as area hospitals within the PPS have gone through consolidation via the Berger Commission in 2006, with many other hospitals following suit in "right-sizing" activities. Beds may be reduced by years 4 and 5 after determined by DSRIP success. This also holds true of long term care beds.

The Ellis PPS will provide palliative care training to PCPs and deploy palliative care coaches to support these providers in offering palliative interventions that are culturally and linguistically appropriate.

✔ 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	229	14
2	Food banks, community gardens, farmer's markets	116	8
3	Clothing, furniture banks	0	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	8	3
5	Community outreach agencies	24	4
6	Transportation services	0	0
7	Religious service organizations	37	6
8	Not for profit health and welfare agencies	48	4
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	8	2
10	Peer and Family Mental Health Advocacy Organizations	23	8
11	Self-advocacy and family support organizations and programs for individuals with disabilities	5	1
12	Youth development programs	32	4
13	Libraries with open access computers	46	1
14	Community service organizations	14	2
15	Education	0	0
16	Local public health programs	16	3
17	Local governmental social service programs	8	2



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
18	Community based health education programs including for health professions/students	0	0
19	Family Support and training	23	4
20	NAMI	0	0
21	Individual Employment Support Services	4	2
22	Peer Supports (Recovery Coaches)	12	4
23	Alternatives to Incarceration	2	1
24	Ryan White Programs	0	0
25	HIV Prevention/Outreach and Social Service Programs	4	1
26	Senior support services	0	2
27	Other	0	4

***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.

The current PPS health homes will continue to work closely with current CBO relationships and foster new ones to coordinate care with members.

The pervasive comment throughout focus groups and listening sessions performed for the CNA was a lack of transportation. The community has a public transportation system, but getting across counties to multiple locations was often described in listening sessions as overly cumbersome and inconvenient at best. Aiding in the creation of increased transportation services the PPS will contract with services in order to provider 24 hour on call transportation services.

To assist in the tracking of clinical measures pursuant to DSRIP benchmarking and milestones as well as to assist in project initiatives such as integration, the use of a RHIO/HIE will be utilized, specifically a partnership with HIXNY.

Given the consumer response in listening sessions and surveys, there is an increased need for appropriate knowledge flow on services available to vulnerable populations. Many individuals expressed surprise at the availability of programs available that they were unaware of, or if they were aware of, were unclear of eligibility and/or enrollment procedures. An increase in the force of patient engagement specialists could assist with this identified gap.

The most striking show of increased Community Based Organizations (CBOs) involvement will be seen in regards to Project 11. In order to address the needs of the uninsured, low utilizing, and non-utilizing Medicaid populations, the PPS has identified and will partner with CBOs that work with these populations, pulling from areas such as places of worship, municipal housing sites, food pantries, community action programs, etc. Within these CBOs there will be an increased need for patient engagement specialists who live in and/or are from the communities they will be serving.

✔ 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 had an estimated population of 950,544. The county pop. range from Albany's 306,945 to Montgomery's 49,897 (Table D-1). Compared to NYS, the 6 county service area had smaller childhood and larger older pop. Montgomery (18.8%) county had the largest < 15 yr. pop.; Albany (15.5%) the smallest. For the pop., 75+ yrs., Montgomery (8.5%) had the largest percentages; Saratoga (6.3%) had the lowest. The 6 counties exhibited similar pop. shifts between the 2000 and 2010 (TableD-2). All counties had decreases in the 0-14 yrs. pop, but major increases in the 45-64 year age group. Montgomery (13.9%) showed the largest decrease in the 75 + age group, while Saratoga (24.1%) showed the largest increase. Medicaid enrollment rates for each of the counties decreased with age. The



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Ellis area rates were: 37.6% for 0-17 year olds; 14.9% for 45-64 year olds; and 14.1% for the 65+ year population. Fulton and Montgomery had the highest rates across all age groups (Table D-3).

*Demographics 2:

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

Albany (11.7%)& Schenectady (10.5%) had the largest Black non-Hispanic (BNH) pop. Montgomery(11.7%) had the largest Hispanic pop. (Table D-4; Maps D-1, D-2). Of BNH pop., 53.7% resided in Albany and 22.5% in Schenectady. Of the Hispanics, 35.3% resided in Albany, and 20.9% in Schenectady. Of the Area Medicaid enrollees, 61.6% were White non-Hispanic (WNH), 16.7% were BNH, and 9.6% were Hispanic. The comparable rates were: 54.3% BNH; 44.9% Hispanic; and 17.6% WNH (Table D-5). Of Area residents, 8.9% spoke a language other than English at home, and 3.0% spoke English less than "very well" (Table D-6, Map D-3). For Montgomery, 13.6% spoke a language other than English at home, and 5.4% spoke English less than "very well". Of the approx. 27,000 residents who spoke English less than "very well", 43% resided in Albany County, and 18% in Schenectady County. In the Service Area, 3% spoke Spanish at home. Montgomery (8.5%) had the largest percentage of population speaking Spanish.

*Demographics 3:

Income levels:

Three of the 6 service area counties were below the NYS Median Household Income of \$57,683. The range was from \$42,830 for Montgomery to \$67,712 for Saratoga households (Table D-7). Lower median household incomes occur in the cities of Albany, Schenectady, Troy, Amsterdam and Gloversville, but also in rural Fulton, Montgomery and Saratoga (Map D-4). About 20.3% of the Area households have incomes < \$25,000 per year. Montgomery County at 28.5% and Fulton County at 27.1% had the largest percentage of households with incomes less than \$25,000 per year. Of the households with incomes < \$25,000 per year, 33.3% resided in Albany, 17.3% in Saratoga, and 17.0% in Rensselaer. The counties with the most households with incomes > \$150,000 per year were Saratoga (11.2%) and Albany (10.7%). When reviewing Median Household Income by Race/Ethnicity (Table D-4), WNH and Asian NH households had higher Median Household Incomes compared to the BNH and Hispanic households across the 6 counties.

*Demographics 4:

Poverty levels:

Of the population in the Ellis service area, 5.2% were less than 50% of the FPL, 11.7% were less than 100% FPL, and 14.8% were less than 125% FPL (Table D-8). Across the three FPLs, Montgomery had the highest percentages (8.4%, 19.2%, 23.6%), while Saratoga (2.7%, 6.5%, 8.8%) had the lowest. Of the Service Area residents <100% FPL, 35.6% resided in Albany. The percent of the population below 100% FPL shows a similar distribution across the 6 county service area as with median household income (Map D-5). Females had a higher percentage living below the three FPLs compared to males. Poverty status by age exhibits the same trend across all counties—the % below FPL decreases with age. A higher percentage of persons with a disability were living below the three FPLs compared to the population with no disability (Table D-8). Similar patterns were seen for families below FPL by Race/Ethnicity, as were seen with Median Household Income (Table D-4).

*Demographics 5:

Disability levels:

Approximately 110,000 residents of the 6 county service area, or 11.8%, indicated that they lived with a disability. This percentage is higher than the NYS average of 10.9%. All but Saratoga County (10.1%) had percentages higher than the State average. Fulton County at 16.4% (n=8,871) and Montgomery County at 16.1% (n=7,921) had the highest disability percentages of the 6 counties (Table D-9; Map D-6). Of the total disabled, Albany (30.8%, n=33,861), and Saratoga (20.0%, n=21,924) counties had the largest percentages. As one would expect, the percentage of disabled increases with age in the 6 county service area: 4.9% (n=9,933) in the < 18 year age group; 9.4% (n=56,028) in the 18-64 year age group; and 33.8% (n= 43,835) in the 65+ age group. Fulton and Montgomery counties had the highest disability rates across the age groups.

*Demographics 6:

Education levels:

When reviewing educational attainment in the 6 county service area, about 59,847 residents, aged 25 years and older, had less than a high school education, or 9.3% of the population. While this rate was better than the NYS average of 15.1%, two counties were above the



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

NYS average: Montgomery (16.5%) and Fulton (15.2%). Conversely, Saratoga County (6.7%) and Albany (8.4%) had the lowest rates for residents with less than a high school education (Table D-10). Of these 60,000 residents, 28.6% (n=17,100) were from Albany County, and 18.2% (n=10,870) were from Rensselaer County. For residents with a four year college degree or greater, the 6 county service area had a rate of 32.0%, slightly lower than the NYS rate of 32.7%. Fulton (14.5%) and Montgomery (16.1%) counties had the lowest rates for residents with a bachelor's degree or greater.

***Demographics 7:**

Employment levels:

The 6 county service area's unemployment rate of 9.4% is higher than the NYS rate of 8.5%. There were over 37,000 individuals who were looking for work but unemployed. (Table D-11). As with other socioeconomic indicators, Fulton (10.6%; n=2,826) and Montgomery (10.4%; n=2,458) counties had the largest rates of unemployment. Saratoga County had the lowest unemployment rate at 7.0%. Of those unemployed: 30.7% (n=11,473) resided in Albany; 21.9% (n=8,193) resided in Saratoga and 17.3% (n=6,482) resided in Rensselaer counties.

***Demographics 8:**

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

There were almost 33,500 individuals living in group quarters in the 6 County service area; over 9,000 Institutionalized and 24,000 Non-Institutionalized. Of the institutionalized, approximately 3,070 (33.9%) were in adult or juvenile correctional facilities; 5,724 (63.3%) in nursing or skilled nursing facilities. Of the non-institutionalized, 18,920 (77.7%) were in college or university housing; and 5,443 (22.3%) in other non-institutionalized, such as emergency and transitional shelters, adult group homes, or adult residential treatment centers. Albany (n=1,831), Rensselaer (n=1,133) and Schenectady (n=988) counties had large nursing home populations. Albany, Rensselaer, Saratoga, and Schenectady counties had large student populations (Table D-12). The correctional facility population shows the rural settings where most prisons are located (MAP D-7). The distribution of the nursing home population reflects the breadth of nursing homes scattered throughout the region (Map D-8).

File Upload (PDF or Microsoft Office only):

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

File Name	Upload Date	Description
3_SEC034_\\efs\users\ELLIS\sminglerd\1115 Waiver\Application\Final Sections\Section3.4AttachmentCNAApplication.pdf	12/19/2014 11:44:05 AM	Ellis PPS CNA Supporting Tables and Maps

✔ Section 3.5 - Community Population Health & Identified Health Challenges:

Description:

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

***Challenges 1:**

Leading causes of death and premature death by demographic groups:

The leading causes of death for each of the 6 county total populations: 1-Heart Disease; 2-Cancer; 3-Chronic Lower Respiratory Disease (CLRD); 4-Stroke; 5-Unintentional Injury. In 2012, the Service Area had 2,311 heart disease deaths (244.5/100,000), 2,045 cancer deaths (216.4), 560 CLRD deaths (59.3), and 377 stroke deaths (39.9). Four of the 6 counties had heart disease mortality rates higher than the Upstate. All 6 counties had a cancer mortality rate higher than Upstate. Five of the 6 counties had higher CLRD mortality rates than Upstate. Three of 6 counties had higher stroke mortality rates than Upstate. No counties had higher unintentional injury rates than Upstate. The leading causes of premature death for the 6 counties were: 1-Cancer; 2-Heart Disease. The 3rd and 4th leading cause varies between unintentional injury and CLRD. For the 6 counties, the 5th leading cause of premature death varies between stroke diabetes and suicide. When reviewing the leading causes of death by gender, males had higher rates for unintentional injury and suicide compared to females in the Service Area. County data were not available by age and race/ethnicity.



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

Page 28 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

*Challenges 2:

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The Area Prevention Quality Indicators (PQI) have been declining since 2009 for each county, both for the Medicaid and All Payer (AP) population. Fulton and Montgomery had AP PQI Composite rates higher than NYS; Fulton, Rensselaer & Albany for Medicaid. When comparing AP to the Medicaid for the composite PQIs, the county Medicaid population had higher rates than the AP population, except for Montgomery. When reviewing the Composite PQI categories for the AP population, Fulton County was higher than the NYS rate for all categories, and Montgomery County was higher for all but the Respiratory Composite. When looking at the Medicaid population, there were over 2,000 adult PQI hospitalizations per year: over 750 were Acute PQIs per year; 1,300 were Chronic PQIs. Four of the 6 counties had Acute rates greater than NYS; 2 counties with Chronic rates higher than NYS. The Composite Pediatric Quality Indicators (PDI) have also been declining since 2009 in all counties. Fulton was the only county that was higher than NYS for the AP or Medicaid. The childhood Medicaid population usually had higher PDIs than the AP population. Of the Area's 78 Medicaid PDIs, 54 were chronic and 24 were acute.

*Challenges 3:

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

Potentially Preventable Emergency Department Visits (PPV) for the service area show that all counties had higher Medicaid rates than the AP rates. Two counties had higher AP PPV rates than NYS: Montgomery and Schenectady. There was an average of 61,650 Medicaid PPVs in the Service Area. Of these 22% were from Albany, 15% from Schenectady, and 15% from Rensselaer. All counties had greater Medicaid PPV rates than NYS. Rensselaer, Schenectady, & Albany counties were in the 4th or 5th risk quintile of all NYS counties for Medicaid PPVs. Rates for Medicaid members using primary care is lower than NYS in all 6 counties. Medicaid members and uninsured cannot find primary care services available at times or locations they need. Eleven percent of the Medicaid members and uninsured represent over half of ED visits, almost 40% of admissions and all 30 day readmissions. These individuals were defined as having 2 ED visits in 6 months and/or a 30 day readmission in the last 3 years. This population were twice as likely to have significant behavioral health conditions, twice as likely to have multiple chronic conditions, and three times as likely to have been treated for substance abuse.

