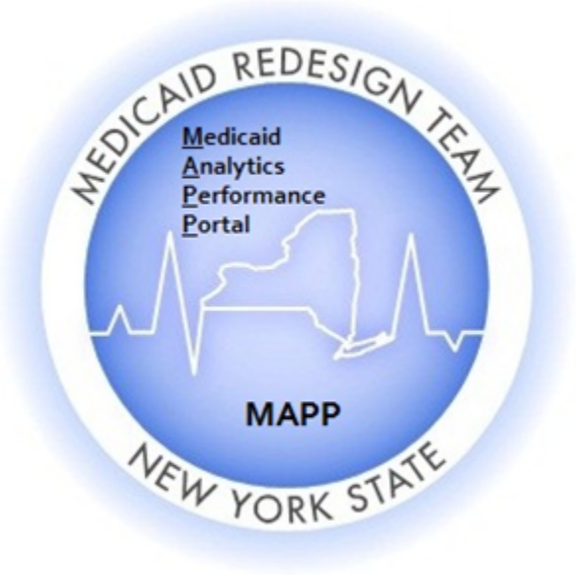
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Millennium Collaborative Care PPS (ECMC)

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

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

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

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

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

Currently Uploaded File: **48_SEC000_ECMC-DSRIP_lead_financial_stability_test.pdf**

Description of File

Millennium Collaborative Care/ECMCC Lead & Financial Stability Test submitted 11/10/2014

File Uploaded By: jstaylor
File Uploaded On: 12/22/2014 09:33 AM

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

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

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

Last Updated By: jstaylor
Last Updated On: 12/22/2014 03:14 PM

Certified By: santiag7
Certified On: 12/22/2014 03:32 PM
Lead Representative: Juan Santiago

Unlocked By:
Unlocked On:

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SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

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

Scoring Process:

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

Section 1.1 - Executive Summary:

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

#	Goal	Reason For Goal
1	Resolve excess bed capacity in inpatient and SNF facilities	There are currently 22 hospitals providing acute care services across Western New York (WNY), 10 of which are in MCC. In the region there are on average 1,240 beds not in use, of which 511 unused beds are in MCC. There are 74 nursing home facilities, of which 41 are in MCC. Projected estimates of WNY public need for SNF beds indicate an excess of 499 beds. Deactivation of unused beds would not have large workforce implications since these unused beds are largely unstaffed. Reuse of these facilities will be explored using redeployed staff. We will work collaboratively to decertify unused, unstaffed beds in hospitals and skilled nursing facilities (SNFs), while seeking beneficial ways of repurposing the unused space for non-inpatient services by the facility.
2	Activate a continuum or providers in the IDS including medical, behavioral, and community	MCC presently has a wide array of providers and community partners participating. They have joined MCC, coming from environments and settings that have traditionally functioned in isolation. The goal is to activate them as one.
3	Achieve care management integration across the IDS including medical, behavioral, and community	Enhanced communication and care management data sharing among primary care, specialists, mental health, Health Homes, and community support agencies does not exist, and interoperability with hospitals and pharmacies needs to be enhanced. This requires universal protocols across settings and interoperable health information exchange (HIE) to makes information accessible in real time.
4	Achieve clinically interoperable care management and community support across the system	We will enhance regional health information organization (RHIO) interoperability by: (a) care coordination for high risk patients in transitions; (b) emergency care changes to prevent improper use; (c) hospital care changes to prevent readmissions; (d) integrated referral to subspecialists; (e) medication safety enhancements; and (f) interoperability with behavioral health and community supports. We will train key personnel across the system to participate in the new model.
5	Achieve PCMH/APCM standards and meaningful use requirements in all safety net primary care locations	In MCC, only 36% (85) out of 235 MCC primary care locations are currently NCQA recognized. Various types of PCMH Coordinators will be deployed to reach Level 3 PCMH rapidly. Evidence-based approaches such as the TRANSLATE model will be used to drive the PCMH recognition process. We will use PCMH workflow changes in pre-visit planning to address access, transportation, and community linkage problems in underserved areas
6	Achieve EHR connectivity to RHIO's HIE for all safety	Gaps in interoperability include lack of enhanced communication and care

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#	Goal	Reason For Goal
	net primary care locations	management data sharing among safety net primary care, specialists, mental health, Health Homes, and community support agencies. The interoperability among hospitals and pharmacies needs to be enhanced.
7	Achieve HIT integrated population health management in all safety net primary care locations	In addition to the RHIO interoperability needed for patient care, it is also needed for population health management that would involve: (a) managing panels of high-risk, rising risk, and low-risk patients; and (b) quality improvement reports for DSRIP metrics that must have practice-level reporting (used by practices for performance feedback to drive continuous improvement) and PPS/community-level reporting (used by the PPS for rapid cycle evaluation).
8	Establish contracts with Medicaid MCOs that includes value-based payment	It is essential for the integrated system to establish value-based payment arrangements with Medicaid managed care organizations (MMCOs) and other payers to support system transformation that is not encounter-based, but is performance-based using an array of means to effect change (community-based and other supports) that are presently not covered by fee-for-service.
9	Achieve transition to a provider compensation model that includes incentive-based payments	Transitioning to value-based payment arrangements with MMCOs will require downstream value-based provider contracts to support and incentivize practice change to reduced avoidable complications an
10	Achieve real service integration with all Health Home agencies	The six emerging Health Home agencies have just started and have limited presence in some areas. There is limited meaningful integration of behavioral health with primary care due in large part to the structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training). Health Homes need to be ingrained in the infrastructure for this behavioral health and primary care integration. In support of leveraging Health Homes for integration, there is a need to create new functionality in primary care safety net settings dedicated to this integration; and in behavioral health settings serving seriously mentally ill, there is a need to embed primary care providers in high-need targeted locations.
11	Engage patients in the integrated delivery system at all levels	Patient engagement is essential for the system transformation to be informed by the patient's perspective in terms of (a) what the problems are and (b) what is feasible and practical. Patient engagement is also essential to understanding how to make real changes occur in the way patients access care and self-manage their health risks and chronic conditions.
12	Address shortages and access gaps for primary care and specialty services in high-need areas	There are primary care shortages throughout the region, including: (a) inadequate primary care physicians and mid-levels (physician assistants, or PAs, and nurse practitioners, or NPs) working in primary care settings; (b) inadequate primary care locations; and (c) inadequate number of safety net primary care locations. We will work with Area Health Education Center (AHEC) partners to influence primary career choice, while working with health professional schools to place mid-levels and physicians in safety net PCP settings. We will also work to increase the number of dentists that accept Medicaid or increase dental services in more safety net primary care settings. We will work with AHEC partners to recruit specialists, such as psychiatrists, clinical psychologists, and other subspecialists into shortage areas.

***Formulation:**

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

MCC will establish a delegated governance structure which will allow for collective accountability for quality of care and foster shared incentive structures that will reduce fragmentation and reward collaboration. Communication across this network of connected providers will be transparent.

The delegated governance structure has been chosen to allow for influence from an extensive network of providers including meaningful consumer advocate and patient representation to improve population health as the collaborative envelops community-based care as opposed to care provided in the traditional hospital setting. MCC will utilize an interoperable data exchange system to share data which will identify high-risk patients in real time and promote quality care that is provided effectively, efficiently, and in a timely manner.

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***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.

Over time, deep relationships across the care network will be fully developed, leading to the expansion of primary care access, strong participation in payment reform, and the rebalancing and restructuring of health delivery to all patients in the WNY region. A comprehensive population health strategy and reformed payment model will reward for quality of care delivered and not input from volume. Hospitalizations will be reduced to trauma emergencies, surgical emergencies, and tertiary prevention emergencies. The health of the population we serve will improve significantly, and the cost to deliver emergent care will be reduced. Further, focusing resources is likely to improve HCAHPS scores. As the need for inpatient services decreases, acute inpatient facilities will transform into community emergency hospitals providing an array of outpatient services.

***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	Determinations of Public Need (10 NYCRR 760.5)	Project: 2.b.vii: CON waiver expedition in order to establish women's behavioral health unit at Terrace View/ECMC to decrease hospitalizations for this underserved segment of the population 2.b.viii: CON waiver expedition for home care agency (CHHA); application to add new services to operating certificate (ECMC) to serve the entire PPS geography Reason for request: 2.b.vii: We have identified a need for a higher level of SNF based behavioral health for women, mirroring a very successful men's behavioral health unit at Terrace View ECMC. This would cross multiple projects, allowing for most appropriate care for a population that is frequently admitted to the hospital. 2.b.viii: There are very few safety net home care providers, and no CHHA in our PPS. There is great need in the Medicaid and uninsured population for continued skilled services post discharge. Expanding ECMC's operating certificate to include a CHHA would allow us to continue to treat patients through the entire continuum, at a level of accountability and quality that will allow us to meet all of our metrics. Alternatives considered: 2.b.vii: We considered consolidating units on the ECMC campus, as this would be where the admission would likely come from or be transferred to. Terrace View has a typical occupancy greater than 98%, which would not allow us to transfer these beds without offset or displacing another population in need. 2.b.viii: We considered engaging partnering organizations, however their