*Challenges 4:

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

The Service Area averaged about 1,000 asthma hospitalizations per year. Fulton (15.6/10,000) and Albany (12.3) fell into the 4th quartile. There were 5,600 ED visits for asthma. Montgomery (102.8/10,000), Schenectady (78.6), Fulton (76.0), Albany (71.8) and Rensselaer (66.7) fell into the 4th quartile. There were 564 adult asthma PQIs and 75 pediatric asthma PDIs. There was an average of 3,270 hospitalizations, and 525 deaths due to CLRD per year. Fulton (47.2/10,000) fell into the 4th quartile. For CLRD mortality, Fulton County (75.5/100,000) fell into the 4th quartile.

The Service Area had 495 cases and 170 deaths per year from colorectal cancer. Montgomery (49.4) fell into the 4th quartile on for incidence, and Fulton (21.6/100,000) fell into the 4th quartile for mortality. The Service Area averaged 780 cases of female breast cancer with 140 deaths per year. Albany (141.0/100,000) had incidence rate that fell into the 4th quartile, while 3 counties had mortality rates that were in the 4th quartile: Saratoga; Schenectady; and Albany.

The Service Area averaged 3,000 hospitalizations and 1,500 deaths per year due to coronary heart disease. Only Fulton (38.6/10,000) and Montgomery (38.5) hospitalization rates fell into the 3rd quartile. For coronary heart disease mortality rates, Montgomery (165.8/100,000) was in the 4th quartile. There were 2,640 Congestive Heart Failure (CHF) hospitalizations and 234 deaths per year. Montgomery County's CHF hospitalization rate of 32.6 per 10,000 put it into the 4th quartile. Montgomery (23.7/100,000), Rensselaer (22.3), Albany (20.0), and Schenectady (19.8) fell in the 4th quartile for mortality. There were over 2,600 stroke hospitalizations and 400 deaths per year. Fulton (28.5), and Montgomery (27.6) had stroke hospitalization rates in the 4th quartile of NYS counties.

The Service Area averaged 1,360 hospitalizations per year where diabetes was the primary diagnosis; 20,600 where diabetes was listed in any diagnosis. For the diabetes (primary) hospitalization rate, Fulton's rate of 19.2/10,000 fell into the 4th quartile. Fulton (237.2) and Montgomery (235.1) fell into the 4th quartile for diabetes hospitalizations (any). Montgomery's diabetes mortality rate of 19.4/100,000 was in the 4th quartile. The Service Area averaged about 454 Diabetes short-term complication hospitalizations per year in the adult population. Both Fulton (8.6/10,000) and Montgomery (8.3) fell into the 4th quartile.

For adults with 14 + poor mental health days in the past month, 5 of the 6 counties had rates higher than NYS. Rensselaer (17.2%), and Montgomery (14.6%) fell into the 4th quartile. The Area averaged of 800 self-inflicted injury hospitalizations. Schenectady (12.1/10,000), Montgomery (12.0), and Fulton (11.6) fell in the 4th quartile. There was about 100 suicides per year. All counties had mortality rates higher than NYS. There were 1,700 drug-related hospitalizations. Fulton (21.9/10,000), Schenectady (21.8) & Montgomery (21.4) fell into the 3rd quartile. A high percentage of Medicaid enrollees in the Service Area have Mental Health (MH) (40.4% or 79,790) and/or Substance Use Disorder (SUD) (10.3% or 20,452).



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

*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:

There was an average of 1,000 premature (< 37 weeks gest.) births/yr. in the 6 County service area for a rate of 10.8%. Albany (11.3%), Schenectady (11.2%), and Montgomery (10.9%) counties fell into the 3rd risk quartile of NYS counties. For the Medicaid premature birth rate, Schenectady (11.8%) was higher than NYS (11.7%). Almost 2,600 births in the Service Area were without adequate prenatal care (Kotelchuck index). Montgomery (61.2%) fell into the 4th & Albany (64.5%) in the 3rd risk quartile. Poor prenatal care rates are seen in the Albany neighborhoods of West Hill/South End, West End, & Center Square; in Schenectady's Hamilton Hill; Amsterdam in Montgomery; and Gloversville in Fulton. There were 67 infant deaths per year in the Service Area, for an infant mortality rate of 6.7 per 1,000, higher than the NYS rate of 5.1. Albany (8.6), and Schenectady (7.0) fell into the 4th quartile of NYS counties; Montgomery (5.7) counties was in the 3rd quartile. The Service Area averaged 800 low birth weight (< 2.5 kg) births per year for a rate of 7.9%, and lower than the NYS rate of 8.2. Schenectady (9.0) and Albany (8.8) counties fell into the 4th quartile of NYS counties.

*Challenges 6:

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

Four of the 6 counties showed rates increasing rates of adult obesity from 2008-09 to 2013-14. All counties had obesity rates higher than NYS. Schenectady's rate of 33.5% put it in the 4th quartile, while Fulton (30.9%) & Montgomery (30.5%) had obesity rates in the 3rd quartile of NYS counties. Three of the 6 service area counties had school student obesity rates higher than NYS. Schenectady (19.5%) and Fulton (19.3%) fell into the 3rd risk quartile. The 2008-09 NYS adult rate for no leisure time physical activity was 21.1%. Fulton (24.3%), Montgomery (24.1%), and Rensselaer (23.6%) fell into the 3rd quartile of all NYS counties. Five of the 6 service area counties have seen their smoking prevalence rates increasing from 2008-09 to 2013-14. Three of 6 the counties had higher smoking prevalence rates than NYS, with Fulton (29.0%), and Rensselaer (23.8%) having rates in the 4th quartile, and Montgomery (23.4%) falling into the 3rd quartile of NYS counties. Six of the 10 service area counties had rates of binge drinking higher than NYS. Fulton (22.8%) fell into the 4th quartile, while Saratoga (18.9%), Montgomery (18.9%) and Rensselaer (18.6%) counties fell into the 3rd quartile.

*Challenges 7:

Any other challenges:

Over 16,000 Medicaid enrollees (8% of the total) were individuals who had a diagnosis of CHF, COPD, diabetes or chronic kidney disease. These individuals had 29,530 ED visits and 15,836 hospitalizations. SPARCS analyses found over 3,300 of admits in the Service Area that have multiple chronic conditions (4+). Eleven percent (11%) of Medicaid members and uninsured represent over half of ED visits, almost 40% of admissions, and all 30 day readmissions. These individuals were defined as having more than 2 ED visits in 6 months and/or a 30 day readmission in the last 3 years. Super-utilizers are twice as likely to have significant behavioral health conditions, twice as likely to have multiple chronic conditions, and three times as likely to have been treated for substance abuse. These super-utilizers are clustered in several high need neighborhoods. Neighborhoods like the South End in Albany and Hamilton Hill in Schenectady have high proportions and numbers of these super-utilizers, along with poverty rates almost double the regional average. Other high need neighborhoods like Troy/Lansingburgh and Amsterdam have elevated rates of anxiety and depression driving ED and inpatient use.

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.**

COORDINATION OF CARE across setting, discipline, and time is critical for those with complex chronic conditions. If providers don't coordinate these, the patient must, however their ability to self-manage is impaired by many factors. Inadequate life management skills, housing stability, and informal supports are further challenged by poverty, literacy/language barriers, recent illness, and moderate or significant mental impairments and/or substance use disorders. This diminished capacity to self-manage is frequently exceeded by the demands expected of the patient by the current delivery system to manage their complex chronic conditions. Access to care coordination support is inadequate in many neighborhoods.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

KNOWLEDGE needed to effectively manage several co-morbid conditions, medications, primary and specialist appointments, and daily life places demands that frequently exceeds the capacity of the entire Medicaid and uninsured population. Even consumers without socio-demographic and behavioral challenges face self-management capacity gaps in the presence of multiple chronic physical conditions. The dually eligible have added age and/or disability demands and reduced capacity, placing them at higher risk. In the community, increased knowledge and engagement combined with effective informal supports are necessary to avoid ED use and admissions, including community health workers and navigators where needed. This subpopulation tends to be white, educated – and overwhelmed.

INTEGRATION of Behavioral and Physical health support is difficult within current delivery system. Medicaid members and uninsured with both physical and behavioral health conditions are currently treated for either one or the other condition. The current delivery system does not make treating both (i.e. the whole person) easy, or in some cases possible with current regulations and delivery silos. People with a diagnosed and treated behavioral health condition are frequently admitted for a physical condition. Likewise, under-diagnosed depression and anxiety complicate the treatment of physical conditions and lead to excess ED visits and admissions, as does under-treatment due to medication barriers and fears. When referrals between settings are made, both providers and the consumers agree that appointments take too long to secure, reducing their likelihood of being kept and often too far in the future to be effective. Substance use disorders are particularly high impact, especially in combination with either physical or mental impairments.

COMMUNITY ALTERNATIVES are inadequate to meet demand shifted from reduced bed use. Historical excess hospital bed capacity has already been right-sized locally through recent consolidations in Schenectady, Amsterdam, and Albany, with efforts in Troy scheduled for completion in 2016. Comparing local admission rates for chronic diseases with non-NYC benchmarks, yet another 10–100 occupied beds could be reduced through successful DSRIP efforts. Nursing home bed need indicates 82 excess beds in the six counties by 2020. PPS efforts to improve chronic care in the Community will increase this opportunity.

*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.

Medicaid members and uninsured cannot find primary care services and care coordination supports available at times or locations they need. In neighborhoods where they live, the only option available evenings and weekends is the ED. 25% of consumers surveyed said they went to the ED because their doctor's office was not open, 17% said they were told to go to the ED by their health provider, and 20% said going to the ED was quicker. Common themes are that life barriers prevent access to primary care and clinics at times and locations only convenient to providers. Expanded office hours and urgent care are not available where these people live. Lack of transportation, working 2 jobs (and risk of losing them if time taken off for health appointments), child care responsibilities, and lack of informal supports make the ED the only place to obtain care in many high need neighborhoods. Poor access to care was reflected in worse rates than NYS in all counties for diabetes screening, screening for 3 types of cancer, and chlamydia screening. In the provider survey, 41% echoed lack of coordination and consistent follow-up, 30% convenient service access, and 25% transportation as barriers.

18% of providers mentioned communication/listening, 17% consumer confusion/knowledge gap, and 16% lack of member engagement as barriers. Half of providers mentioned lack of adequate staff and financial resources plus 13% regulatory barriers for why coordination, knowledge, and integrated physical/BH resources are not conveniently available. This was echoed by Consumers in listening sessions and focus groups.

Combined gaps have disproportionate impacts. 11% of Medicaid members and uninsured represent over half of ED visits, almost 40% of admissions, and all 30 day readmissions. Super utilizers are twice as likely to have significant behavioral health conditions, twice as likely to have multiple chronic conditions, and three times as likely to have been treated for substance abuse. Super-utilizers are clustered in high need neighborhoods: South End in Albany and Hamilton Hill in Schenectady (high proportions and numbers of these super utilizers, with poverty rates almost double the regional average and a more diverse racial mix); other high need neighborhoods like Troy/Lansingburgh and Amsterdam have elevated rates of anxiety and depression driving ED and inpatient use.

*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



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

The key strategy to address identified gaps and meet needs in the community is to shift focus to the health of the people served rather than just the services they access. This means integrating services and availability around the needs of the whole person, including ALL of their medical, mental, substance, and socio-demographic needs and strengths. It also means enhancing consumer knowledge, coordination of care and communication between the consumers and providers, as well as between providers across settings and disciplines, and over time. Interventions were planned and organized to address three major subpopulations.

System redesign interventions are at the core. They "raise all boats" and apply to all of the subpopulations, including moderate and low utilizers (51% of Medicaid and Uninsured). Expanding hours of operation and convenient location of ED alternatives, coordinated scheduling and transportation support for encounters, co-location of physical and behavioral health providers, and expanded use of community health workers/CBOs that live/work in the local community are examples of specific interventions. A subset within this group is Medicaid members that are low or non-utilizers and the uninsured. Engaging them now and building habits of appropriate use of health services is an investment in lower future avoidable use of the ED and hospital.

Interventions to address the elevated Coordination, knowledge, and support needs of people with Chronic behavioral and physical conditions (38% of Medicaid and Uninsured) include active engagement in self-management, specific knowledge of their chronic conditions, and system redesign to reduce demands on their self-management capacity and supplement self-management capacity through effective use of informal and community supports.

A focus on the remaining 11% who are Super-utilizers will leverage hot spotting benefits documented in the literature. DSRIP makes possible very local and personal high touch interventions beyond those of traditional health care delivery to address the SDS drivers of their ED and IP hospital use. Piloting and roll-out of high-impact/high touch interventions across projects will be in targeted sub-populations in targeted neighborhoods to enhance both scale and speed. Trusted community health workers and CBOs with strong local community ties are critical to these efforts.

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).