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		operational models and lack of scope through the eight counties would not allow for them to expand to serve a population without a standard reimbursement schedule that they are accustomed to. We will continue to engage these partners and use their expertise in the development of the new CHHA specializing in the underserved and Medicaid population. Protecting patient safety: 2.b.vii: A current successful model of men's behavioral health would be mirrored to ensure patient safety. Policy, procedures, and staffing models would be duplicated to ensure continued success. Upon establishment of the unit, the PPS Governance will assign an audit to be done on the unit to ensure all safety concerns are met and mitigated. 2.b.viii: This project would work to increase patient safety by increasing the level of care post discharge. We will work with our partnering organizations to develop policies and procedures, expanding on them with the INTERACT principles so that patients received the highest level of care possible.
2	Physician Assistants and Nurse Practitioners in SNFs (18 NYCRR, Section 540.6(4))	Project: 2.b.vii: Implementation of the INTERACT protocol and reducing transfers to the ER/Hospital Reason for request: Waiver or medication of this regulation would encourage facilities to employ physician assistants and nurse practitioners because it would allow them to keep Medicare Part B offset funds that would normally be taken away from the Medicaid rate. PAs/NPs would allow the facilities to support an ever increasing acuity of patients and fully operationalize the INTERACT project. Alternatives considered: Contracting services with PCPs and PAs/NPs, the total hours on site are far less that this waiver would allow. Protecting patient safety: Through implantation of the INTERACT protocol, and utilizing staffing models such as the Coleman and Cambrigdge model, this would increase patient safety and outcomes, better allowing our PPS to reach and exceed its metrics. For cases that exceed the scope of the extender, they would refer to a PCP who would provide oversight to them. Policies and procedures would be developed to encourage safety and reduce hospitalizations *We recognize that this is a Social Services regulation which cannot currently be waived under DSRIP, but we ask that DOH amend the applicable regulations and submit to CMS an amendment to New York's Medicaid State Plan (SPA).
3	Telemedicine/Telehealth (18 NYCRR Section 505.9)	Project: 2.bvii – Implementation of the INTERACT protocol; would allow for practitioners to be reimbursed for communicating via telemedicine with facility staff to avoid hospital transfer via remote consultation 2.bviii – Would allow lower level practitioners and Care transitions specialists to correspond with specialists and PCPs to avoid hospitalizations via remote consultation 3.aii- Would allow psychiatrists to be reimbursed for remote consultation with patient's in the community and in their homes reducing hospital transfers Reason for request: This waiver would allow for specialists to reach a higher volume of patients throughout the day than would normally occur if patients required transportation or the specialist needed to travel between facilities. It would allow for specialists to be reimbursed for this care, lending to system transformation and viability exceeding the five years of DSRIP. Current regulations do not allow telemedicine reimbursement in most circumstances, which impedes the ability of specialists to utilize the efficiency of such a model. Alternatives considered: Current alternatives are higher costs, and do not take into account specialists and physician shortages; these would be transporting patients to specialists or having specialists travel to all facilities to consult. Protecting patient safety: Many partners do currently utilize telemedicine at various levels of sophistication. We would capitalize on the policies and

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		procedures currently in progress and improve and modify where necessary. This intervention would increase patient safety by allowing a higher level of skill to be involved in more patients care, and offer an alternative to ER transfer. *We recognize that this is a Social Services regulation which cannot currently be waived under DSRIP, but we ask that DOH amend the applicable regulations and submit to CMS an amendment to New York's Medicaid State Plan (SPA). We also request DOH, OMH and OASAS to issue regulations supporting the use and reimbursement of telemedicine/telehealth.
4	SNFs and Patient Review Instrument (PRI) (10 NYCRR 400.11 and 10 NYCRR 415.26)	Project: 2biii- Expedite transfer to SNF from ER to divert hospital admissions for patients with higher acuity but do not require acute care 2bvii- Would allow SNFs to receive transfers quicker without waiting for qualified PRI screener, could divert ER to hospital secondary to decreasing wait time for transfer. Also expedite the process for SNFs that border Pennsylvania, where PRI screening regulations vary Reason for request: The PRI requirement as it stands today can prolong admission in the hospital and delay transfer to an SNF. Coordination of appropriate professionals to screen with PRI increases cost and time patients spend in hospital or ER awaiting transfer. Waiving this regulation could allow SNFs to more quickly review a patient and transfer them from the ER or community, reducing hospitalizations. Alternatives considered: There are no current alternatives. Protecting patient safety: Policies and procedures will be developed to ensure that patients are adequately screened for appropriate admission, building off current processes that exist between many SNFs and MCO and HMOs within our PPS.
5	Changes in existing medical facilities (10 NYCRR 401.3 and 10 NYCRR 710)	Projects: The application and approval process for changes to existing facilities may need to be waived for implementation of several projects, including 2.b.vii (INTERACT), 2.b.viii (Hospital-Home Care Collaboration) and 3.a.i (Integration of Primary and Behavioral Services). Reason for request: The PPS will develop detailed requests for regulatory waivers as project plans are developed. Plans will ensure that patient safety is considered and addressed in any scenario where a regulatory waiver is sought.
6	Certificate of Need regarding establishment (10 NYCRR 405.1, 10 NYCRR 600 and 10 NYCRR 710)	Project: 2.b.vii (INTERACT), 2.b.viii. (Hospital-Home Care Collaboration) Reason for request: The activities undertaken for these projects could implicate establishment requirements. As project plans are developed in more detail a specific waiver request will be submitted.
7	Management Contracts and Sharing of Revenue (10 NYCRR 405.3 and 10 NYCRR 600.9)	It is anticipated that certain arrangements entered into by PPS hospitals could be deemed "management contracts" requiring prior DOH approval. As the intended arrangements are developed specific requests for waiver may be submitted.
8	Billing (10 NYCRR 86-4.9(b)	Project: 3.a.i. Reason for request: To support the integration of primary care and behavioral health, providers may require waiver of regulations that restrict them from generating more than one threshold visit bill per day to support the costs of multiple providers of service. While we acknowledge that these regulations may not be eligible for waiver at this time, we wanted to note the issue.
9	Practitioner Home Visits (10 NYCRR 401.1; 10 NYCRR 401.2(b);	Project: 2.b.viii (Hospital-Home Care Collaboration) Reason for request: Under current regulation operating certificate holders, except in limited circumstances, may not provide services off site, including services at patients' homes. Article 28 hospitals and D&T Centers within the PPS request waiver of applicable regulations to permit home visits for outpatient departments of such Article 28 hospitals and D&T Centers. We also note that implementation of this project and other projects involving home visits may require an amendment to 10 NYCRR §§ 86-4.9, 86-8.14 and 401.2 to permit Medicaid reimbursement for such services, and an

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		amendment to New York's Medicaid State Plan (SPA).
10	Restrictions on Part Time Clinics (10 NYCRR 401.1; 10 NYCRR 700.2(a)(22); 10 NYCRR 703.6)	Project: Various Reason for Request: An Article 28 facility providing services off site may only do so in an extension or part time clinic. Part time clinics are limited to low-risk procedures and examinations and may not operate for more than 60 hours per month. The PPS may require flexibility with respect to part time clinics. The scope of the waiver required will become more evident as projects are planned in detailed.
11	Admission, Discharge and Transfer (10 NYCRR Parts 400.9, 400.11 405.9, 415.38 and 700.3; 18 NYCRR 5	Project: Various Reason for request: As project plans are developed, it is anticipated that the referenced regulations may pose impediments to smooth and rapid transition of patients between care levels. More specific requests for regulatory relief will be submitted once project plans are developed
12	Observation Services (10 NYCRR 405.19)	Project: 3.a.ii (Behavioral Health Community Crisis Stabilization) Reason for request: It is anticipated that flexibility will be needed for use of observation services in connection with this project, including the physical space requirements and an expansion of the maximum observation unit stay from 24 to 48 hours.
13	Nursing Home Transfers (10 NYCRR 415.3 and 10 NYCRR 415.4)	Project: 2.b.vii (INTERACT) Reason for request: Regulations that compel nursing homes to transfer patients (in particular behavioral patients) to hospitals to protect the safety of other residents, should be modified or waived to allow for appropriate therapeutic interventions within the nursing home. Protecting patient safety: The safety of other residents will be ensured during the therapeutic intervention process.
14	Home Care Orders by Nurse Practitioners and Physician Assistants (10 NYCRR 763.7)	Project: 2.b.viii (Hospital-Home Care Collaboration) Reason for request: Home care ordering authority should be broadened to allow for workforce flexibility. *We recognize that DOH cannot authorize nurse-driven protocols pursuant to its authority under PHL § 2807(20)(e) and (21)(e), as statutory changes would be needed. However, we encourage DOH to develop a legislative proposal to achieve this.
15	Home Health Aide Supervision (10 NYCRR 766.5)	Project:2.b.viii (Hospital-Home Care Collaboration) Reason for request: Broader range of clinicians should be able to perform home health aide supervision, including utilizing methods other than on-site supervision
16	Relocations: 10 NYCRR 708.3. And 708.4 Facility and service changes and closures: 10 NYCRR 401.3(g)	It is anticipated that project plans may involve bed and service relocations between established providers within the PPS as well as closures of services and facilities. The PPS requests that these relocations and closures be permitted upon notification to DOH. Specific requests for waiver will be submitted as plans are further developed.
17	Construction projects 10 NYCRR Part 600.	Project: 2.a.i (Integrated Delivery System); 2.b.iii (ED Triage); 2.b.vii (INTERACT); 3.a.i (Integration of Primary Care and Behavioral Health); 3.a.ii (Behavioral Health Community Crisis Stabilization) Reason for request: The PPS requests that the level of CON review for construction related to the above projects be limited to architectural review, with an expedited review process and requests that the PPS be permitted to self-certify for architectural and other code compliance to expedite PPS projects.
18	Prohibitions Against Fee-Splitting (10 NYCRR § 600.9).	Project: 2.a.i (Integrated Delivery System) Reason for request: Regulations prohibiting fee splitting or sharing in gross revenues of non-established entities must be waived with respect to the financial components of any agreements dictating the flow of dollars, such as distribution of DSRIP proceeds among PPS providers sharing a patient population.
19	Co-location. 10 NYCRR Part 83 (Shared Health Facilities); Shared Space (Two or More Providers) (10	Project: 3.a.i (Integration of Primary Care and Behavioral Health Services) Reason for request: There are a numerous restrictions on co-location and agency approvals required for co-located services that will need to be