The web-based healthcare and community based organization (CBO) survey was conducted in October and sent to 516 providers and CBO's. The response rate was 35.7% (n=184). The provider survey was designed to ask for information not readily available from secondary sources such as whether they were a safety net providers, hours of operation, profile of patients, whether they were accepting new patients, accessibility, access to public transportation, sliding scale payment, participation in quality measurement programs, RHIO use, and specific expertise. The remainder of the survey asked about barriers to care and which services would prevent avoidable inpatient admissions, re-admissions and ED visits. An additional survey was sent to 540 physicians in November with 115 responses or a 21.3% response rate. Physicians were asked specific questions about behavioral and primary care, and palliative care. A web based consumer survey asked those with Medicaid and the uninsured about their health status and conditions, use of tobacco products, alcohol and drug use, where they usually go to get healthcare and dental care, emergency room use, knowledge of healthcare services, traveling to healthcare services, healthcare literacy, barriers to care, and recommendations on how to improve the delivery of healthcare and community based services. Over 16,000 Medicaid and uninsured consumers were contacted via email or postcard and asked to take the online survey which was available in English and Spanish. An incentive prize drawing was offered to increase the response rate. A total of 120 responses were received or a less than 1% response rate. Eight focus groups were held, summarized below. Three Provider/CBO and 5 Community Listening sessions were held to capture a broad viewpoint of observations, needs/barriers, resources, and suggested solutions from across the region. Findings are summarized in CNA Section C.2 with details for each Qualitative data source available in Appendix B-1 through B-5. In addition, initial (Stage 1) CNA findings were posted for comment. Webinars were held to inform stakeholders and are also posted on the Ellis Hospital DSRIP website.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

***Community 2:**

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

Eight focus groups were held: three directed to those suffering from chronic disease, two for people with behavioral health needs, two addressing substance abuse and one covering those with both substance abuse and mental health needs. The eight focus groups were held in six different counties in highly assessable locations that were reachable by public transportation. A number of participants in the chronic care focus groups included individuals that were blind and wheelchair users. Focus group participants were asked about the challenges and barriers they faced in obtaining healthcare services.

***Community 3:**

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

While approaching the issues and concerns to be addressed from different perspectives, there was general agreement on major themes, resources, and possible solutions from all sources (healthcare and CBO providers, physicians, and Medicaid and uninsured consumers. Qualitative input to the CNA identified that Medicaid consumers were generally satisfied with individual services provided, but less so in how these services are connected. They were particularly dissatisfied with paperwork, coverage/payment, and regulatory constraints impeding access to combinations of medical, mental, and substance services needed. Consumers and providers alike expressed a need for more readily available information about services available, more convenient locations for services particularly alternative to the ED, less waiting time to schedule needed appointments and consultations, less time spent in waiting rooms, and more appointment times convenient to the consumer, and better listening and communication between providers and consumers.

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.

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Ellis Medicine	Ellis Medicine is a multi-campus healthcare system located in the Capital Region of New York.	PPS lead applicant
2	St. Peter's Health Partners	A health system encompassing three organizations, St. Peter's Health Care Services, Northeast Health and Seton Health, that together provide quality, compassionate care while continuously adapting to changing community needs.	One of main seven partners in PPS structure.
3	Whitney Young Health Center	Whitney M. Young, Jr. Health Center, Inc. is a registered 501(c)3, non-profit community health center dedicated to providing affordable, accessible, high-quality, innovative medical, dental and behavioral health services, regardless of income or insurance status.	One of main seven partners in PPS structure.
4	Hometown Health Center	Hometown Health Center provides high-quality, cost effective health care to all in need, with particular concern for low-income residents who live near the health center.	One of main seven partners in PPS structure.
5	St. Mary's Healthcare Amsterdam	St. Mary's Healthcare features an award-winning acute care hospital, primary and specialty care centers throughout Fulton and Montgomery counties, more than 30 behavioral health services for persons in Fulton, Montgomery and Hamilton counties, a full continuum of physical rehabilitation services and a 160-bed nursing home. The organization has earned exceptional national rankings for excellence in medicine and has a continuing commitment to provide an exceptional patient experience. St. Mary's Healthcare is a member of Ascension Health, the largest not-for-profit Catholic healthcare network in	One of main seven partners in PPS structure.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		the world.	
6	Community Care Physicians	A multispecialty medical group with 200 providers, 37 practices, and 16 specialties across 4 counties of the Capital Region.	One of main seven partners in PPS structure.
7	Capital Care	physician-owned medical practice serving Albany, Rensselaer, Saratoga, and Schenectady counties providing primary care services in Family Practice, Internal Medicine and Pediatrics as well as specialty care services in Endocrinology, Pulmonary and Sleep Medicine, Developmental-Behavioral Pediatrics, Pediatric and Adult Neurology, Nephrology, medical nutrition therapy, and comprehensive diabetes education and a clinical laboratory.	One of main seven partners in PPS structure.
8	HIXNY	HIXNY is the Regional Health Information Exchange (RHIO) that serves as a local hub to securely collect and deliver health information in real-time between authorized users, connecting hospitals, physician practices, health plans and other stakeholders.	To share vital patient information in real time, the Ellis PPS will utilize HIXNY's current and continuously developing capabilities. The HIE contains data from more than 530 connected entities, including 28 hospitals, creating a single community system. Through HIXNY, the Ellis PPS region has achieved a critical mass of patient-centric data, thus positioning the PPS to leverage the power of real-time data to inform providers and care coordinators throughout the region who are capable of using the information in a meaningful way to improve population health and meet individual needs one patient at a time.
9	Hope House, Inc.	Residential recovery program located in the Capital District of New York State. It is an intensive, full-immersion therapy program caring for the special needs of adults, teen, and mother, supported by an Outpatient Clinic and a Community Services staff.	Hope House will be integral to achieving goals of strengthening mental health and substance use disorder across the PPS area as well as in development of ambulatory detoxification alternative to ED use for this purpose. Hope House was involved in the project design committees for both of these projects.
10	Belvedere Health Services	Belvedere Health Services provides a range of home care services within many of the counties served by the PPS.	Belvedere Health Services' success in the arena of home care make them an excellent resource to utilize in the planning and implementation of projects relating to strengthening mental health and substance abuse infrastructure as well as the development of ambulatory detoxification initiatives.
11	Schenectady County Office of Community Services	The Office of Community Services, under NYS Mental Hygiene Law Article 41, is responsible for ensuring a comprehensive array of services across the disability groups of mental health, substance abuse and mental retardation/developmental disabilities for the citizens of Schenectady County. The office operates the County's adult and children's SPOA (Single Point of Access) and AOT (Assisted	Schenectady County Office of Community Services had much insight to lend to the development of the PPS's MH/SUD Infrastructure



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Outpatient Treatment) programs and contracts out direct service provision to a network of provider agencies.	
12	Healthy Capital District Initiative	An incorporated not for profit that has helped over 35,000 needy children and adults in the Capital Region get health services that they might not have accessed otherwise.	HCDI was essential in performing the community needs assessment and will participate in community outreach pursuant to project 11. Their input into the development of project 11 interventions and project discussions were invaluable. Their experiences in cultural competency will be an asset to the PPS in this and many other projects moving forward.
13	Albany County Department of Mental Health	The Department of Mental Health offers a wide range of services to Albany County citizens, including treatment for mental illness and substance abuse.	The Department of Mental Health offers a wide range of services to Albany County citizens, including treatment for mental illness and substance abuse.
14	Community Health Center Homecare	CHC offers a full range of in-home health care services. Competent, professional staff is dedicated to bring quality, compassionate, and patient-centered home health care to residents of Fulton, Montgomery, Hamilton, Herkimer, Saratoga, Schoharie, and Warren Counties.	CHC's comprehensive knowledge in home healthcare made them a logical choice for assistance in the development of multiple projects, including hospital home care collaboration, ED triage, and palliative care.
15	Rensselaer County Department of Mental Health	Rensselaer County Department of Mental Health works collaboratively with a consortium of agencies that serve individuals enrolled in programs funded by the NYS Offices of Mental Health, Mental Retardation and Developmental Disabilities and the Office of Alcoholism and Substance Abuse. They provide comprehensive mental hygiene services that promote individual growth, interpersonal functioning, rehabilitation and recovery.	In conjunction with other mental health and substance providers, Rensselaer County Department of Mental Health lent their prowess in these areas to project development, particularly the initiatives to strengthen mental health and substance abuse infrastructure.
16	Mohawk Opportunities	A Schenectady based not-for-profit agency committed to helping individuals livings with Mental Illness, HIV/AIDS and those who are homeless achieve stable community living and independence by providing housing that is safe and affordable, services that facilitate growth and recovery, relationships are built on a foundation of caring and respect and a sense of hope for the future.	As a long standing provider of support to those community members dealing with mental illness, HIV/AIDS, and homelessness, Mohawk Opportunities lent their considerable knowledge in these area within the service area to the development of interventions.
17	Catholic Charities of Albany	Catholic Charities, a ministry of the Catholic Diocese of Albany, is committed to active witness on behalf of the Scriptural values of mercy and justice. Catholic Charities, recognizing human need at all stages of life, responds to all persons regardless of race, creed, or lifestyle, with special emphasis on the economically poor and the vulnerable. Catholic Charities serves and empowers persons in need, advocates for a just society, calls forth and collaborates with women and men of good will in fulfillment of its mission.	Catholic Charities has been duly represented in the development of many projects, particularly lending their SUD experience and knowledge to efforts surrounding the ambulatory detoxification project. This Catholic Charities program (Project Safe Point) will be leveraged to expand PPS harm reduction services including syringe access, overdose prevention, HIV/Hepatitis C screening/referral, and treatment readiness.
18	Asthma Coalition of the Capital Region	The Asthma Coalition of the Capital Region (ACCR) is one of eight regional asthma coalitions funded by	The asthma coalition was a logical choice to invite to consult on the



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		the New York State Department of Health. ACCR is also supported by its lead agency, Whitney M. Young Jr. Health Center, Inc. The goal of ACCR is to decrease asthma morbidity and mortality, in low-income Capital Region residents ages 0-40. ACCR serves the following counties in the Greater Capital Region: Albany, Fulton, Montgomery, Rensselaer and Schenectady.	development of the asthma project given its membership integration with providers within the community to be served. Their knowledge and expertise was essential in the planning process of the PPS's asthma project and their continued support during implementation will be critical to success.
19	Community Hospice	Community Hospice is a non-profit 501(c)(3) organization, accredited by the Community Health Accreditation Program.	Hospice organizations will be an essential function in the planning and implantation of the PPS's palliative care project planning and implementation.
20	Equinox, Inc.	Equinox provides comprehensive treatment, services, and support to over 5,000 people each year at 11 different locations throughout Albany County.	Given the PPS's goals in projects relating to substance abuse and mental health infrastructure, equinox's services and experience in this area were essential to planning this and other behavioral health related projects.
21	Rensselaer County Department of Health	County health department aimed at the promotion of health and prevention of disease, injury, and disability. Services include prevention programs, public health preparedness, nursing services, children with special needs programs, environmental services.	Rensselaer County Department of Health's initiative in public health provided copious opportunity for modeling of many of the PPS's projects.
22	Unity House of Troy	Rensselaer County-based human service agency that provides a wide range of services to meet the otherwise unmet needs of people in our community who are hurting and struggling. Services include assisting those who are living in poverty, adults living with mental illness or HIV/AIDS, victims of domestic violence, and children with developmental delays.	Unity House's prevalence in the target Medicaid and uninsured community will be a valuable asset in reaching these populations for outreach initiatives.
23	NYS Office of Mental Health	The Office of Mental Health (OMH) operates psychiatric centers across the State, and also regulates, certifies and oversees more than 4,500 programs, which are operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient programs, emergency, community support, residential and family care programs.	NYS office of mental health was duly represented during discussions related to the integration of behavioral health and primary care integration.
24	Northern Rivers Family Services	Northern Rivers Family Services is a not-for-profit organization that provides business management and program guidance to its affiliate agencies, Northeast Parent & Child Society and Parsons Child and Family Center.	Northern rivers agencies were of considerable assistance in the development of behavioral health related projects and assuring advocacy of their service members.
25	Senior Hope Counseling	Senior Hope, Inc. is a non-intensive outpatient not-for-profit clinic licensed by New York State Office of Alcoholism and Substance Abuse Services.	Senior Hope's commitment to advocating for and providing services to the senior community was ideal in discussions relating to primary care and behavioral health integration.
26	Schenectady Community Action Program	SCAP was established under the Economic Opportunity Act of 1964 to fight America's War on Poverty. Community Action Agencies help people to help themselves in achieving self-sufficiency. Today there are approximately 1000 Community Action	SCAP's pervasive foothold in the local community makes is an ideal resource to utilize the discussion and focusing of project interventions related to project 11.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		Agencies, serving the poor in every state as well as Puerto Rico and the Trust Territories.	
27	US Committee for Refugees	USCRI is a private, nonprofit, nonpartisan, nonsectarian charitable agency registered with the IRS as a 501(c)(3) organization. They protect the rights and address the needs of persons in forced or voluntary migration worldwide by advancing fair and humane public policy, facilitating and providing direct professional services, and promoting the full participation of migrants in community life.	The US Committee for Refugees responded to the PPSs call to assist in discussions surrounding the project 11 population, as many of their service members are within that population. Their perspective on cultural competency was and will be of vital importance moving forward with initiatives germane to that project and potentially others.
28	Trinity Alliance	Provides services to the community that will support and promote healthy families, adults and children	Trinity Alliance brought their culturally relevant perspective to Project 11 discussions and plans given their extensive experiencing serving high-need communities such as Arbor Hill, where they offer many programs to enrich live in these neighborhoods.
29	University at Albany	Located in New York's capital city, the University at Albany offers its more than 17,300 students the expansive opportunities of a major research university and an environment designed to foster success. The University of Albany School of Social Welfare faculty is training behavioral medicine graduate level social workers to work in primary care settings managing chronic diseases.	The Ellis PPS will provide practice locations for these programs to increase the number of providers and offer incentives for retaining these providers after training.
30	Hudson-Mohawk Recovery Center, Inc	Hudson Mohawk Recovery Center, Inc. operates five NYS Office of Alcoholism and Substance Abuse Services licensed treatment facilities for addiction throughout Rensselaer County, New York. There are Outpatient Clinics in Troy, East Greenbush and Hoosick Falls. Services include a continuum of care including both outpatient and residential programs .	Hudson Mohawk Recovery Center's experience and success as an OASAS provider within the PPS service area were instrumental resources in planning for the PPS SUD interventions. The PPS will further leverage these knowledge and skills as well as the existing referral relationship they maintain with key PPS partners.
31	Conifer Park	Conifer Park Inc. has been providing treatment services to those who suffer from the disease of Chemical Dependency and their families since 1983	Conifer Park's experience and success in providing drug and alcohol rehabilitation both in inpatient and outpatient settings were instrumental resources in planning for the PPS SUD interventions. The PPS will further leverage these knowledge and skills as well as the existing referral relationship they maintain with key PPS partners.
32	Albany College of Pharmacy	Albany College of Pharmacy is placing residents under faculty members for training in primary care settings to maximize patient engagement and medication adherence.	Albany College of Pharmacy is placing residents under faculty members for training in primary care settings to maximize patient engagement and medication adherence. The Ellis PPS will provide practice locations for these programs to increase the number of providers and offer incentives for retaining these providers after training.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
33	Empire State College	State university located in Saratoga County offering degrees in twelve broad areas including nursing, fine arts, business, community and human services, educational studies, historical studies, human development, interdisciplinary programs, labor studies, public affairs, science math and technology, and social science.	HMAHEC is currently offering care coordinator training in PCMH practices in collaboration with Empire State College. The Ellis PPS will provide practice locations for these programs to increase the number of providers and offer incentives for retaining these providers after training.
34	Schenectady County Community College	Community college located in downtown Schenectady.	Schenectady County Community College will train 12 CHWs using a comprehensive curriculum that includes topics such as community navigation, cultural competency and health literacy.
35	Schenectady Coalition for a Healthy Community	An active, broad-based, community coalition with over 70 partners.	This group, along with similar coalitions in the Ellis PPS, will be mobilized to provide guidance on hot spotting and assist with the identification of individuals who will serve as community navigators.
36	Innovative Health Alliance of New York	A new regional alliance that will provide the platform for the two systems (Ellis Medicine and St. Peter's Health Partner's) to explore a variety of collaborative opportunities. This includes the creation and operation of the Capital Region's first innovative Clinically Integrated Network (CIN) that will focus on access, quality, population health and health costs	A Clinical Integration Committee will be established as a standing committee of the Ellis PPS governance structure. Through that committee the PPS will coordinate its effort with the Clinical Integration Committee of the IHANY MSSP (and possibly contract for IHANY services) to insure standardization of clinical best practices. The IHANY and PPS Clinical Committees will collaborate in the development of operating standards, best-practice clinical guidelines, and care pathways that support integrated care through a collaborative, evidence-based process that will include interdisciplinary hospitalists, PCPs, social workers, CBOs, members, and others.
37	Schenectady Bridges Out of Poverty	Schenectady Bridges exists to build bridges that support individuals from the community as they move from poverty to sustainability.	The Schenectady Bridges Out of Poverty program has influenced a number of interventions at Ellis Medicine over the past few years such as the creation of a free community shuttle and open access scheduling for the dental health and primary care practices. The Ellis PPS will look to expand such successful models across its service area and engage certified Bridges trainers in its planning and implementation.