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		waived or modified in order to efficiently implement this project.
20	14 NYCRR Parts 510 & 520 (accessing or correcting OMH record) 14 NYCRR Parts 803 & 804 (accessing	Project: 3.a.i (Integration of Primary Care and Behavioral Health Services); 3.a.ii (Behavioral Health Community Crisis Stabilization) Reason for request: There are various regulations that govern and restrict how health and behavioral information can be shared. To effectively integrate behavioral health and physical health services as contemplated by the above projects, patient information must be able to be shared between providers and record-keeping requirements should be uniform so as not to require duplicate efforts. Alternatives considered: Alternatives would require separate record-keeping based on type of provider and burdensome patient consent/authorization requirements. Patient safety and the privacy of patients' data will be ensured by secure data sharing processes and monitored access control.
21	\ 10 NYCRR §§ 405.9, 400.9, 400.11, 700.3, 415.38 18 NYCRR §§ 505.20 and 540.5 14 NYCRR § 36.4 and 1	Project: 2.a.i (Integrated Delivery System);3.a.i (Integration of Behavioral Health and Primary Care); 3.a.ii (Behavioral Health Community Crisis Stabilization) Reason for request: Currently, various agencies have rules and regulations governing patient transitions. These processes must be waived or streamlined in an integrated environment. The specific waiver needs will become more apparent as project plans are developed.
22	3 (OASAS Providers) 10 NYCRR Parts 94 and 707 10 NYCRR §§ 405.2 a	Project: 2.a.i (Integrated Delivery System) Reason for request: In order to effectively establish an integrated delivery system, the PPS must implement a uniform credentialing process, which will require waiver or modification of the referenced regulations Protecting patient safety: Patient safety will not be impacted because the PPS will ensure that all PPS providers are properly credentialed, the waiver or waivers will only function to permit a centralized credentialing function.
23	14 NYCRR Part 77 (governing physical plant standards for behavioral health facilities)	Project: 3.a.i (Integration of Primary Care and Behavioral Health Services) Reason for request: Integration of behavioral health and primary care under Models A and B may require waiver of some physical standards for behavioral health facilities. Alternatives considered: The alternative would be to construct or renovate integrated facilities to applicable regulatory standards which would be costly and time consuming, and may not be necessary for effective delivery of care, particularly where, for example, only behavioral screenings will be performed in a primary care setting
24	Article 32 Home/Off-Site Visits (14 NYCRR 822 and 14 NYCRR 841)	Project: 2.a.i (Integrated Delivery System); 2.b.viii (Hospital-Home Care Collaboration) Reason for request: The PPS hopes to provide engagement and outreach services in the community because many patients fail to receive the care they need. The PPS would like to offer service to patients under Home and Community Based Services-Adult Mental Health to patients eligible for Health and Recovery Plans (HARP). We understand that no regulatory waiver is available due to federal requirements, but we request that OASAS submits a SPA to move OASAS services to the rehabilitation option of the State Medicaid Plan, which would allow federal participation for off-site services.
25	Article 31 and Article 32 Clinic Reimbursement for Primary Care Services	Project: 2.a.i (Integrated Delivery System); 3.a.i Integration of Primary Care and Behavioral Health Services) Reason for request: Currently, a provider licensed by OMH under MHL Article 31 to provide outpatient mental health services or certified by OASAS under MHL Article 32 to provide outpatient substance use disorder services must obtain PHL Article 28 licensure by DOH if more than 5 percent of total visits are for primary care services or if any visits are for dental services. We request regulatory changes to facilitate integration of primary care and behavioral health services and simplify the licensure process. Furthermore, we request that primary care is allowed to be

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		provided under Title 14 regulations and payment is allowable regardless of the percent of visits for primary care.
26	Limitation on the number of physician assistants a physician may supervise (10 NYCRR 94.2)	Projects: 2.a.i. (IDS) and 3.a.ii. (Behavioral Health Crisis Stabilization) Reason for request: To increase capacity of PCPs within the IDS. Data from the CNA clearly indicates inadequacies of PCPs for both medical and especially behavioral health patients. With PCP shortages locally and nationwide and accompanying increase in demand for practitioners at the gate-keeper levels, increase in mid-level providers to accommodate the shortage is inevitable. Without assistance from adequately trained mid-level practitioners, implementation of the project will yield less than optimum results: patients will be disengaged due to long waiting times to see practices (sometime months), and patients may opt out of the program which will negatively impact the PPS. Follow-up of behavioral health patients from inpatient stays may be impeded due to inadequacy of providers, which may result in readmission within 30 days, thus negatively impacting the project. Alternatives considered: Hiring more PCPs will require a nationwide search. This is more expensive and may require more time. For best results we would do both (hire more PCPs and increase the number of mid-level practices). Protecting patient safety: Raising the limit on mid-level practitioners at primary care sites will not risk patient safety. It is very likely to improve patient outcomes and reduce risk. *We recognize that waiver of this regulation by itself is not sufficient to achieve our goal because NYS Education Law § 6542 also limits the number of physician assistants a physician may supervise. We request that DOH coordinates with the NYS Education Department to amend the existing education statutes pertaining to physician assistant supervision.
27	Allowance of self-referral for sub specialties such as cardiology/primary care (10 NYCRR 34)	Project: 3.b.i. (Population Health Management) Reason for request: Allowance of self-referral for qualified subspecialties (especially cardiology) would increase patient engagement and adherence, which would positively impact the project. Cardiology subspecialists who provide services for the Medicaid population often prefer to provide cardiology rather than primary care services because of referral regulations and payment structure. This waiver would allow cardiologists to offer both primary care and cardiology services, and physicians will be willing to provide more primary care services. This will reduce the chasm of increasing demand and reducing supply vis-à-vis cardiology, which is a high need for all Medicaid population. This will also enable patients to receive service in a one-stop-shop fashion, which is very helpful especially with difficulties in transportation associated with the Medicaid population. We acknowledge that the practice may implicate federal law as well. Alternatives considered: Hiring more cardiologists who are willing to provide services to the Medicaid population is more expensive and may require more time. For best results we would do both (hire more cardiologists and allow self-referrals).
28	Approval of Protocols Article 30, Section 3002-A-2(c)	Project: 2.b.iii. (ED Care Triage) Reason for request: This article states in part: "The State Emergency Medical Services Advisory Council (SEMAC) shall also review protocols developed by regional emergency medical advisory committees (REMACs) for consistency with statewide standards." The proposed DSRIP program will require protocols that exceed the current state standards (i.e., more correctly viewed as the scope of practice for a paramedic); and, the SEMAC's three meetings or fewer a year are insufficient to meet the quickly evolving needs of this program. Further, SEMAC statewide protocols do not take into account the vastly different types of care that would be delivered by our community paramedics. In fact, it could be argued that treatment of patients in the field by mid-level providers and physicians in the call/coordinating center using telemedicine and community paramedics as

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#	Regulatory Relief(RR)	RR Response
		proxies is not EMS at all. Modification of the scope of practice for community paramedics will need to be redefined by the NYS DOH. While we acknowledge that these issues do not directly relate to regulations that are eligible for waiver, we wanted to note the issue. Alternatives considered: DSRIP-related protocols could be made subject to review by the appropriate REMAC only. The REMAC covering the eight counties of WNY meets monthly. The REMAC could report all activates and approvals to the SEMAC and local DOH office.
29	Alternate Site/Transport Methods New York State Basic Life Support (BLS) Protocol	Project: 2.b.iii. (ED Care Triage) Reason for request: DSRIP agencies may utilize alternate transportation methods and transport destinations based on specially created and regionally approved DSRIP protocols. This will require relief from sections of the current BLS protocols, which limit approved transport methods and transport destinations. We believe that these protocols are less than statutory or regulatory, but will still require some type of relief by the governing body (the NYS DOH Bureau of Emergency Medical Services) and wanted to make note of the issue.
30	Alternate Site/Transport Methods New York State (BLS) Protocol Reimbursement for Transportation (18	Project: 2.b.iii. (ED Care Triage) Reason for request: MA currently only reimburses EMS agencies for care of patients who are transported to a receiving facility. Since the ED Care Triage project will involve treatment by community paramedics without transport and/or transport to a non-traditional facility (perhaps by another non-medical transportation entity such as a cab service), reimbursement for this care by MA is not allowable at this time. While we acknowledge that applicable regulations may not be eligible waiver, we wanted to note this issue and request relief to allow for payment by MA for care by community paramedics regardless of transport to an approved receiving facility. In addition, we request that MA recognize and provide reimbursement for the mid-level/physician care provided via telemedicine from the call/coordination center using the community paramedical as the hands/eyes/ears of the clinicians (i.e., care proxies).

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SECTION 2 – GOVERNANCE:

Section 2.0 – Governance:

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

This section is broken into the following subsections:

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

Scoring Process:

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

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

Section 2.1 - Organizational Structure:

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

***Structure 1:**
Outline the organizational structure of the PPS. For example, please indicate whether the PPS has implemented a Collaborative Contracting Model, Delegated Model, Incorporated Model, or any other formal organizational structure that supports a well-integrated and highly-functioning network. Explain the organizational structure selected by the PPS and the reasons why this structure will be critical to the success of the PPS.

The Millennium Collaborative Care (MCC) PPS intends to operate under a hybrid of the Delegated Governance and Collaborative Contracting models. The decision-making and overall governance of the MCC PPS will be delegated to a limited liability company subsidiary (Millennium Collaborative Care, LLC) of the Lead Entity (Erie County Medical Center Corporation, or ECMCC). As a public hospital, the Lead Entity has determined that adopting the Delegated Model will allow for expedited decision-making, contracting, and overall more efficient management of the PPS operations. It will also allow the functions of the PPS to be separate and distinct from the function of the public hospital, which is critical for transparent management and effective implementation. The Lead Entity will retain authority to veto actions or make determinations in the event of a conflict.
Millennium Collaborative Care, LLC (the "MCC LLC") will be governed by a Board of Managers that is representative of the PPS partners, stakeholders, and geographic regions served by the PPS. Through the initial planning and implementation phases, the MCC LLC will be a wholly-owned subsidiary of the Lead Entity. ECMCC and its partners recognize that as the PPS achieves clinical integration, this model

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may progress into a full Delegated Model or other shared risk model where partners have ownership interest in the LLC or a newly-formed entity. The MCC LLC and its Board of Managers will carry out the management of the MCC PPS pursuant to an Operating Agreement that is developed by the Governance Committee and ratified by the Board of Managers.
The MCC PPS organizational structure will also have elements of the Collaborative Contracting Model, in that each performing provider within the PPS will enter into a Master Participation Agreement with the LLC and the Lead Entity. The Master Participation Agreement will set forth the participating providers' performance obligations and, among other things, will describe a transparent process for addressing poor provider performance.
The MCC PPS will also enter into service agreements with clinical providers and non-clinical vendors (physician services, case management, data analytics, etc.) and memoranda of understanding with community organizations. By delegating decision-making and contracting authority to the MCC LLC under the Delegated Model, the decision-making and contracting processes will be more efficient, resulting in more effective implementation of project plans. The MCC LLC will be responsible for management of the MCC PPS and overseeing vendor agreements, reducing some of the management burden on the Lead Entity. The elements of the Delegated Model that have been adopted allow for efficient decision-making by the Board of Managers and broad representation on the Board of Managers and within the governance layers from PPS providers, stakeholders, and community organizations. The process for appointment of the 13 Board of Managers seats (described subsequently) ensures adequate and comprehensive representative governance and transparency.

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: **48_SEC021_Millennium_PPS_2_org-chart.pdf**

Description of File

Millennium PPS Organizational Chart

File Uploaded By: santiag7

File Uploaded On: 12/22/2014 12:21 PM

***Structure 2:**

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

MCC includes several emerging PPSs that combined to form a coalition of partners with ECMCC as Lead Entity. Prior to submission of the Design Grant Application, the Lead Entity joined with two other organizations that had submitted Letters of Intent: an organization representing primary care providers and FQHCs and a major post-acute care provider. The organizations determined it was in the best interests of the community to form a single partner coalition with ECMCC as the Lead Entity. After design grant awards were issued, the Niagara-Orleans emerging PPS also joined MCC. These main coalition partners formed a governance working group in the early planning stages which determined that the governance structure should include councils representing interests of rural PPSs that merged with MCC (Southern Tier Council and Niagara Orleans Healthcare Organization). Physician Steering Committee (PSC) was established to engage community providers and advise the Board of Managers on clinical and quality issues. Community-Based Organization (CBO) Task Force comprised of representatives from CBOs across the region will be established to advise Board of Managers. Project Advisory Committee (PAC), an advisory entity that provides recommendations and feedback on PPS initiatives, participated in development of the DSRIP application and will be engaged in implementation and oversight of the implementation plan. The working group determined that each council and advisory committee should have representation on Board of Managers, along with representation from main categories of stakeholders comprising the continuum of care. This resulted in a 13-member Board of Managers:
1. PPS Lead Entity (CEO, ECMCC)
2. Hospital (president, Buffalo General)
3. Pediatrics/Perinatal (president, Women & Children's Hospital of Buffalo)
4. Behavioral Health/Substance Abuse (elected by PAC)
5. Post-Acute Care (elected by PAC)
6. Primary Care (elected by PAC)
7. Niagara County (appointed by Niagara Orleans Healthcare Organization)
8. Orleans County (appointed by Niagara Orleans Healthcare Organizatio
9. Cattaraugus County (appointed by Southern Tier Council)

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10. PSC Chair
11. Labor (elected by labor groups)
12. PAC
13. CBO (elected by CBO Task Force)
The following Standing Committees will be appointed by the Lead Entity:
a) Finance (oversee distribution of DSRIP funds; monitor financial impact across organizations)
b) Clinical/Quality (standardized care management processes/pathways and clinical metrics to support accountability; common performance metrics for each project; processes for accountability for population outcomes; monitor performance and implements corrective actions with respect to poorly performing providers)
c) IT Data (implement data sharing processes; joint performance management tools/reporting; data sharing/exchange infrastructure; dashboards)
d) Compliance (compliance program; contract review)
e) Governance (committee charters; adequacy of governance structure)
PSC advises Board of Managers with respect to clinical and quality issues and provide clinical direction for achieving goals. Sub-committees: Physician Performance, Network and Trends Outcomes, Clinical Integration, Patient/Stakeholder.
PAC sub-committees: CBO Task Force, "Voice of the Consumer" (populated by Medicaid beneficiaries).
Geographic councils report to Board of Managers with respect to the regions they represent and appoint representatives to Board of Managers: Niagara Orleans Healthcare Organization, Southern Tier Council.
Executive Team responsible for PPS operations and implementing Board of Managers directives of: Executive Director, Chief Medical Officer, Chief Clinical Integration Officer, Population Health Manager, Administrative Director, Chief Reporting Officer, Compliance Officer, and Finance Director.

***Structure 3:**
Specify how the selected structure and processes will ensure adequate clinical governance at the PPS level, including the establishment of quality standards and measurements and clinical care management processes, and the ability to be held accountable for realizing clinical outcomes.

The Clinical/Quality and Finance Committees will be charged with the establishment of quality standards and quality metrics, using NYSDOH metrics identified in the DSRIP Measure Specification and Reporting Manual as a starting point, and adding additional metrics that the Committees deem necessary to achieve quality integrated care.
The Clinical/Quality Committee will be responsible for working closely with the Finance Committee to establish performance incentives and associated metrics. Both committees will, in turn, instruct and work closely with the IT Data Committee with respect to the development of project-specific dashboards which will be populated with internal and external provider measurement data. The Clinical/Quality Committee will report regularly to the Board of Managers on clinical quality outcomes and on how results compare with targeted metrics.

***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.

As MCC works to achieve an IDS, it is anticipated that the governance model will evolve. As integration and payment reform is implemented, the Governance Committee will monitor the governance structure and will make recommendations to the Board of Managers in the event that the governance structure requires modification. MCC may determine down the road that a risk-sharing model is most appropriate after full integration is achieved where key participating providers will have ownership interest in the PPS. NYSDOH will be consulted prior to any change to the governance structure.

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.

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Board of Managers:
PPS Lead (ex-officio): Richard Cleland, CEO, ECMCC
Labor (elected by labor partners): TBD
Hospital (ex-officio): Cheryl Klass, President, Buffalo General Medical Center
Pediatrics/Perinatal (ex-officio): Allegra Jaros, President, Women & Children's Hospital of Buffalo
Behavioral Health/Substance Abuse (elected by PAC): Anne Constantino, President/CEO, Horizon Health
Post-Acute Care (elected by PAC): Jim McGuire, CEO, The McGuire Group
Primary Care (elected by PAC): Joanne Haefner, Executive Director, SNAPCAP
Cattaraugus County (appointed by Southern Tier Council): TBD
MCC PSC Chair (elected by PSC): TBD
PAC Representative (elected by PAC): TBD
Niagara County (appointed by Niagara Orleans Healthcare Organization): Sheila Kee, VP/COO, Niagara Falls Memorial Medical Center
Orleans County (appointed by Niagara Orleans Healthcare Organization): Mark O'Brien, Director of Mental Health and Community Services, Orleans County Department of Mental Health
CBO Representative (elected by CBO Task Force): TBD

***Process 2:**

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

As currently structured, the Board of Managers has 13 seats. The CEO of the Lead Entity holds one seat on an ex officio basis. Recognizing the broad geographic span that the PPS covers, and the fact that emerging PPSs have merged to form MCC PPS, each of Niagara, Orleans, and Cattaraugus Counties have a seat on the Board of Managers, appointed by the Southern Tier Council and Niagara Orleans Healthcare Organization. Because the implementation of project plans will involve and impact organized labor, one of the Board seats is designated for a Labor representative, which will be filled by election of the labor groups within the MCC PPS. To ensure adequate representation on the Board from the continuum of care, Board seats were established for Hospital, Post-Acute Care, Primary Care, Pediatrics, and Behavioral Health/Substance Abuse. The Hospital and Pediatrics seats are populated on an ex-officio basis, with the Presidents of Buffalo General Medical Center and Women and Children's Hospital of Buffalo, respectively, filling these seats. The remaining seats are elected by the PAC. The PAC also has an at-large Board seat representative that is filled by election. The Chairperson of the MCC Physician Steering Committee (an advisory committee to the Board of Managers comprised of physicians in the MCC PPS) also fills a seat on the Board of Managers. The CBO Task Force also designates a representative to the Board of Managers. The Lead Entity (ECMCC) retains the authority to appoint the Chair of the Board of Managers.