✔ Section 3.8 - Summary of CNA Findings:

Description:



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need to coordinate and integrate person-centered health delivery across settings and over time	Barriers to effective population health and health delivery were described in detail during CNA surveys, listening sessions, and focus groups. Participants ranging from individual and institutional providers, CBOs, and individual community members uniformly describe challenges in obtaining convenient and effective access to physical and behavioral health services. Common barriers described by participants were communication between providers and consumers, coordination and communication between providers themselves, as well as geographic, regulatory, and organizational challenges. This was particularly true when dealing with a population with complex chronic physical and BH challenges such as the Medicaid and uninsured. The most basic concern is that the current delivery system is not patient centric. Quantitative data demonstrated that very few practice sites are patient centered medical home certified in the region. This system misalignment results in low primary care rates, and higher than benchmark and costly ED visit rates and preventable hospitalization rates. The literature demonstrates that rationalizing and reorganizing the current delivery silos into a true system sensitive to the broad needs of the people they serve combined with aligning patient and service flow to do so efficiently and effectively is a means to have a significant impact on reducing costly hospital ED and inpatient encounters. To this end the PPS will pursue project 2.a.i.	CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 2012.
2	Need to change focus from fixing problems to activating people for health and healthy lifestyles	The CNA quantified local neighborhood "hotspots" in the six County region where there were disproportionate numbers of potentially avoidable ED visits and inpatient admissions. In many cases these hotspots aligned with disadvantaged neighborhoods with higher rates of poverty, limited language skills, limited education, unstable housing, and racial ethnic and cultural diversity. It also	CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. ACS Census data 2012.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>quantified high rates of chronic physical, mental, and substance related conditions in the neighborhood population. These metrics demonstrated a synergistic impact when combined with the socio-demographic factors outlined above.</p> <p>Qualitative input from surveys, community listening sessions, and focus groups described the above interactions in the barriers they placed on members seeking care for their physical and behavioral needs. They also described communication transportation and other access barriers and a distrust that the current system cares about them. Community based organizations participating indicated a strong willingness to be part of the solution to overcome these barriers, and wanted direction as to how best they could help. To this end the PPS will pursue Project 2.d.i.</p>	
3	Need to shift consumer expectation for basic healthcare to non-ED settings where appropriate	<p>Overall, a significant portion of Medicaid beneficiaries have one or more chronic physical and or behavioral health conditions that result in an avoidable ED or IP encounter. A significant number of these encounters are level one or two severity, making them ideal for ED triage. Moving these encounters to more appropriate care settings such as primary care, urgent care, or a behavioral health provider could provide better care at lower cost. Qualitative data from the CNA shows that there is limited primary care availability for the low income target population, with many informants describing using ED services as their only convenient source of primary care. Sociodemographic challenges such as single parenthood, working two jobs, housing instability, and transportation make it difficult for this population to manage multiple visits in different locations over a period of time. ED triage could make the services convenient to access so that higher cost ED use is not necessary. To this end the PPS will pursue project 2.b.ii.</p>	SPARCS Analysis, beginning 2012 Medicaid Chronic Conditions, IP Admissions and ER Visits CNA Primary Data Collections, surveys, focus groups and listening sessions
4	Need to address the well-being of entire person - both physical and behavioral - when providing care	<p>Capital Region residents have higher rates of poor mental health days than Benchmarks, and these rates are growing. The majority of Medicaid members utilizing ED and hospital inpatient services have comorbid physical and behavioral health conditions. Elevated and super utilizers of these hospital services are 2 to 3 times more likely to have a mental or substance disorder. Providers and consumers alike report difficulty in obtaining timely access to services for members with both physical and behavioral needs. These access barriers in turn result in under treatment of combined needs until a physical or behavioral health crisis drives a hospital ED visit or admission. Co-location/integration of</p>	EBRFSS population health data. NYSDOH chronic disease data. CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 2012



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>medical services with behavioral health providers and co-location/integration of behavioral health services with medical providers were identified by both providers and consumers as a way to provide more convenient and timely care for the whole person. NCQA Domain 3 clinical metrics for overlapping medication, mental, and physical health needs show varying needs across counties, suggesting the need to target interventions in specific locations. Shortages of behavioral health providers also vary across counties. To this end the PPS will pursue project 3.a.i.</p>	
5	<p>Need to provide improved coordinated support during transitions when patients need it most</p>	<p>Quantitative analysis demonstrated high rates of both chronic physical and behavioral health conditions in the Medicaid and uninsured population. In addition, this population has demonstrated socio-demographic challenges that impair their capacity to manage these complex chronic diseases. To make matters worse, the qualitative surveys, listening sessions, and focus group participants went into great detail on how misaligned the current health delivery system silos are from the perspective of both providers and consumers. Some current regulations forbid effective coordination of care (e.g. between physical and behavioral health) and setting specific payment methodologies do not pay for, and sometimes even penalize providers seeking to coordinate care for their patients across settings. CNA analysis showed much of the avoidable hospital ED and inpatient volume is associated with transition handoffs between settings. A small number of Super utilizers of repeat ED use and 30 day readmissions account for over half of total ED visits and 38% of admissions. Reducing this repeated use by better coordination at time of transition is a proven strategy to eliminate this waste. From the patient's perspective, transitions are when they are least capable of self-management and most in need of additional support - from a delivery system designed and incentivized not to provide it. To this end the PPS will pursue Project 2.b.iv.</p>	<p>EBRFSS population health data. NYSDOH chronic disease data. CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 2012.</p>
6	<p>Need to provide chronic disease self-management education and coordination in the patient's home</p>	<p>Given the high chronic disease burden driving the higher than Benchmark PQI and PPV rates in most PPS service counties, there is an opportunity to reduce these encounters through increased coordination of care between the hospital and home care settings. While counties within the PPS demonstrate below average PPR rates, there is room for improvement in this area as well. During a transition from hospital to home a patient is at their most vulnerable, their capacity for self-care and self-management at its lowest this is an ideal time to implement interventions within the home to assist</p>	<p>Medicaid Chronic Conditions, IP Admissions/ ER Visits Hospital IP Prevention Quality Indicators Medicaid Hospital Inpatient Potentially Preventable Readmission Rates Medicaid Chronic Conditions, IP Admissions and ER Visits</p>



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>with this delicate transition. Boosting coordination and self-management skills will help support them. Qualitative findings also validate these assumptions, with consumers indicating poor coordination and fragmentation of services. The PPS has demonstrated strength in the area of home care, and so a targeted home care intervention program is a compelling opportunity to demonstrate success in these measures. The six County region has a higher proportion of hospital discharges going home with no services with a corresponding lower proportion of discharges going to nursing homes. Readmission rates are higher than benchmarks. This suggests that increasing access to effective home care supports for the high number of enrollees with chronic physical or behavioral health conditions could help reduce avoidable hospitalizations and readmissions. To this end, the PPS will pursue project 2.b.vii</p>	<p>CNA Primary Data Collections, surveys, focus groups and listening sessions</p>
7	<p>Need to create community based alternatives to ED for substance use withdrawal and maintenance</p>	<p>Medicaid members and uninsured that have a substance use disorder are approximately 3 times as likely to receive care in the hospital ED or inpatient bed. Rates are even higher for those with opioid overuse. They make up a disproportionate number of the super utilizers identified in the CNA. Many have comorbid mental and physical health needs, making their access to needed care extremely complex. Housing instability and lack of transportation are significant barriers to ongoing attendance in withdrawal management. Providers are reluctant to enroll members in a program unless transportation is readily available. Many providers also expressed reluctance to manage buprenorphine maintenance patients in their practice, citing lack of personal expertise, barriers to obtaining consistent consultant support over time, and inadequate fee-for-service rates. NCQA Domain 3 clinical metrics for overlapping medication, mental, and physical health needs show varying needs across counties, suggesting the need to target interventions in specific locations. Shortages of Mental Health providers also vary across counties. To this end the PPS will pursue Project 3.a.iv.</p>	<p>CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 2012.</p>
8	<p>Need to implement targeted asthma self-management and environmental trigger reduction plans</p>	<p>Asthma is one of the primary sources of avoidable ED visits and hospitalizations in the six counties. It was highlighted by the Controller's office as some of the worst rates in the state. We selected asthma as a Domain 3 project in part due to the potential to reduce these encounters quickly within the DSRIP timeframe. The response speed will provide positive reinforcement to the consumer of the value of effective self-management. The self-management skills taught and learned can be</p>	<p>Medicaid Chronic Conditions, Inpatient Admissions and Emergency Room Visits New York State Office of the State Controller NYS Expanded BRFSS Data</p>