***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.

All providers in the region have been invited to participate in the PPS, including the Catholic Medical Partners PPS and Finger Lakes PPS. PAC was the first "governance" body formed, and PAC members were elected by MCC PPS partners at large. PAC is responsible for electing/appointing 4 of 13 Board of Managers seats. In addition, the emerging PPS which merged with MCC PPS and the Southern Tier Council are represented at the Board of Managers and advisory council level. PSC members were elected by the physicians within the PPS; the Chair of that Committee also serves on Board of Managers. MCC providers are therefore represented on Board of Managers, PAC, PSC, and standing Committees of the Board of Managers. Recognizing the importance of community organizations in the success of the PPS, a CBO Task Force will be established and populated with representatives from CBOs across the PPS region. The Task Force will advise the PAC and will have a representative seat on the Board of Managers.

***Process 4:**

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

The Board of Managers includes representation from 10 coalition partners, many of whom were elected by the PAC, which is a representative body of all coalition partners. In addition, the CBO Task Force includes representation. CBOs will be engaged as described above through the CBO Task Force. With respect to contracting with CBOs for services, a competitive RFP process will be implemented, and proposals will be requested in a uniform format. The RFP process will also be utilized for clinical services (e.g., home visits for prenatal care). The MCC LLC as well as the Lead Entity will be parties to the contracts along with the vendor.

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***Process 5:**

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

The MCC PPS will implement the Delegated Governance model, with the Board of Managers directing the overall management, operation, and initiatives of the PPS. The Board of Managers will take action by majority vote. Certain decisions will require a super majority (2/3) vote of the Board of Managers, including the removal of any partner and significant financial decisions. The decisions requiring super majority approval will be described in the Operating Agreement. The Lead Entity will have the authority to veto any action taken by the Board of Managers to the extent that the Lead Entity determines that such action is not in the best interests of the PPS or is not in compliance with the PPS's existing obligations to the State or its partners.
The Finance Committee shall be responsible for all financial and budgeting matters, and will propose an annual operating budget to the Board of Managers for approval. Once approved, the Board of Managers will present the budget to the Lead Entity for ratification. Once ratified, the Executive Director shall have the authority to administer the budget. Changes to the budget exceeding established thresholds will require Board of Managers approval. Changes to the budget exceeding higher established thresholds will require Board of Managers and Lead Entity approval.
The Physician Performance Sub-Committee of the Physician Steering Committee will oversee partner performance and report performance issues to the Clinical/Quality Committee of the Board, which will in turn report to the Board of Managers and make recommendations for corrective action with respect to provider performance.
The IT Data Committee will develop the performance dashboards that will be monitored by the Committees charged with performance oversight.

***Process 6:**

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

Conflicts at the Committee level that cannot be resolved may be raised to the Board of Managers for review and decision. At the Board of Managers level, majority approval is required for all actions taken by the Board of Managers. The Board of Managers has been established with an odd number of seats to avoid deadlock and promote efficient decision-making. If an action receives near majority approval by the Board of Managers, but cannot attain majority approval due to conflict, the Lead Entity has the right to review and approve the action. The Board of Managers, standing Committees, and Advisory Committees have been established to provide a transparent and balanced governance structure for the MCC PPS.

***Process 7:**

Describe how the PPS governing body will ensure a transparent governing process, such as the methodology used by the governing body to transmit the outcomes of meetings.

The MCC PPS governance structure ensures transparent election and appointment of providers representing the care continuum, while ensuring that certain key PPS stakeholders are represented utilizing ex officio seats. The Master Participation Agreement will describe transparent governance processes for monitoring performance, implementing corrective action, and incentivizing achievement of DSRIP goals. Board of Managers will function in accordance with an Operating Agreement available to all participating providers. Operating Agreement will describe how Board of Managers members are elected and removed and roles of Board Committees. Detailed meeting minutes will be recorded at all Board and Committee meetings. Minutes will be taken in a format developed by Governance Committee and attached to the Operating Agreement. Minutes from public meetings will be available on the MCC PPS website. PAC and Board of Managers will each hold annual meetings that will be open to the public.

***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 Board will engage provider stakeholders on key and critical topics through two-way communication with the PAC. The PAC is populated with provider stakeholders and will regularly report to the Board of Managers with respect to project implementation issues and stakeholder concerns. The Board will also engage provider stakeholders through the Physician Steering Committee, which will report to the Board of Managers on a regular basis. MCC has established two Committees to engage community stakeholders, including Medicaid beneficiaries: the CBO Task Force and the "Voice of the Consumer" Sub-Committee. The CBO Task Force will be comprised of representatives from CBOs across the MCC PPS region. A representative from the CBO Task Force will serve on the Board of Managers. The "Voice of the Consumer" Sub-Committee will be comprised of Medicaid beneficiaries. Community forums will be held across the PPS region to invite Medicaid beneficiaries to participate in this Sub-Committee.

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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.

MCC proposed an alternative structure for its PAC reflective of the State's proposed structure for PPSs with fewer than 20 partners and to support representation from collaborative partners and community stakeholders. Members represent the local community and are dedicated, passionate, and committed to embracing the IHI Triple Aim of improving patient experience of care, improving population health, and reducing per capita healthcare cost. Given the number of partners and expanse of the geographic service area, the proposed structure is a leaner overarching PAC with input from Niagara Orleans Healthcare Organization and Southern Tier Council. PAC consists of 26 member organizations representing 10 organizational categories: primary care, behavioral health, post-acute care, Medicaid Health Homes, hospitals, physicians/physician groups, social service organizations, developmental disability organizations, the rural population, and WNY Public Health Alliance. Members include organization representatives, union representatives, and worker representatives. To determine PAC organizations, PPS partners were surveyed, asking for volunteer participants. Respondents indicating a desire to be a PAC member were asked to vote for member organizations. The vote took place over a week's time via email and was completed prior to submission of the Planning Grant application in June 2014. Voting resulted in the following PAC members:
Raul Vazquez, MD, GBUAHN
Ray Ganoe, Evergreen Health Services
Howard Hitzel, Lake Shore Behavioral Health
Michael Weiner, United Way of Buffalo and Erie County
Jody Lomeo, Kaleida Health
Rich Cleland, ECMC
Dennis Robinson, ECMC Worker Representative
Priyanka Desai, ECMC Union Representative
Clare Ganey, ECMC Worker Representative
Frank Azzarelli, People, Inc.
Bridget Bartolone, Person Centered Services of WNY
Anne Constantino, Horizon Health Services
Mike Cummings, MD, ECMC
Christine Pigeon, RN, ECMC Union Representative
Chris Koenig, The McGuire Group
David Smeltzer, Heritage Ministries
Joanne Haefner, Neighborhood Health Center
Bonnie Sloma, ECMC
Sharon Mathe, Healthy Community Alliance
Mike Pease, The Chautauqua Center
John Fudyma, MD, UBMD
Myron Glick, MD, Jericho Road Health Center
Vanessa Barnabei, MD, UBMD
Heather Lehman, MD, UBMD
Gale Burstein, MD, Erie County Health Department
Christine Schuyler, Chautauqua County Department of Health

***Committee 2:**
Outline the role the PAC will serve within the PPS organization.

The PAC serves as an advisory entity within the PPS to provide recommendations and feedback on PPS initiatives. The PAC participated in various facets of developing the DSRIP application and will be engaged in implementation and oversight of the implementation plan. PAC meetings/conference calls serve as a forum to share and review project plans and proposals, as well as discuss ideas that will affect the PPS and its workforce.
In addition, PAC members were enlisted to provide input on project selection based on actual community need as determined by the CNA.

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They will further provide oversight of the PPS to assure person-centered policies, performing provider network effectiveness, and delivery integration across the continuum in the implementation of DSRIP projects

***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 PAC oversaw and provided input in the development of the CNA, in coordination with an external consultant, and the PPS's collaborative partners. This included support and development of an approach to ensure participation by community stakeholders, including a community health needs survey (7,000 completed surveys), focus groups to obtain the voice of the customer (16 completed), and key informant provider interviews (45 completed). The PAC members understand that healthcare is local, and are committed to facilitating input and feedback on healthcare needs and priorities on a local basis.
The PAC members were involved in the development of the PPS organization structure as it relates to obtaining ongoing community input and keeping the PPS informed regarding the needs of the community. The PAC members suggested that the PPS develop a CBO Task Force to obtain input from the local community, and a "Voice of the Consumer" Sub-Committee to obtain direct input from Medicaid recipients.

***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.

Given the number of partners and expanse of the geographic service area, the proposed structure is an overarching PAC with input from Niagara Orleans Healthcare Organization (formerly an emerging PPS representing Orleans and Niagara counties), and Southern Tier Council (Allegany, Cattaraugus, Chautauqua Counties). The overarching PAC consists of 26 member organizations from primary care, behavioral health/substance abuse, post-acute care, Medicaid Health Homes, hospitals, physicians, developmental disability organizations, rural communities, and public health. Members include organization representatives, union representatives, and worker representatives. Members represent their organizational category, not their individual organization. A CBO Task Force will be established to advise the Board of Managers and PAC. CBO Task Force and PAC have representation on Board of Managers, along with representation from main categories of stakeholders comprising the continuum of care.