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		<p>replicated in other chronic physical and behavioral health areas, making it a priority over alternative domain 3 projects that do not have the speed or comprehensive impact. Engagement of broad range of community agencies including the Asthma Coalition as well as the ability to utilize existing asthma educators and training for these positions makes this project a logical choice. The link to tobacco use directly and through second hand smoke strengthens the selection of this project in correlation to the selection tobacco cessation. To this end the PPS will pursue Project 3.d.ii.</p>	
9	<p>Need to address pain and anxiety associated with chronic conditions through palliative care</p>	<p>Chronic disease healthcare resource utilization within the six counties is demonstrably high, with hypertension, cardiovascular disease, and respiratory disease and asthma being the largest drivers. The excess use of services to treat these conditions in a hospital setting can be lowered with the use of palliative care methodologies in the primary care setting. The the palliative care project was chosen over other more targeted chronic disease projects such as diabetes or cardiovascular disease since it will allow the PPS to take a broader approach to lessening the impact of several chronic illnesses impacting the region rather than simply choosing the single most prevalent. To this end the PPS will pursue Project 3.g.i.</p>	<p>Medicaid Chronic Conditions, IP Admissions/ ER Visits Hospital IP Prevention Quality Indicators Medicaid Hospital Inpatient Potentially Preventable Readmission Rates Medicaid Chronic Conditions, IP Admissions and ER Visits</p>
10	<p>Need to understand & act on behavioral health issues & challenges across all health related settings</p>	<p>Capital Region residents have higher rates of poor mental health days than benchmarks, and these rates are growing. The majority of Medicaid members utilizing ED and hospital inpatient services have comorbid physical and behavioral health conditions. Elevated and super utilizers of these hospital services are 2 to 3 times more likely to have a mental health or substance use disorder. Providers and consumers alike report difficulty in obtaining timely access to services for members with both physical and behavioral needs. These access barriers in turn result in under treatment of combined needs until a physical or behavioral health crisis drives a hospital ED visit or admission. Medical providers expressed a willingness to incorporate mental, emotional and behavioral health treatment into their practices, however, expressed the difficulty in obtaining the necessary knowledge and reliable ongoing BH support for this currently. Providers described regulatory barriers across agency and provider types as particularly frustrating. Waivers to allow person centered treatment spanning the current regulatory silos were seen as critical to success. NCQA Domain 3 clinical metrics for overlapping medication, mental, and physical health needs show varying needs across counties, suggesting the need to target interventions in</p>	<p>CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 2012.</p>



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

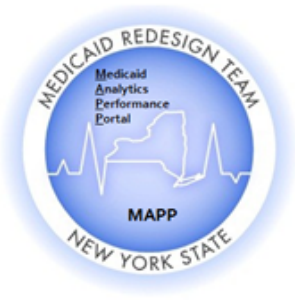
[Ellis Hospital] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		specific locations. Shortages of behavioral health providers also vary across counties. To this end the PPS will pursue Project 4.a.iii.	
11	Need to address disease burden related to tobacco use especially in low SES and MH populations	In the latest prevention agenda data release, tobacco smoking rates in the non-NYC benchmarks counties show a modest decline. In the six counties of the Capital District however, there was a minor decrease for Albany County and increases for the other five. Smoking rates in all local counties exceed the prevention agenda 2017 objective. Rates for tobacco-related chronic physical diseases such as cardiovascular, asthma, COPD, and stroke are also higher than benchmarks. The same is true for moderate and mild significant mental disorders and substance use disorders. In the number of the local hotspots of avoidable ED and inpatient hospital use, there is in alignment of smoking, mental health and substance disorders, and socio-demographic challenges. Focusing on evidence-based programs for tobacco cessation in these populations should improve quality of life for residents of these neighborhoods, a healthier community, and lower ED and inpatient hospital use rates. To this end the PPS will pursue Project 4.b.i.	EBRFSS population health data. NYSDOH chronic disease data. CNA analysis of SPARCS hospital OP & IP claims. CNA survey, listening, and focus group primary data. NCQA Domain 3 Clinical Metrics. DSRIP Managed Care Provider Network Data. ACS Census data 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
3_SEC038_\\efs\users\ELLIS\sminglerd\1115 Waiver\Application\Final CNA 12-17-2014\HCDI CNA Report Final and Appendices 12-17-14.pdf	12/17/2014 02:39:14 PM	Ellis PPS and Albany Med PPS Community Needs Assessment



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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: Ellis_Section4_Text_Ellis Section 4 (Projects) Final.docx
Description of File
Ellis Section 4 Projects - text document
File Uploaded By: smingler
File Uploaded On: 12/20/2014 10:53 AM

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

Currently Uploaded File: Ellis_Section4_ScopeAndScale_Ellis Speed and Scale Draft 12_21.xlsx
Description of File
Ellis DRAFT Speed and Scale Spreadsheet - awaiting new template and data from DOH
File Uploaded By: smingler
File Uploaded On: 12/20/2014 10:54 AM



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

Changes in the healthcare delivery system envisioned by Ellis PPS (EPPS) will have significant impact on healthcare employment in the region. The major DSRIP goals are: using hospital resources only when appropriate through proper, timely interventions and providing members with more knowledge of their own health situation and more tools to take charge of their health.

EPPS estimates significant health labor environment changes through the projects- the region will have fewer hospital inpatient stays and fewer ED visits and community-based providers will be touching more lives and meeting health needs in new ways.



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

Page 46 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

With the formation of the Ellis PPS Workforce Issues Team (PPSWIT) in cooperation with the Steering Committee and from consultation with the PAC, Ellis has formulated a comprehensive workforce strategy. The PPSWIT will meet current and developing needs of the PPS' health delivery system infrastructure: training to fill current and future vacancies, attracting community members as potential employees and if necessary retraining, redeploying and reducing certain functions within the current PPS workforce. The PPSWIT is comprised of HR leaders from the key partner organizations, regional health care workforce consulting groups and representatives from labor unions present in the area health care institutions that participate in the PPS.

Generally employment opportunities will decrease at hospitals' inpatient and EDs and increase among other provider venues. There may be a significant increase in job openings in other levels of care including CBOs. Many of EPPS' projects intend to use Patient Engagement Specialists and Navigators of various credentials and skills ranging from RN to entry level with organized training. Increases will be significant in Primary and Behavioral Health areas. EPPS intends to use a culturally competent workforce to support members in gaining confidence, health coverage and understanding choices that encourage individual health and, when in need of care, get it at the right time, in the right place, with the right follow up.

This PPSWIT assessed the likely impact of these changes on the current labor force, roughly 16,500 individuals. The biggest impact will be in EDs- there will be a drop of 5.4% in total volume based on the 25% reduction of potentially avoidable admissions (PAA). The 6 EDs may see a reduction across all jobs of about 30.4 FTEs concentrated in 3 areas: Patient Care Technicians (6), admin/clerical (6), RNs (15.6). The remaining 4 FTEs are fractions of 14 other job categories.

IP job reductions will have less personal impact due to PAA rate of 4.42%, higher job vacancy and turnover rates. Nurse managers, physical/occupational therapists, radiology technicians and social workers are the only positions where there is risk of job loss due to low vacancies. With turnover rates of 14-25% most job reductions will be met through attrition.

Other hospital departments will be modestly effected due in part to middle management/clerical reductions that PPS hospitals have implemented recently. The only union workforce that will be impacted to any degree is the nursing staff at Ellis Hospital.

With potential reductions in all departments, there will be redeployment opportunities. Among non-hospital PPS members, opportunities representing career growth are projected for all jobs at risk.

EPPS will engage Iroquois Integrated Workforce Strategies and Hudson Mohawk Area Health Education Center (HMAHEC) as workforce consultants. The many healthcare educational providers in the region have been inventoried. A big challenge will be filling newly created positions designed to provide new care approaches as well as filling existing positions for which recruitment has been an historic challenge.

*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.

Using the PPSWIT as the guiding body to translate proposed project staffing needs into definable positions while utilizing existing workforce assets, EPPS will endeavor to meet the staffing needs using a prudent approach to retraining and redeploying as many engaged existing staff members as possible. As the impacts of DSRIP become apparent to staff throughout EPPS, their anxiety will inevitably increase. Frequent and transparent communication with employees will be essential to ease these anxieties. EPPS will provide knowledge of the process and the risks and opportunities that are present, with the goal being to minimize risk and maximize opportunity for each individual. As appropriate, the strategies described will be developed in cooperation with unions and non-union employees leaders. All opportunities will be posted in the usual position posting locations and employee interest actively solicited. All jobs at risk will be discussed with those at risk individually.

Inpatient and ED related employment opportunities may shrink but impact on individual employees are not always directly linked to the market place. Agency or temporary workers fill some jobs in the hospitals; these we consider vacant positions. Generally RN jobs of various titles are subject to reductions but this is offset by the highest vacancy rates among RN positions.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Notwithstanding that reality, EPPS has developed a process to deal with potential job loss. The process would be as follows (subject to agreement with unions and respecting individual PPS member and past practices): when applicable, consult with unions in all appropriate individual cases in inverse order of longevity/seniority; discuss other employment opportunities within the organization with appropriate retraining; whenever possible, promise of return to the former position when/if an opening occurs. It is possible that such a job transfer would be mandated if unavoidable. If no alternatives exist within the particular PPS partner, other PPS members would be made aware of the employee's availability. If all possibilities are exhausted the person would face a layoff. The employee would have a week to consider options and if they chose to face layoff the employment would be maintained for an additional three months to allow time for a job search. Outplacement services will be made available to any employees that opt not to accept a retraining opportunity and are not successful in locating a similar position elsewhere in EPPS.

The current market shortage for RNs, Primary Care Doctors, MSWs and Mid-level practitioners will be a threat to EPPS' goals. The first strategy to deal with this will be to make efforts to retain staff and encourage job enhancement. The second will be to work with PPSWIT and workforce consultants to design and encourage partnerships with the locally abundant educational institutions to expand program to a deepen employee pool in these areas. Coupled with that will be programs to offer incentives to pursue these opportunities. Job growth consultants will be available to staff and community members as dictated by need. Lastly jobs integrated into the DSRIP projects, such as Patient Engagement Specialists, provide the PPS with an opportunity to workers who don't necessarily have a health-related degree to consider the wonderful choices that a health care career can offer.

Two of the three PPS Hospital systems have nursing schools, and the local BOCES and community Colleges offer RN and LPN degrees as well as CNA certification. A number of the local home care agencies offer certification as Home Care Workers and other titles. Not only will these opportunities be available to CHWs, but also the same CHWs can function as education marketers in EPPS communities.

Incentives for job growth and development will be available.

***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	1%
New Hire	2%

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.

EPPS expects no job functions to be fully eliminated. Due to existing personnel shortages and turnover, very few people will be asked to leave a position. That said, it may happen and EPPS has prepared for that reality in the following ways:
 1. When a job is identified as redundant due to DSRIP within any of the PPS employers, the hospitals' union contracts regarding this issue will be honored and respecting individual PPS member Policies and past practices. Otherwise, the expectation is that the individuals involved will be selected by seniority/longevity.



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

Page 48 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

2. Repositioning would be the first consideration leveraging opportunities both within the current employer and across the PPS.

3. Retraining will be assessed individually:

a. Retraining would include skills needed, the new work environment including location and schedules, the nature of the people to be worked with or served, issues of diversity and unique job expectations. Training would match the needs of the individual it could be as simple as a peer job coach, cultural training, IT skill training or professional skill development through the two PPS partner nursing schools or other educational organizations. Currently the PPS is aware of active use of online MSW training, this is another online opportunities should be considered. Training would match the needs that the new job demands and an individualized training needs assessment.

b. If the identified employee was to be integrated into some of the newly available jobs through DSRIP, they would be part of the development of the position, involving both development of policies and procedures and training. This would likely be an interactive process.

As an example, the PPS expects growth in the need for positions of Patient Engagement Specialists, similar to Community Health Workers. While this job category is not new to the PPS, it will be a more significant part of the approach toward integrated care. EPPS expects to involve some of the current CHWs to lead the development of training and to become mentors/people to be shadowed and also to help in the development of a curriculum for an organized training program that will be deployed by one of the workforce consultants mentioned above.

c. If the identified employee were interested in a job that required new skills or credentials, the PPS would seek opportunities within the abundant local resources, on line opportunities, or job shadowing, among other options.

EPPS hopes that all retraining will be voluntary, but if necessary, retraining may be mandated.

If mandated, EPPS will try to find a position that represents the best opportunity as seen by the individual selected. It is very likely that such a choice would be one within the same work setting. If so, the transition would be handled within the department but evaluated by the partner's HR department. The individual would have open access to the HR staff.

If the individual chose an opportunity outside of the current employment setting, the individual would be offered the support of an "interview coach" and follow up as desired between the current employer's HR and the potential new employer's HR departments. The goal would be to mitigate potential negative impacts as seen by the individual being transitioned (attention would be given to the choices of the employee and the legal requirements regarding employment information exchange).

*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.

Obviously the wages and benefits would be a significant factor of the employee's decision between the choices available. It is expected that most job losses within the hospital setting will be matched by job opportunities in that same setting due to current staffing patterns of consistently available openings. However, if an individual accepts a position in a different setting, the HR department will do a careful comparison of wages and benefits so the individual understands the impacts. If the job accepted represents a partial placement the PPS would try to find other "wrap around" opportunities until a full placement comes available. The current employer's HR department will be available to discuss impacts of the change for the first year. In the case of an undesired partial placement this availability would be extended until a full replacement is found.

Should a new opportunity present itself within the employee's initial setting, the individual would receive priority consideration for return.

*Retraining 3:

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

If opportunities are offered, EPPS would expect a decision within a week. If the opportunity is refused and after due consideration of their issues, concerns and appropriate discussion with any union affiliated with the employee, the PPS would honor all union agreements. Also, EPPS, with respect to individual PPS member policies and past practices and the suggested model will include maintaining the employee



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

for an additional 3 months to allow time for that employee to find a better choice within the PPS or elsewhere. Should the impacted employee opt not to accept redeployment then he/she would face layoff.

***Retraining 4:**

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

There is very modest commonality of union representation among EPPS partners, making inter-entity issues complex and therefore they need to be considered individually. As appropriate and/or required by contract, unions would be involved in any job changes/movements. The PPS unions are involved in the PAC. EPPS' position on DSRIP job tenure issues has been discussed at the PAC meetings. If unions offer retraining opportunities locally or within their larger organization structure they would be considered for use by the PPSWIT. This workforce section of the application has been made available to the unions for comment.