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.

Upon review and recommendation from General Counsel and the PAC, a Compliance Officer will be hired and will be an employee of MCC. The Compliance Officer will have no ties to any MCC partners, but will bring considerable insight within NYS through his/her previous experience. The Compliance Officer will begin his/her new role with MCC in early 2015. The Compliance Officer will report directly to the Board of Managers (see organizational chart in section 2.1). A member of the Board of Managers will chair the Compliance Committee, which will be a standing committee consisting of the Compliance Officer and Executive Team to review the Compliance Officer's audit workplan, identify compliance risk areas, and discuss any compliance concerns.

***Compliance 2:**

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

Compliance problems will be identified/addressed by this mechanism:
Compliance Committee and Compliance Officer will agree on DSRIP, State, and Federal rules and regulations included in this oversight role. Compliance Officer will develop annual audit workplan to be approved by Compliance Committee.
All agreements, contracts, policies, and procedures require review by Compliance Committee prior to execution.
Compliance Officer will attend Executive Team and MCC management meetings.

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Compliance Officer will review complaints and/or concerns received and report contents and actions taken to Compliance Committee on a monthly basis.
Compliance Officer will provide guidance to employees, community members, beneficiaries, and others to assist in identifying potential compliance questions and concerns.
A compliance hotline will be established for employees, community members, beneficiaries, and others to communicate concerns to Compliance Officer/Committee. Potential compliance problems will be promptly investigated and resolved; potential concerns will be reported to Chair of Compliance Committee. Compliance Officer will have autonomy to escalate compliance concerns to Board of Managers.

***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.

As a part of completing the MCC compliance plan, Compliance Officer is responsible for developing compliance education, training, and audit procedures and schedules which will be rolled out between April 1 and July 1, 2015, after Compliance Officer completes the inventory of partners' existing compliance training programs. Compliance Officer will have the option of adopting an existing program or designing new programs tailored to DSRIP. Compliance education/training is expected to provide information on the definition of compliance, expectations, operations of the compliance program, and how compliance irregularities can be reported. Compliance Officer will be responsible for enforcing and monitoring compliance, privacy and security policies, and procedures established as part of the compliance plan and HIPAA privacy provisions. In addition, Compliance Officer and/or designee will be responsible for oversight of a Change Review Board (CRB) composed of clinical, management, and technical staff from the PPS members. CRB will be responsible for reviewing, approving, and communicating changes to all supporting systems, as well as monitoring tools, policies, and procedures.

***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.

Compliance Officer will effectively communicate compliance standards, policies, and procedures to all community members, Board of Managers, and staff by requiring participation in training programs and disseminating information. Compliance Officer will develop publications, training, posters, websites, and other texts to inform community members and all others affiliated with MCC regarding compliance policies and expectations.
Compliance Officer will develop and implement a confidential hotline number, email blasts, webinars, and a compliance web page. The compliance hotline and process on how to file a complaint will be readily available to all community members, Medicaid beneficiaries, and uninsured community members to ensure all are aware of the process. The web page will contain education and information for community members, Board of Managers, and staff to reference. There will also be a question and answer section to further explain the process and how to file a compliance complaint.
Compliance training will be required annually for all Board of Managers and staff. The emphasis on compliance and education is designed to cultivate a culture of compliance within MCC.

Section 2.5 - PPS Financial Organizational Structure:

Description:

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

***Organization 1:**

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

During DY1, Finance Committee of the Board of Managers will develop policies and procedures to monitor financial and other key performance indicators (KPIs) of the PPS's participating providers during the implementation phase and thereafter. Providers will be required to report on financial performance to the Finance Committee. The rapid cycle evaluation plan will support the monitoring of KPIs and shifts in volumes and net revenues to ensure that participating providers remain financially viable. "Red flags" (alerts tied to KPI thresholds) will be reported to the Board of Managers, and the Finance Committee will work with the provider to develop a plan for stabilization. Certain milestones and quality measures will be tied to financial incentives as described in Section 2.6.

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***Organization 2:**

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

The Finance Committee of the Board of Managers will monitor provider performance and financials and the flow of PPS funds. The Finance Committee is also responsible for preparation of annual operating and capital budgets. Provided that an applicable certificate of public advantage is issued, the Finance Committee will work with area health plans on behalf of the PPS with respect to pay-for-performance arrangements and bundled payments.

***Organization 3:**

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

The Finance Committee and Finance Leadership plans to use internal auditors to monitor providers' financial performance and achievement of project goals. External auditors will review financial reports issued by the MCC PPS.

***Organization 4:**

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

Compliance Committee, in conjunction with Finance Committee, will develop a compliance program in accordance with NYS Social Security Services Law Section 363-d. The compliance program will include written policies and procedures that describe MCC compliance expectations. Compliance Officer will be responsible for day-to-day operation of the compliance program, training, and education of all providers in the PPS, and a system for routine identification of compliance risk areas including internal/external audits as appropriate.
The compliance program will encourage reporting of potential compliance issues to Compliance Officer. The PPS will make it as easy as possible for people to report potential compliance issues by providing multiple contact options (confidential hotline number, email, "open door" policies, and the PPS website). The PPS will also require formal compliance training of all Board of Managers and leadership staff as deemed necessary by the Compliance Officer and offer all participants access to compliance training when appropriate. This ease of access and emphasis on education is designed to cultivate a culture of compliance within MCC.

Section 2.6 – Oversight:

Description:

Please describe the oversight process the PPS will establish and include in the response the following:

***Oversight 1:**

Describe the process in which the PPS will monitor performance.

A work group comprised of members of the Physician Performance Sub-Committee, IT Data Committee, Clinical/Quality Committee, and Finance Committee, with input from Governance Committee and Chief Reporting Officer, will develop a performance measurement program, including incentive payment provisions. The work group will direct IT Data Committee in implementation of project-specific performance dashboards. IT Data Committee will implement and support data reporting systems and processes for auditing data integrity. Reporting dashboards will be populated with internal and external data, including measures identified in the DSRIP Measure Specification and Reporting Manual. The work group will develop additional measures and milestones to measure project implementation, quality, and integration. The work group will also identify milestones and measures that will be tied to financial incentives. After approval by Finance Committee, Clinical/Quality Committee, and Board of Managers, the program will be memorialized in the Master Participation Agreement. Measures and incentives will be reviewed and updated on an ongoing basis to foster continuous improvement.

***Oversight 2:**

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

Performance will primarily be measured on an individual provider basis; however, partner organizations will be accountable for the performance of their employee providers. The Physician Performance Sub-Committee of the Physician Steering Committee will continuously monitor performance measures and will escalate performance issues to the Clinical/Quality Committee of the Board of Managers if performance does not improve after an initial warning and intervention. The Master Participation Agreement will set forth the process through which the PPS governing body will address poorly performing providers (described in following section).
In addition to performance measurement, the program will include an incentive payment structure which will provide incentives for partners who achieve certain milestones and quality measures. Providers who do not meet incentive metrics will not be eligible for incentive bonuses.

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The Master Participation Agreement will also describe the obligations of the participating partners with respect to timely reporting of data to the PPS.

***Oversight 3:**

Describe the process for sanctioning or removing a poor performing member of the PPS network who fails to sufficiently remedy their poor performance. Please ensure the methodology proposed for member removal is consistent and compliant with the standard terms and conditions of the waiver.

A work group comprised of representatives from the Governance, Compliance, Clinical/Quality, and Finance Committees of the Board of Managers will develop a detailed progressive action program for poorly performing providers:
Review of performance by the PSC Physician Performance Sub-Committee
Initial warning, intervention, and education of the provider (or provider's employer, if applicable) by Physician Performance Sub-Committee with recommendations for improved performance
If provider has not demonstrated satisfactory improvement in the timeframe allotted, the Physician Performance Sub-Committee may make a recommendation to the Clinical/Quality Committee for progressive disciplinary action
Formal notification of performance issues will be provided to provider or provider's employer (partner) along with a deadline for submitting a detailed corrective action plan
Opportunity to be heard before the Clinical/Quality Committee or a sub-committee thereof
Provider will be required to develop a corrective action plan which will be modified as necessary and approved by Clinical/Quality Committee
Continuous monitoring of provider's compliance with corrective action plan during probationary period by Physician Performance Sub-Committee, which will report back to Clinical/Quality Committee
Potential withhold of performance incentives (as applicable and approved by Finance and Clinical/Quality Committees)
Master Participation Agreement will provide for a limited number of corrective action plans that may be implemented with respect to one provider/partner within a calendar year. Providers/partners demonstrating repeated failure to comply with Master Participation Agreement will be brought before Physician Performance Sub-Committee for a full hearing. The hearing process may result in the Physician Performance Sub-Committee recommending to the Clinical/Quality Committee that the provider/partner be removed from the PPS. Removal will be treated as a last resort, only considered after all administrative steps of intervention, education, and corrective action have been exhausted without improvement. Any recommendation for removal must be approved by the Board of Managers and Lead Entity after consultation with NYSDOH.