***Retraining 5:**

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

Placement Impact	Percent of Retrained Employees Impacted
Full Placement	100%
Partial Placement	0%

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 lead agencies in EPPS asked the respective HR departments within the three hospital systems to review a list of vulnerable job positions, with consideration given to the potential loss of in-patient and ED stays, and rank the likelihood for redeploying some employees in each job title. The study of current job markets supports a strong feeling that significant redeployment of staff is not expected, due to vacancies and turnover realities. The census of current job realities shows that while job opportunity shrinkage is likely to happen among licensed professionals who are generally in short supply in the area. These are employees who the PPS partners work very hard to retain. While redeployment implies a similarity between job qualifications and duties, in reality no two jobs are alike. The PPS wants and needs redeployed staff to find success. Hence the process below includes shadowing to try to limit surprises at the new job.

As the PPS sets out to redeploy employees to different settings, the considerations would be as follows:

1. Seek volunteers for such a change. If there are none, select candidates based on seniority/longevity.
2. Identify the available opportunities within the PPS detailing job duties, expectations, requirements, cultures, patients as well as the benefits.
3. Offer those staff interested in redeployment opportunity to shadow a similar worker at the potential new work site within the PPS. These opportunities will be posted on our web based PPS job opportunity platform.
4. Have a follow up conversation by HR from the initial employer with the redeployed staff after a week, then a month then as needed.
5. Priority return to the prior job would be offered if an opening occurred.

***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.

EPPS would honor all union agreements and respect individual PPS member policies and past practices. The suggested model for this situation is as follows:



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

The PPSWIT will develop descriptions for new positions and have each of those positions graded following existing procedures in each partner organization. Newly graded positions will have the corresponding salary levels attached to them and impacted staff will be counseled on the comparison between the old and new positions.

The PPSWIT will work collaboratively to make inter-PPS referrals for any staff being displaced in any one organization to facilitate employment in other partner sites that may have an opening for such a position. The PPSWIT will use a PPS-wide website to post all open positions and related qualifications.

The HR department of the current employer will do a careful comparison of wages and benefits so the individual understands the impacts. The current employer's HR department will be available to discuss impacts of the change for the first year.

Should an opportunity present itself within the initial employer's setting the individual would receive priority consideration for return.

*Redeployment 3:

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

EPPS hopes that all redeployment will be voluntary, but it may be mandated based on longevity/seniority.

To measure impact of redeployment the initial employer will follow mandated staff. The new employer will send a shadow companion to the initial job to observe the culture, tasks and expectations. That person will partner with redeployed staff at the new job for some time after which HR will interview the employee and consider needed steps.

If an employee refused redeployment or wished to abandon a redeployed position, after consideration of issues and discussion with an affiliated union, if no reconciliation is possible there may be a layoff, with consideration of a severance package based on policies/procedures, past practice and union obligations of the previous and current employer

*Redeployment 4:

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

There is very modest commonality of union representation among EPPS partners, making inter-entity issues complex and needing to be considered individually. As appropriate, unions will be involved in any job changes/movements as contracts require. As members of the PAC, unions are aware of the redeployment plan. The plan as detailed is multilayered and could be complex dependent on jobs and individual skills. Union involvement would be desired and welcome. EPPS partners believe that thorny individual issues are resolved with a clear understanding of hopes needs and wants of all parties. Unions would be welcome to help gain and communicate those desires.

If a non-union employee had an advocate, they would be offered the same opportunity while always considering privacy and other appropriate issues.

If unions offer retraining opportunities locally or within their larger organization they would be considered.

Non-union labor representatives to the PAC will be encouraged to join the PPSWIT work sessions as EPPS projects are developed to assure that both union and non-union staff have the opportunity to provide their unique perspectives on the various staffing plans.

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.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

As the project committees have been developing plans, the PPSWIT looked to each project committee to describe the skill and number of staff they envisioned to carry out their project. While the projects were developed individually, they will not be implemented in isolation. EPPS sees the projects as a set of approaches to person-centered care. Accordingly, a coordinating group has been assembled to envision the collective implementation. Workforce management would consider what kind of staff would be needed in what quantities, and explore opportunities for the staff to share multiple project tasks. For example, Patient Engagement Specialists going into homes would be trained in causes of Asthma and in impacts of Tobacco, would note "red light" home care issues, report potential poly pharmacy issues, etc.- all of which are components of various projects.

The new jobs created total 220 FTEs. They are concentrated as follows:

- Clerical/office 47.25 These fall in to two general categories, 11 who will help facilitate DSRIP management and 36.25 who will aid primary care doctors in their offices.
- Primary Care Physician 16.3 These Doctors will support the Integrated Delivery System (IDS), the expansion of primary care into behavioral health and expanding palliative care
- Registered Nurses 49.8 The emphasis of these positions will be IDS, ED triage and Ambulatory Detox
- MSWs 21 The need for these positions is almost entirely due to the ED triage, integration of primary care and behavioral health, and palliative care services.
- Patient Engagement Specialists/CHW 38 Largely entry-level health care positions, they will serve in the transition from hospital to home, Asthma training and "project 11," and will hopefully be representative of the communities they serve. EPPS will encourage these people to consider job development into shortage health jobs

All jobs will be posted within the PPS network, using a website as well as established individual PPS member recruitment systems. EPPS will begin hiring and training based on the speed and scale process identified for each project. Training will likely take be a two-step process, with training provided by the employer first and then DSRIP training regarding the common goals and processes. Likely some standard employment practices will need to be developed; for example how DSRIP leadership observations about staff evaluations are managed.

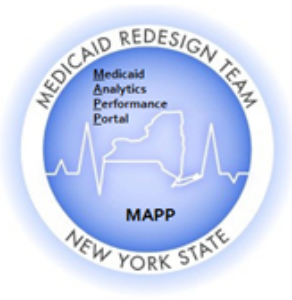
Parallel to this process, EPPS will begin working on the problems among needs for staff in "shortage occupations." This will be done with the support of labor consultants Iroquois and HMAHEC. One certainty is that the PPS' current training partners will be leveraged and staff desiring growth will be incentivized to fill some of these needs.

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	5
Physician	22
Mental Health Providers Case Managers	38
Social Workers	29
IT Staff	11
Nurse Practitioners	19
Other	100

✔ 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.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Funding Type	DY1 Spend(\$)	DY2 Spend(\$)	DY3 Spend(\$)	DY4 Spend(\$)	DY5 Spend(\$)	Total Spend(\$)
Retraining	50,000	75,000	100,000	150,000	75,000	450,000
Redeployment	10,000	50,000	50,000	50,000	25,000	185,000
Recruiting	500,000	500,000	400,000	250,000	150,000	1,800,000
Other	6,628,115	11,484,721	16,962,431	21,341,295	21,583,608	78,000,170

✔ 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.

In order to move from traditional care delivery models to population health management, new skills and competencies must be developed by the full clinical team as well as healthcare leaders. To accomplish this, existing state programs such as Doctors Across New York, Physician Practice Support, Ambulatory Care Training, Diversity in Medicine and Health Workforce Retraining Initiatives will be utilized. These training programs will assist in recruiting and retaining the level and diversity of staff needed to deploy the eleven projects proposed in this DSRIP application. In addition to state programs, EPPS will take full advantage of opportunities to place eligible clinicians through the National Health Service Corps (NHSC) and J-1/H1B Visa physicians. Both workforce consultants have extensive histories working with each of the above mentioned state and federal programs.

✔ 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.

In an early brainstorming session with ED professionals, it became obvious a change is needed- ED focusing on emergencies as opposed to the "catch-all" EDs have become.

The PPS tested nascent ideas at public listening sessions in all parts of the DSRIP region. Focus groups followed with providers and Medicaid participants. In these meetings, physicians expressed wanting to truly know their patients and the public wanted to be personally known by their doctors. With the confidence that change was needed and wanted, many employers in the PPS had various forms of communication with their staff.

EPPS' collaborative DSRIP model involved 150 individuals. The PAC has been made aware of employment issues and workforce plans. Staff issues were considered in multiple ways with both union and non-union representatives from across the EPPS. Several local clinical higher education programs were involved in the planning and strategy discussions around workforce needs at the PPSWIT level.

***Engagement 2:**

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

Labor groups are well represented on the PAC. Each of the PAC meetings involved a conscious effort to engage the audience and learn from their view of DSRIP. Three PAC meetings involved specific projects, one concentrating on behavioral health, a second on issues regarding integrating health care and the most recent on two subjects, the interactions of the various projects and case studies drawn from imagined patient profiles. But the second PAC meeting had a large focus on the issues of employee displacement. Throughout this process, several non-labor worker representatives, including PAs and other doctors, came to the meetings. The union representatives that participated in the PAC and PPSWIT meetings/calls were as follows:

CSEA - Jeffrey Decker and others
NYSNA - Susan Mitnick and others



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

1199SEIU - Rosa Maria Lomuscio and others
NYSUT - Tracy Burrows

*Engagement 3:

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

EPPS will soon begin an electronic newsletter marketed to staff, patients and the community. EPPS will use its planned website which will retain a workforce section that will contain information on workforce efforts being undertaken, and it will be used to drive interested applicants for open PPS positions to the hiring PPS partner organization with the intent of recruiting appropriate staff to make the projects succeed.

As EPPS continues to use the PAC to inform development of the chosen projects, the workforce reps will continue to be asked to share their input and reaction to those plans and tactical steps taken over the next several years to insure that PPS partner staff members and EPPS leadership are collectively working toward reaching EPPS' goals.

Current labor markets do not supply enough critical staff, primarily RNs and Primary Care professionals. EPPS wants to form partnerships to encourage interest in health careers in these and other levels. EPPS will be counting on frontline workers to encourage others to join them in meeting local healthcare needs. They are seen as individual and collective partners in the emerging healthcare system.

*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.

The PPSWIT will continue an active role throughout the 5 year DSRIP period in assuring that all stakeholders and staff remain engaged in the issues relative to staffing all projects and in keeping current with the evolution of the care strategies being deployed and the staff needed for each project. The PPSWIT will be on each PAC agenda to assure that workforce transitions and recruitment issues remain in the dialogue with all PAC participants.

Person-centered care is fundamentally different than how many perceive their health system now. While individuals that have the confidence, will and knowledge to insist on person-centered care likely get it, most do not. EPPS needs to lead to this end. Building confidence and trust among the Medicaid/uninsured in DSRIP is perhaps the PPS' biggest challenge. EPPS will start by instilling that value in staff and working in communities with CBOs build trust one member at a time.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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 PPS is well positioned to begin sharing patient health information. Most PPS partner organizations are already connected entities within Health Information Exchange of New York (HIXNY). The PPS will encourage providers currently not connected to consider the option and join HIXNY, but it's a significant expense and requires a great deal of time. This will be an on-going challenge. HIXNY is the Regional Health Information Exchange (RHIO) that serves as a local hub to securely collect and deliver health info in real-time between authorized users, connecting hospitals, physician practices, health plans and other stakeholders. The PPS considers the existing data-sharing arrangements with HIXNY appropriate and inclusive and intends to expand it over time to include partner organizations (downstream providers, CBOs) that are not part of the RHIO. Some non-clinical CBOs will not have the required capital or operational need to join HIXNY, but their input will be valued at the PAC level.

***Confidentiality 2:**

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

HIXNY is a NYS-Certified Qualified Entity that exists under the auspices of the Statewide Health Information Network of New York (SHIN-NY) and abides by the policies and procedures defined by the NY eHealth Collaborative (NYeC) and DOH. HIXNY has a participation agreement among all members in the Health Information Exchange (HIE), defining the data-sharing arrangement and adjoining SHIN-NY regulations with further regional policies- details of using this agreement will be a broader conversation at the governance level.

The HIXNY participation agreement requires members to uphold security mechanisms, follow data recipient privacy requirements, breach of privacy protocols and HIPAA privacy provisions to facilitate safe and secure system interoperability. As HIXNY members, the PPS will include all partners in unison to uphold privacy policies and evaluate adherence to procedures using the resulting audit trail for pattern analysis and review.

***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

NYS Confidentiality – High



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

and care is provided efficiently and effectively while maintaining patient privacy.

To share vital patient information in real time, the PPS will utilize HIXNY's continuously developing capabilities, a decision agreed upon by the PPS and the IT planning committee, comprised of the key member organizations' CIOs and other relevant representatives. The HIE contains data from over 530 connected entities, including 28 hospitals, creating a single community system. Last year HIE processed nearly 1.7 billion clinical messages contributed by participating community providers. HIXNY members access on average over 200,000 records per month, including near real-time notifications when patients visit the ED or are admitted to the hospital. The system delivers more than 8,700 event notifications and almost 88,000 lab, radiology and transcribed reports every month better coordinating care and reducing readmissions. Nearly all PPS partners already have or are in the process of adopting HIXNY- the key partners in the PPS are all early adopters of HIXNY data exchange and most key partners were founding members and still retain a governance role with HIXNY. The PPS region has achieved a critical mass of patient-centric data through HIXNY, positioning the PPS to leverage the power of real-time data to inform providers and care coordinators who are capable of using the information in a meaningful way to improve population health and meet individual needs one patient at a time. The key partners share many patients across various care settings in the 6 county region and already use features that HIXNY offers to those providers connecting to its data exchange. Care coordination efforts that involve multiple existing PPS partners touching a current patient are already benefiting from this technology. This functionality will only become greater once non-connected PPS partners become HIXNY members. Most key partners in the PPS use various digital population health management products that often rely upon HIXNY data to complete their total utility.