***Oversight 4:**

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

The CBO Task Force and "Voice of the Consumer" Sub-Committee will be integral in facilitating communication between the leadership of the MCC PPS and the community stakeholders. The Governance and Clinical/Quality Committees, with recommendations from the CBO Task Force and "Voice of the Consumer" Sub-Committee via the PAC, will establish a process through which Medicaid beneficiaries and their advocates can register complaints, comments, and other feedback with the MCC PPS. A designated Ombudsman will serve as a liaison between the MCC PPS and the Medicaid beneficiaries and presides over community forums and participating in CBO Task Force and "Voice of the Consumer" Sub-Committee meetings to receive feedback from the Medicaid beneficiary community. The MCC PPS intends to have a process in place which will allow Medicaid beneficiaries multiple forums through which feedback can be provided, including a form on the website, email contact, and phone hotline. The Ombudsman will be responsible for responding to each inquiry that requires response within a certain timeframe to be established.

***Oversight 5:**

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

The removal of a provider will be a last resort after a full hearing and multiple attempts at education and corrective action have been made in a single year without improvement. In the event that a provider is removed for reasons associated with suspension or revocation of licensure, the provider will be removed immediately to protect the health and safety of the patients served by the PPS. In the event that removal is for performance reasons, reasonable notice will be provided to patients in accordance with applicable law. In either scenario, a plan will be developed by the Clinical/Quality Committee and Physician Steering Committee for coordinating the care of the provider's patients. Patients will be provided with adequate notice of the provider's removal and a list of comparable providers within the PPS in the

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event that the patient elects to remain in the PPS.

Section 2.7 - Domain 1 – Governance Milestones:

Description:

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

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

☑ Please Check here to acknowledge the milestones information above

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SECTION 3 – COMMUNITY NEEDS ASSESSMENT:

Section 3.0 – Community Needs Assessment:

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

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

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

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

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

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

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

This section is broken into the following subsections:

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

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

Scoring Process:

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

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

Section 3.1 – Overview on the Completion of the CNA:

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

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

The WNY CNA was jointly conducted and led by two PPSs: Catholic Medical Partners (CMP)/Catholic Health System and Millennium Collaborative Care (MCC), comprised of Erie County Medical Center Corporation (ECMCC), Kaleida Health, Niagara Falls Memorial Medical Center (NFMMC), the McGuire Group, and SNAPCAP. This collaboration led to the collective identification of the region's most overarching needs and resulted in six projects being jointly selected. These joint projects cover the most critical and challenging system-wide and community health gaps.

The WNY CNA was compiled in three separate volumes: Volume One: CNA Summary; Volume Two: CNA Details; and Volume Three: CNA Resource Inventory.

The detailed volumes (two and three) were compiled by the University at Buffalo Regional Institute, working closely with HMS Associates, the P2 Collaborative of Western New York, and FTI Consulting Center for Healthcare Economics and Policy. The CNA Summary Report (volume one, compiled from volumes two and three, with additional sources as needed) was orchestrated by the University at Buffalo Primary Care Research Institute with extensive assistance from analytic content experts from CMP, NFMMC, ECMC, FTI Consulting Center for Healthcare Economics and Policy, Greater Buffalo United Ministries, and Computer Task Group.

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

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

The following quantitative data sources were used to conduct this CNA:
(a) DSRIP Performance Data Dashboard (for Medicaid domain 2 and 3 metrics; zip and county level)
(b) NYS Prevention Agenda Data Dashboard (for population domain 4 metrics, county level)
(c) SPARCS data (for additional needs assessments not covered by domain 2, 3, or 4, zip and county level)
(d) CDC mortality data (for cause of death needs assessment, county level)
(e) US Census, American Community Survey (for demographic profiles and assessment, zip, county, and tract level)
(f) Statewide Perinatal Data System, WNY dataset (zip and county level)
(g) NYS Extended BRFFS Survey (for chronic disease prevalence estimates, county level)

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(h) Additional sources (for provider and resource inventories: DSRIP dashboard, NPI database, D&B, 211 Information Referral, and other miscellaneous sources)

In addition to the extensive quantitative data sources listed above, three community engagement approaches were used to gather extensive qualitative data that provided dimension and human context to the numbers, providing us with the means to explain some of the dynamics at play in our healthcare system today:
(a) Community health needs survey: Completed by more than 7,000 community members
(b) Focus groups: 16 "community conversations" engaging people served by the system to better understand those patient perspectives
(c) Key informant provider interviews: A series of 42 interviews with providers from every part of the region and every phase of the healthcare system, from primary care to mental health and behavioral care to emergency department (ED) settings

Section 3.2 – Healthcare Provider Infrastructure:

Description:
Each PPS should do a complete assessment of the health care resources that are available within its service area, whether they are part of the PPS or not. For each of these providers, there should be an assessment of capacity, service area, Medicaid status, as well as any particular areas of expertise.

***Infrastructure 1:**
Please describe at an aggregate level existing healthcare infrastructure and environment, including the number and types of healthcare providers available to the PPS to serve the needs of the community. Please provide a count both of the resources in the community in general, as well as resources that are part of the PPS Network. Use the table below. Add rows for additional Provider Types.

#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
1	Hospitals	22	10
2	Ambulatory surgical centers	11	5
3	Urgent care centers	20	20
4	Health Homes	6	6
5	Federally qualified health centers	4	3
6	Primary care providers including private, clinics, hospital based including residency programs	1416	789
7	Specialty medical providers including private, clinics, hospital based including residency programs	5210	3126
8	Dental providers including public and private	812	15
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	136	136
10	Behavioral health resources (including future 1915i providers)	521	521
11	Specialty medical programs such as eating disorders program, autism spectrum early	46	46
12	diagnosis/early intervention	16	16
13	Skilled nursing homes, assisted living facilities	74	41
14	Home care services	48	48
15	Laboratory and radiology services including home care and community access	1841	1104
16	Specialty developmental disability services	135	135
17	Specialty services providers such as vision care and DME	161	161
18	Pharmacies	323	168
19	Local Health Departments	8	8
20	Managed care organizations	4	4
21	Foster Children Agencies	16	16
22	Area Health Education Centers (AHECs)	3	3

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

***Infrastructure 2:**

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

Resolving excess bed capacity: There are currently 22 hospitals providing acute care services across WNY, 10 of which are in MCC. The inpatient occupancy rate varies from 69% in the Central region to 47% in the South region. Rural hospitals have greater challenges with occupancy and minimum staffing requirements. In the region there are on average 1,240 beds not in use, of which 511 unused beds are in MCC. There are 74 nursing home facilities, of which 41 are in MCC. Projected estimates of WNY public need for SNF beds indicate an excess of 499 beds. Deactivation of unused beds would not have large workforce implications if these unused beds are currently largely unstaffed. Reuse of these facilities will be explored using redeployed staff. We will work collaboratively to decertify unused, unstaffed beds in hospitals and SNFs, while seeking beneficial ways of repurposing the unused space for non-inpatient services by the facility.
Addressing primary care shortages: There are primary care shortages throughout the region, including: (a) inadequate PCPs and mid-levels (PA, NP) working in primary care settings; (b) inadequate primary care locations; and (c) inadequate number of safety net primary care locations. We will work with AHEC partners to influence primary career choice, while working with health professional schools to place mid-levels and physicians in safety net PCP settings.
Enhancing primary care PCMH status: Only 21% (110) out of the 512 primary care locations in the region are currently NCQA-recognized as PCMH facilities. In MCC, 36% (85) out of 235 MCC primary care locations are currently NCQA-recognized. Various types of practice facilitators will be deployed to aggressively reach Level 3 PCMH. Evidence-based approaches such as the TRANSLATE model will be used to drive the PCMH recognition process. We will use PCMH to expand pre-visit planning workflows to address access, transportation, and community linkage problems in underserved areas.
System change for provider integration: We will explore mechanisms for meaningful IT system integration by overcoming structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training, etc.) and improving coordination among partners through mandated use of EMRs and the RHIO. We will enhance interoperability by:
(a) care coordination for high-risk patients in transition;
(b) emergency care changes to prevent improper use;
(c) hospital care change to prevent readmissions; (d) integrated referral to subspecialists; (e) medication safety enhancements; and (f) interoperability with behavioral health and community support providers. We will train key personnel across the system to participate in the new model. Standard training protocols will be developed for new roles. When possible, excess staff from reductions will be redirected to fill new positions.
Addressing specialty gaps: We will work to increase the number of dentists who accept Medicaid or increase dental services in more safety net primary care settings. We will work with AHEC partners to recruit specialists, such as psychiatrists, clinical psychologists, and other subspecialists into shortage areas.

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	370	370
2	Food banks, community gardens, farmer's markets	437	437
3	Clothing, furniture banks	199	199
4	Specialty educational programs for special needs children (children with intellectual or developmental	17	17

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#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
	disabilities or behavioral challenges)		
5	Community outreach agencies	120	120
6	Transportation services	91	91
7	Religious service organizations	21	21
8	Not for profit health and welfare agencies	120	120
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	172	172
10	Peer and Family Mental Health Advocacy Organizations	23	23
11	Self-advocacy and family support organizations and programs for individuals with disabilities	115	115
12	Youth development programs	121	121
13	Libraries with open access computers	27	27
14	Community service organizations	73	73
15	Education	487	487
16	Local public health programs	150	150
17	Local governmental social service programs	184	184
18	Community based health education programs including for health professions/students	20	20
19	Family Support and training	1212	1212
20	NAMI	1	1
21	Individual Employment Support Services	317	317
22	Peer Supports (Recovery Coaches)	41	41
23	Alternatives to Incarceration	16	16
24	Ryan White Programs	32	32
25	HIV Prevention/Outreach and Social Service Programs	43	43

***Resources 2:**

Outline how the composition of community resources needs to be modified to meet the needs of the community. Be sure to address any Community Resource types with an aggregate count of zero.