Section 6.2 – Rapid-Cycle Evaluation:

Description:

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

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

*RCE 1:

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

The PPS will have a Clinical Integration Committee (CIC) in place with the charge of setting clinical standards and reviewing specified clinical data and outcomes. The CIC will report results to the PPS governing board. The data will be collected through the reporting tools developed by the Health Information Exchange of New York (HIXNY). The PPS' success is dependent upon measurable data that demonstrates the improvement of an individual's health over time. The CIC will assess the data based on the standards provided. The CIC will have direct access to the project teams to review the data and discuss actions that may be needed to improve overall outcomes.

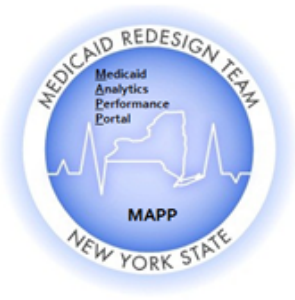
*RCE 2:

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.

HIXNY can give info necessary to identify programmatic hot-spots and mobilize resources to address needs at a local level, bringing greater clarity to project champions as they engage chronic disease patients with the challenge of delivering better health outcomes. HIXNY has capabilities to enable real-time analytics, dashboards and patient clinical registries that can be used in conjunction with event notification services to support care coordination and point of care decision-making.

Population health initiatives can use HIXNY resources to track patients and plan interventions. The platform is customizable and flexible. It is capable of including claims and other disparate data elements to analyze both clinical and financial outcomes. The platform is also capable of producing customizable dashboards that leverage near real-time data to conduct quality assessment and improvement activities as well as evaluate performance of PPS partners.



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

Page 56 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

***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 Integration Committee (CIC) is tasked with the collection and review of data that will look at provider/practice level performance as defined by the PPS' eleven chosen projects. Best practices will be learned overtime and shared. A Quality Committee consisting of clinical professionals will work with the CIC to analyze data and make recommendations. Data will also be shared with Project Advisory Committee (PAC) to keep the group informed and to engage in a broader discussion about improving health outcomes in the communities being served.

***RCE 4:**

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

Another advantage of leveraging HIXNY data analytics is that the HIE captures data in real-time and therefore is a timely source of information that providers and care coordinators can access at the point of care when treating a patient. The HIXNY solution has the potential to detect changes in health indicators much more rapidly and efficiently than typical data sources used in community population health programs by supporting rapid-cycle program evaluation and outcome measurement needs. Simply put, HIXNY's solution supports program definition, operations and outcomes measurement.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

Improving cultural competency across the PPS is a challenge due to diverse populations in the service area. Schenectady has a largely uninsured Guyanese population- about 10% of total city population. Fulton/Montgomery Counties have large rural Amish populations. Albany has refugee populations from Burma, Iraq, Bhutan, Afghanistan, Congo and Sudan. Cultural competency training will be tailored to these unique groups to provide optimal levels of care and ultimately reduce racial/ethnic health disparities. Race/ethnicity data will be collected consistently to increase awareness of disparities, facilitate targeting of interventions and tracking progress. Healthcare profession populations don't always proportionately reflect the race, gender, age and other cultural differences of the community/consumer population. The PPS will recruit a diverse workforce that reflects the PPS community, establish baseline knowledge, develop tools/programs to assess and address cultural needs and gather input from the community to determine progress in achieving cultural competency and limiting health disparities.

Education to providers and frontline staff about barriers experienced by people living in poverty is a challenge. Poverty is pervasive in the PPS particularly among racial/ethnic groups. According to the NYS Poverty Report released by the NYS Community Action Association in 2013, poverty rates in the PPS are: Albany County 13.8%, Fulton County 16.9%, Montgomery County 18.3%, Rensselaer County 12.6%, Saratoga County 6.3% and Schenectady County 12.5%. Racial/ethnic disparities are apparent when the data are stratified (e.g. in Albany County, whites living in poverty=9.6% while African Americans and Hispanics/Latinos living in poverty=25.9% for both groups.) Healthcare, especially preventive, is often not a priority for people living in poverty. There will be training on the "culture of poverty" to truly address the



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

factors that inhibit these populations from accessing care.

*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.

The Ellis PPS will develop an Organizational Cultural Competence Assessment Profile that will allow for tracking of cultural competency proficiency in the following domains: organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure and services/interventions. The profile will be reviewed on a regular basis and will guide the PPS in implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS). In order to imbue cultural competency throughout the PPS and at an executive level, the governing body will monitor and incorporate these efforts.

The regional planning group, Healthy Capital District Initiative (HCDI), was recently awarded a Population Health Improvement Program (PHIP) grant. HCDI will work in partnership with Albany Medical Center's Clinical Education Division of HIV Medicine to conduct cultural competency trainings that will reinforce the CLAS standards. Also under the PHIP grant, HCDI will assist in offering Bridges Out of Poverty trainings in Albany, Rensselaer and Saratoga Counties.

Additional questions will be added to intake forms across the PPS to capture data on race/ethnicity, sexual orientation, gender identity and social needs due to the unique medical needs and health disparities experienced by these populations.

The Ellis PPS will explore adding the cultural competence item set to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to ensure that patients can provide feedback related to the cultural competence of their health care providers.

A Community Advisory Group will be developed that has representatives from each of the racial/ethnic populations, as well as other marginalized groups typically found in the Medicaid population such as low-income, LGBTQ, people with disabilities, Veterans, formerly incarcerated individuals, etc. This group will provide guidance to the PPS on proposed intervention

*Competency 3:

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

Community Based Organizations (CBOs) that serve racial/ethnic and other marginalized populations will play a crucial role in helping the Ellis PPS identify individuals who will (1) participate in the Community Advisory Group and (2) serve as community navigators/Patient Engagement Specialists. These individuals will also assist the PPS by informing the cultural competency training curriculum and conducting components of the trainings that pertain to their culture and background. In addition, CBOs will serve as hot spots where community navigators, who are a reflection of the population, will be stationed to link patients to culturally-appropriate resources and primary and preventive care services.

The PPS plans to partner with the Schenectady Bridges Out of Poverty program that trains front line workers, community service providers and health care providers to understand the barriers experienced by people living in poverty. There are a number of certified Bridges trainers and the PPS will identify individuals in Albany, Rensselaer, Saratoga, Fulton and Montgomery Counties to become certified trainers to expand the Bridges Out of Poverty program beyond Schenectady. The PPS will also explore the opportunity for some of the Bridges trainers to become trained in cultural competency. For example, there is a five-day Training of Trainers Institute through the Cross Cultural Health Care Program out of Seattle, WA. Bridges trainers would work with their expert trainers and professional colleagues to develop a cultural competency education program for the PPS.

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



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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

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

*Literacy:

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

- Describe the PPS plan to improve and reinforce the health literacy of patients served.
- Indicate the initiatives that will be pursued by the PPS to promote health literacy. For example, will the PPS implement health literacy as an integral aspect of its mission, structure, and operations, has the PPS integrated health literacy into planning, evaluation measures, patient safety, and quality improvement, etc.
- Describe how the PPS will contract with community based organizations to achieve and maintain health literacy throughout the DSRIP Program.

To improve health literacy of patients served, the PPS will need a better understanding of the health literacy needs of the population. Additional questions will be added to intake forms across the PPS to capture data on education and preferred language. This information will inform the standardization of policies such as reading level and language availability of all educational materials. The PPS will also explore adding the health literacy item set to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to ensure that patients can provide feedback related to providers' activities to foster and improve the health literacy of patients. Organizational assessments of health literacy will be conducted annually to measure progress in improving health literacy across the PPS.

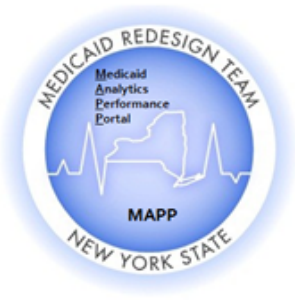
A number of initiatives will be pursued by the PPS to promote health literacy. The Organizational Cultural Competence Assessment Profile, specifically the domain focused on communication, as well as the ten Attributes of a Health Literate Organization (Institute of Medicine Roundtable on Health Literacy), will be guides for the integration of health literacy policies and practices into the PPS. Cultural competency trainings will cover health literacy strategies, particularly techniques to navigate cross-cultural communication. Front line staff will need to understand how to address health literacy in high-risk situations, including care transitions and communication regarding medication adherence. The PPS will work with community navigators and facilitated insurance enrollers to provide easy-to-understand descriptions of health insurance policies. Where it is not possible to have in-person interpreters, the PPS will expand the use of a Video Remote Interpreting service in both inpatient and outpatient settings that provides face-to-face translation in multiple languages through an iPad. A Community Advisory Group will be developed that has representatives from each of the racial/ethnic populations in the PPS service area. This group will be a resource for feedback on acceptability and feasibility of health literacy interventions prior to implementation, such as reviewing educational materials.

The Ellis PPS will partner with organizations such as the US Committee for Refugees and Immigrants (USCRI) to achieve and maintain health literacy. USCRI offers Health Access Support Services to the refugee populations it serves and has experience helping people with unique cultural beliefs and needs navigate the health care system. For example, they have created a Primary Care Physicians Map for Albany and Rensselaer that identifies providers that use interpreters, are near bus stops and accept one or more insurance plans including Fidelis, CDPHP and Medicaid. It also indicates the gender of the providers, as this is an important consideration for a number of cultures. The PPS would like to expand this tool as a health literacy resource for other racial and ethnic groups prominent across the service area. Community Based Organizations that offer English as a Second Language (ESL) classes, such as Refugee and Immigrant Support Services of Emmaus (RISSE) in Albany, will be a valuable resource for identifying the literacy needs of the populations they serve and developing interventions to be applied in the healthcare arena.

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



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

Page 60 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

allow DOH to effectively monitor DSRIP program progress and sustainability. The following outlines the milestones that will be required and expected of the PPS to earn DSRIP payments. The milestone is presented for informational purposes only, however, the PPS will be expected to develop a work plan to outline the steps and timeframes in which these milestones will be achieved.

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



Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

DSRIP funding of the Ellis PPS will support the overall goals of the PPS. Distributions will be based upon the specific projects selected and the attainment of the overall goals of the DSRIP program. The governing body of the PPS will approve the distribution of DSRIP funds.

Critical in the attainment of the Ellis PPS goals is the ability to: (1) cover overall PPS administrative costs and specific project costs to be incurred, (2) cover non-reimbursed Medicaid costs critical to success of projects (3) provide loss revenue support to partner organizations, (4) provide financial incentives for attainment and exceeding milestones and goals of projects and (5) maintain a reserve of funds to meet unforeseen needs of the PPS over the 5years of DSRIP to support partners and programs.

Domain projects will have budgets developed at the provider group level based upon the projects' specific needs. As the projects involve various provider groups including primary care, specialties, nursing homes, homecare and community support groups, allocations to these provider groups are being considered in the development of the flow of funds plan. As a starting point, one project already includes percentage allocations between primary care physicians and specialists and additional allocation methods are in development. Such allocations will be based upon the specific integration of clinical specialties as required for the success of the specific domain project.

The budgets will be based upon costs, anticipated revenue loss, financial incentives and other needs of the project. Using project budgets, the attributable lives being served by the project, and the allocation of funds between clinical specialties, the overall flow of DSRIP funds will be developed and implemented. As many of the projects and providers overlap, a process to evaluate the integration of projects and partners is being developed as an additional distributional attribute to avoid duplication.

The flow of funds methodology must be consistent with the overall governance structure of the PPS. The composition of the Ellis PPS governing body is representative of the overall PPS Partners. The governing body will be made up of sub committees for specific tasks.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

Initially these will include finance, audit, clinical integration and data/IT. Other committees as determined by the governing body may be added over the course of DSRIP. This structure will provide the oversight and integration of the partners while assuring that the flow of funds are in alignment with the budgets as proposed and support the overall project goal outcomes, while maintaining financial stability of the PPS as a whole. The PPS' approach for the distribution of DSRIP funds and the governance structure support the successful achievement of the PPS selected project goals.

Funds provided will support the major components required for success. Costs may be incurred by a partner to expand primary care services and support the project. This may in turn reduce inpatient or ED usage of another partner, who may require revenue loss support while it restructures to a new delivery model. The fund distribution method will support these components to allow for the success of the project and the financial stability of the partners. In addition in order to meet specific benchmarks or milestones of a project, or the PPS overall goals, the plan will provide financial incentives to partners who meet and/or exceed these milestones.

This approach has been developed through input and support of the emerging governance structure of the PPS, including project leads, thus allowing participation and understanding of the needs of the projects and the overall PPS goals. It will provide the foundation for success of the projects, the PPS and the overall DSRIP goals and to works to assure financial sustainability after DSRIP has ended.

✔ 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.

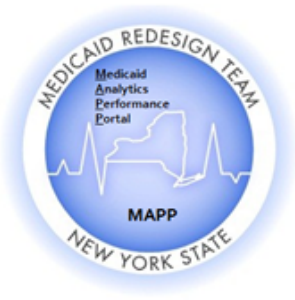
Please complete the following chart to illustrate the PPS' proposed approach for allocating performance payments. Please note, the percentages requested represent aggregated estimated percentages over the five-year DSRIP period; are subject to change under PPS governance procedures; and are based on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

#	Budget Category	Percentage (%)
1	Cost of Project Implementation	25%
2	Revenue Loss	25%
3	Internal PPS Provider Bonus Payments	30%
4	Costs of Services not covered by Medicaid	10%
5	Contingency Fund	10%
Total Percentage:		100%

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

Description:

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



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

Page 63 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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



Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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.

The PPS has completed an initial assessment of the overall financial condition of the Ellis PPS partners with a particular focus on key partners of the PPS using financial and income related data to determine the financial stability and identify fragile safety net providers. The key partners in the Ellis PPS include Ellis Hospital, St. Peter's Health Partners, St. Mary's Healthcare (Amsterdam), Whitney M. Young Jr. Health Center, Hometown Health Centers and two privately owned physician groups. For the first five, financial, operational and income related data, both past and most recent available, was reviewed and compared to standard industry metrics. The remaining two key partners are privately owned physicians groups with a long community track record, but financial statements are not available. Based upon this analysis, no partners in the PPS are identified as financially unstable and unable to move forward with DSRIP.

In addition, the analysis of the key partners is continuing through the work of the finance committee, clinical leads and project leads to include a cash flow sensitivity analysis. This is to further assess possible financial instability that may occur, as the result of participation in a specific DSRIP project or the overall DSRIP goals of the PPS and state. This will look at projected revenue losses, additional costs to be incurred as well as other factors to develop financial reporting mechanisms to assure that needed supports are provided to maintain the financial stability of these providers. The historical financials will provide a baseline and in combination with the sensitivity analysis will allow for comparison and the quick identification of providers who may become financially fragile due to their participation as a PPS provider.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

*Assessment 2:

Identify at a high level the expected financial impact that DSRIP projects will have on financially fragile providers and/or other providers that could be negatively impacted by the goals of DSRIP.

The Ellis PPS projects were selected based on gaps identified through the Community Needs Assessment. These projects continue to be analyzed to determine the financial impacts they will have on the PPS partners. The effect will vary for each partner depending on their current service delivery and business model and their role in the various projects and current financial stability.

Generally hospitals and to a lesser degree nursing homes and other inpatient focused providers will be negatively affected by the DSRIP overall goals. However the degree to which they are negatively affected will depend on their overall service mix and how they restructure as a result of the projects.

Conversely, a primary care provider, such as an FQHC, who is financially stable today, but asked to increase capacity, either by extended hours, or additional clinic sites, could in the short term become fragile until such time as the revenue catches up to the investment needed to expand. This transition period during the early years of DSRIP will require monitoring and possible financial support to maintain financial stability. In addition, in order to provide for a continuum of care and a coordination of care, additional communication and care management models will need to be developed, and grow over the DSRIP period which will initially require investments.

There are a number of ways that the DSRIP projects could potentially impact the financial stability of providers overall and particularly those who are serving a higher proportion of Medicaid and uninsured, who tend to already be financially fragile. These include:

- Requirements to reduce inpatient admissions or readmissions resulting in less revenue at a faster pace than costs can be reduced or eliminated or offset by changes in service mix.
- Incurring initial startup costs to provide additional services or modify existing services needed to meet PPS project goals such as increased hours of operation.
- Incurring new costs currently not covered or insufficiently covered by Medicaid that are critical to meeting project goals, including such items as transportation, navigators, case managers and other care coordination costs.
- Workforce hiring, retraining, realignment of staff resulting in additional costs or lost time during transition, without corresponding revenue to support such costs.
- Capital investment to purchase or lease buildings, equipment, technology software needed to expand or integrate services that will over the course of the DSRIP program reduce operating costs by directing services to more appropriate levels and increased communication among the providers in the health care delivery network.
- The failure or inability of a provider to meet plan requirements for project goals either reduction in services and related costs, or the reduced performance based payments for non-attainment of these milestones.

The PPS continues to develop and refine the overall financial sustainability plan and is making specific provisions in the budget and funds flow plan to support safety net and vital access providers, especially those who are or could become financially challenged due to DSRIP. This plan also includes the effects of non-DSRIP related financial effects on providers from other payers and changes currently occurring or expected to occur over the next few years such as Disproportionate Share reductions from both Medicare and Medicaid and other funds that are drying up or changing.

✔ 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.

The PPS established a finance committee within its governance structure. This committee will be responsible for the overall financial stability monitoring and integration of the PPS as a whole. The committee is currently developing the overall financial stability program for the PPS which will be fully developed during the next several months and early on in Year 1 of DSRIP. This plan will be developed in conjunction with the project teams and PPS partners, so as to provide for collaboration and transparency. The plan will include but not be limited to the following concepts and components:



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

Page 66 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

- Financial data and monitoring will begin at the partner level with reports provided to the finance committee on a pre-described regular basis.
- Project teams will also provide financial report information related to their budgets in implementation of their individual projects to assure budgets and expenditures are aligned.
- Finance committee will analyze data and develop a report for the overall governance body and steering committee for their review, input and approval. Summary reports will be developed and shared with the partners of the PPS.
- Specific financial and operational metrics will be developed and used consistently across the PPS as needed. These metrics and reports will be ones currently used by providers in their normal course of work so not create significant additional work on providers.
- As part of this monitoring, a Distressed Provider Plan (DPP) will be developed to provide an additional tool to be used by providers experiencing financial instability, as the DSRIP program and projects are implemented. This plan will include additional needed data, demonstrate the cause of the instability and include a corrective action plan recommending steps to be taken. The finance committee will work with these providers to develop a comprehensive solution to re-establish the financial stability

*Path 2:

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

The plan under development for financial sustainability will require regular reporting on the financial condition of the PPS partners. Safety net providers' financial stability is critical to this plan. To ensure this stability, the financial structure of the PPS will also include:

- Budgets and the flow of DSRIP funds will take into consideration the fragile safety net providers and their specific roles in the projects of the PPS. Revenue loss, implementation costs and financial incentives and awards will be included.
- Reporting of financial and operational data regularly by the partners to the finance and steering committees to avoid or quickly uncover possible financial instability of a specific provider and develop a DPP.
- Communication flow among PPS partners will be open and often and include project leaders, finance committee, partners and the PPS governing body.
- Financial and operational supports will be in place to assist financially unstable providers to regain stability.

*Path 3:

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

The Ellis PPS will develop a plan of collaboration with the payers of the healthcare services to build on existing shared savings contracts for post DSRIP based upon new or expanded performance based systems. Medicaid managed care plans are participating with the PPS to provide them with the understanding of how the PPS is planning to meet the goals. Participation will provide additional experiences in shared savings, quality and value based reimbursement systems with the PPS to sustain DSRIP outcome after the conclusion of DSRIP. The collaborative implementation of the projects among partners to provide for continuity of care, improve quality and patient outcomes in a cost efficient manner will support the PPS after DSRIP.

This mature health care services market will enable the providers of the PPS and their organizations to operate as a financially sustainable network in a value based rewards payment environment beyond the DSRIP period.

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.



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

Page 67 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

The vision of the PPS is to create an integrated, community based health care delivery system that operates on a value based payment system that is transparent, equitable, provides for increased quality and directs services to the appropriate level of care at an efficient cost, thus decreasing avoidable inpatient and ED usage.

The three largest Medicaid managed care plans (CDPHP, MVP and Fidelis) are engaged in the process and project selection by the PPS. Their involvement throughout DSRIP will be instrumental in transforming the reimbursement systems that provides financial stability to the providers using a value based system.

Currently some of the PPS partners have several shared savings and risk based contracts with the managed care plans in the counties being served. These contracts include both Medicaid, Medicare and commercial populations and include in excess of 20,000 lives overall and include preventative health and population management systems where both the providers and plans share in savings attained. These projects will provide needed experience in various areas of health care delivery, allow for the expansion and new payment systems, like PCMH's, and provide flexibility to partners to transform into a successful mature value based reimbursement and delivery system.

*Strategy 2:

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

It is the basis of the PPS that the projects proposed will drive down admissions and other avoidable complications, reduce ED usage, improve quality outcomes and the overall health of the Medicaid and uninsured population. These results will drive down current Medicaid payments per patient while transforming the current fee-for-service reimbursement system to a value based system. This transformation will result in reduced revenue for inpatient providers and increased costs for primary care and related services and require a change in service and business models of the partners.

However, while this transformation will challenge the financial stability of the financially challenged providers, it will be done over a period of years, with the supports in place to provide for the transition and learning experience through the 5 years of DSRIP. Participation in this transformation by all providers in collaboration will provide them with the opportunity to transform their business model and delivery system over time. In addition, any shared savings or value based contract would need to include scalability and flexibility to provide financial stability to the partners of the PPS.

Currently several PPS partners have shared savings contracts based upon population health and care management, where savings attained are shared by both provider and plans based upon pre-defined targets. One of these contracts also includes a large physician group (IPA) where the physicians, plan and providers all share risk and benefit from savings attained.

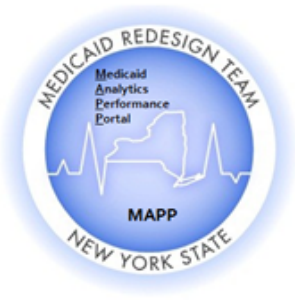
This transformation will also result in reimbursement models and contracts between provider and managed care plans, which will have the knowledge and collaboration of the 5 years of DSRIP working together, allowing for shared savings approaches, financial incentive programs and bundling of service payments. Also the data on patient outcomes collected through the DSRIP period will provide direction for the development of the various value based reimbursement methodologies.

Section 9.4 - Domain 1 – Financial Sustainability Plan 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.

- 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.



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

Page 68 of 71
Run Date : 12/22/2014

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)



Please click here to acknowledge the milestones information above.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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 Ellis PPS population health infrastructure began in 2011 with the launch of Care Central, the Ellis care management organization. Care Central manages three contracts.

First a phase-one Health Home launched in 2012. Care Central's approach was designed for health improvement for the entire population, regardless of payer. Care Central's HH, under VNS of Northeastern NY, is the highest performing HH in outreach to enrollment ratios. It was the first HH to meet SHIN-NY EHR standards and has produced significant reduction in ED utilization and increased primary care in all cohorts and members managed for at least 12 months demonstrated reduction in inpatient stays.

The second and third contracts included establishing patient registries, monitoring/measuring clinical and cost metrics and patient-provider attribution for affiliated and non-affiliated providers. A CDPHP contract manages all Medicaid members in Schenectady County: 16,000 lives. MVP and MVMA contract for management of Commercial, Medicare, and ASO: 14,000 lives. Ellis receives monthly feeds of all medical claims into Verisk Population Health, a clinical, financial and risk analytics tool utilizing predictive science and evidence-based clinical intelligence. Ellis' Data Analytics Group identifies targeted populations, health trends, gaps in care and patterns in BH and chronic conditions.

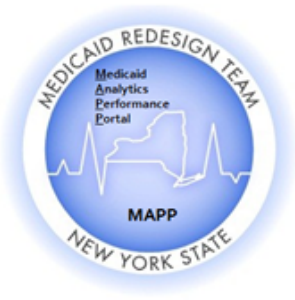
Additional competencies are hot-spotting CNA strategies (UMatter), social determinates of care competencies (Schenectady Bridges) and clinical practice guidelines (outpatient palliative). Recent awarding of a Medicare MSSP will be broadened across the majority of key partners in the Ellis PPS and include a Clinically Integrated Network, launching in January 2015. Ellis' track record, inclusive approach and capabilities will lead to successful delivery and reaching set goals of the Project 2.a.i.

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 PPS has elected to work with the Iroquois Healthcare Association (IHA), a proven and experienced organization ready to help execute the workforce strategy. IHA has successfully collaborated with hospitals, nursing homes and home care agencies across Upstate NY on a variety of workforce recruitment, retention and training initiatives. IHA has demonstrated success in the ability to identify eligible candidates for training programs, organize appropriate training and assist with retention and employment for trained individuals in the health care sector. IHA has successfully administered over \$24 million in federal and state grant training projects over the past 16 years. Those training projects include HWRI Health Workforce Retraining Initiatives (DOH), TANF Health Worker Retraining Initiatives (DOH), Emerging and Transitional Worker Training Initiative (DOL) and Strategies to Assist Workers Impacted by the Berger Commission (DOL). Over 9,000 health care workers have been trained through these initiatives delivered in both online and classroom training formats.

IHA has an existing infrastructure in place to meet expected DSRIP metrics including technology, communication systems, workforce data collection and distance learning capabilities. A proven model of comprehensive policies and processes for data collection, reporting



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

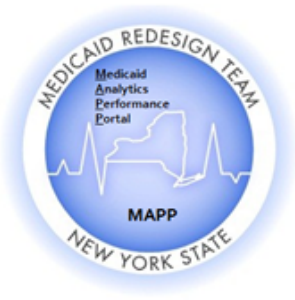
DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

requirements and program compliance is in place. An existing centralized database provides the ability to track and monitor participant, program and performance requirements. IHA commits to manage, implement and assure timely completion of the DSRIP projects by dedicating qualified key personnel. IHA is also prequalified to do business with NYS.

The PPS will also work with Hudson Mohawk Area Health Education Center (HMAHEC) to collaborate on Care Management Skills Training. HMAHEC will identify the number of training opportunities to be conducted in the 6 county region and the most effective means of engaging staff for attendance.

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.



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

DSRIP PPS Organizational Application

Ellis Hospital (PPS ID:3)

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 Ellis Hospital that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.

Primary Lead Provider Name: ELLIS HOSPITAL
Secondary Lead Provider Name: ST PETERS HOSPITAL ALBANY

Lead Representative:	James W Connolly
Submission Date:	12/22/2014 12:11 PM

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