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

There are 184 local government agencies, such as food stamp programs and Medicaid offices, located throughout WNY. There are 317 employment support services, such as job centers, located predominantly in counties with urban areas. There are 121 youth development programs, including those designed to keep at-risk youths away from gun violence and substance abuse. There are 487 education programs, including schools, colleges, and CBOs providing educational services. Some of these organizations focus on special populations such as children with emotional disturbances, at-risk youth, immigrants, and refugees. There are approximately 16 programs offering alternatives to incarceration services located in Erie and Niagara Counties. There is not necessarily a gap in these community resources; rather, the problem is that they are not deployed in ways that the safety net health system can utilize optimally. Each PPS will strive to improve the use of these community resources by deploying patient navigators/community health workers and retooling care management functions in primary care, hospital discharge, and ED settings.

A significant asset tying these resources together is an online 211 information referral system that is well developed. Many medical providers are not aware of these resources and are not geared to assess patients for social determinants of health and to actively assist them in accessing these resources. Connecting chronic disease patients to community support resources is one of the most neglected components of the Chronic Care Model for improving and sustaining patient self-management skills. MCC will integrate community

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support resources into the continuum of care by applying the 2014 PCMH standards in a way that addresses those gaps.
There are 42 organizations involved with crisis intervention services. Protocols are lacking to not only deescalate behavioral health crisis situations, but to activate and connect beneficiaries with the healthcare system. Most crisis services are local, with limited coordination across the region, and there is virtually no interoperability with the RHIO. Strategies like forming a regional crisis intervention alliance as a collaborative learning group to implement best practices will help connect this function to all PPSs.
There are 91 transportation service programs. However, transportation is still a pervasive problem that contributes to no- shows to primary care appointments. This will be addressed in the PCMH setting by making transportation arrangements a vital component of the pre-visit planning workflow.

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

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

African-Americans are heavily concentrated in the cities of Buffalo and Niagara Falls and constitute as much as 90% of the population in several zip codes in each city. African-Americans also live in other locations around the metropolitan area (two to three times the 10% WNY rate), such as Cheektowaga.
Latinos/Hispanics follow a somewhat less concentrated, with higher concentrations (two to three times the 4% WNY rate) on Buffalo's West Side, Lackawanna, and Niagara Falls, but also in Dunkirk, Jamestown, and Orleans County.
Non-English speakers are concentrated (three to five times the 3% WNY rate) in various locations of the region. Many live in Buffalo, especially on the West Side, where over 40 languages are spoken by non-English speakers, many of whom are refugees.

***Demographics 3:**
Income levels:

The median household income in WNY is $49,304, 15% below the NYS median of $58,003. Erie County is 13% below the State median; however the City of Buffalo is 47% below NYS median. Niagara County is 17% below the State median; however the City of Niagara Falls is 44% below NYS median. Most rural counties are 27% below the State median, and some small cities in rural areas are 46% below the state median.

***Demographics 4:**
Poverty levels:

Poverty status is perhaps the most important indicator of healthcare need. In the region, 15% of the population lives below federal poverty level compared to 10% for the State. People at 200% of the Federal poverty level are overwhelmingly concentrated (two to four times the 15% WNY rate) in the cities of Buffalo and Niagara Falls, and widely across the Southern Tier counties of Chautauqua, Cattaraugus, and Allegany in both small cities and rural areas. These areas also have excessively high rates (50% above the 21% WNY rate) for children under 18 living in poverty.
In June 2014, the U.S. Census Bureau ranked the City of Buffalo as the fourth poorest city in the nation, where nearly 27% of the population (two times WNY) lives in poverty and nearly two-thirds (four times WNY) under 200% of the federal poverty level. Literacy and health literacy are also low in areas of high poverty.

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***Demographics 5:**

Disability levels:

In WNY the population with disabilities is 103,347 or 11% of the total, almost double the State percentage. The disability percentage is high in every county and ranges from a low of 9% in Genesee County to a high of 14% in Orleans County.

***Demographics 6:**

Education levels:

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

***Demographics 7:**

Employment levels:

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

***Demographics 8:**

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

Institutionalized population: The region as a whole has 25,155 people living in institutional settings that are not correctional or SNF. Most of the institutionalized population is in Erie County where a large psychiatric center is located.
Correctional facilities: Region-wide there are 13,592 adults in jails, mostly in Erie, Wyoming, Orleans, and Chautauqua Counties where prisons are located. There are juvenile facilities housing 552 people, mostly in Erie County.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description

No records found.

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 top cause of death is CVD or heart related for the region, for every county and the State. The top five specified causes of death in every county are all smoking-related (heart followed by lung). The top five leading causes of death for African-Americans are also CVD and smoking-related. The top five leading causes of premature death in the region, in every county, and the state are lung cancer, CVD/heart, or smoking-related. The African-American top cause of premature death are lung (smoking related), followed by violet crime, then CVD/heart related. Other than violent crime, the African-American top cause of premature death is smoking related.

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

As with the leading cause of death, in every county the leading causes of hospitalization was CVD/heart-related. What is different from the leading cause of death rankings, is that mental illness and complication of pregnancy dominate leading causes of hospitalization (in top 4). WNY is similar to the State. African-Americans (WNY and NYS) have a similar profile for leading causes of hospitalization: CVD related

was top cause, complication of pregnancy was second top cause, and mental disorders number 3.

***Challenges 3:**

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

The rates of many ambulatory care sensitive conditions (ACS) in WNY region are below State rates. Where the region differs is for CVD-related conditions such as heart failure (389.0/100,000) vs 272.0) and angina without-procedure (24.0/100,000 vs 20.0). Niagara County seems to have the biggest problem with ACS conditions.

***Challenges 4:**

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

Compared to the State, the region and all counties have higher prevalence for CVD-related diseases: high blood pressure (32.7% vs 26.8%), cardiovascular (9.1% vs 7.7%, and coronary heart (7.6% vs 6.3). Some counties have higher prevalence than the State for diabetes. The region was equal or slightly below the State prevalence for asthma (14.9% vs 15.0%). As is the case for many other indicators, Niagara County is above the State prevalence for all these conditions. These estimates were compiled from the NYSDOH Expanded BRFFS Report 2009.

***Challenges 5:**

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

The % of preterm birth is 12.1%, above NYS Prevention Agenda goal of 10.2%. This is the case in Erie and Niagara Counties and in the South region (as high as 15%). The minority disparity between non-minority rates is slightly above State targets. The Medicaid percentages versus non-Medicaid are 26% higher, especially in the Central region as well as Niagara County. The maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000. The rate in Erie and Cattaraugus Counties are very high (34 and 35.7, respectively). The 69.5% of children who have had the recommended number of well child visits in government-sponsored insurance programs is below the State goal of 76.9%. This is more of a problem in the rural counties (rates as low as 55.7%). The 87% of children aged 0-15 months who have had the recommended number of well child visits in government-sponsored insurance programs is below the State goal of 91.3%. Chautauqua (92.7%) is the only county above the State goal. High-risk pregnancies occur for Medicaid mothers 10.9% of the time. The five-year goal is to reduce it to 9.8% (10% reduction). High-risk pregnancies are highest in Erie County (12.7%).

***Challenges 6:**

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

The WNY region has a major problem with obesity in the general population. The % of adults who are obese is 30.2% compared to the NYS Prevention Agenda goal of 23.2%. Every county has a serious problem. The % of children and adolescents who are obese at the county level is closer to the NYS Prevention Agenda goal of 16.7%. Erie and Allegany Counties are near or below the state goal. The other six counties are above the State goal, with rates as high as 20%. The % of cigarette smoking among adults is 20.8% compared to the NYS Prevention Agenda goal of 15%. Five of the rural counties seems to have more smoking problems (Genesee, Orleans, Allegany, Cattaraugus, and Chautauqua Counties) with rates as high as 28.4%. The age-adjusted % of adult binge drinking in the general population is 18.9%, slightly higher than the NYS Prevention Agenda goal of 18.4%.

***Challenges 7:**

Any other challenges:

Low primary care utilization: WNY has a 28% lower PCP visit rate and a lower proportion of beneficiaries (60%) with a PCP visit compared to NY State (64%). Problem with depression: WNY's admission rate for depression is high (45.5/beneficiary with depression), exceeding the NYS rate (40.6). Transportation is a problem: The region ranks last (12%) among upstate regions for households without access to a vehicle. Households without access to a vehicle provides a crucial indicator of the ability of people to obtain access to healthcare services. Where a vehicle is unavailable, and given the poor state of public transit across the region, getting to appointments and filling prescriptions are onerous, sometimes impossible, tasks. As with many other indicators, concentrations of households with no vehicle are in the cities of Buffalo and Niagara Falls and along the Southern Tier.

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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**.

Excess bed capacity: The region has a total of 3,455 licensed hospital (non SNF) beds, of which 1,766 are in MCC. MCC has an aggregate occupancy rate of 71% (actual bed days/bed days available) that translates into 511 beds not in use. The reality is that not all used beds are staffed units, except for small rural hospitals with few beds and minimum staffing requirements. The NYSDOH projected (2016) that there are 499 excess beds for residential healthcare facilities in WNY.
Gaps in interoperability: Enhanced communication and care management data sharing between primary care and specialists, mental health, Health Homes, and community support agencies does not exist and the interoperability with hospitals and pharmacies needs to be enhanced.
Primary care shortages: Large portions of the inner city and rural areas of the region are designated as population Health Professional Shortage Areas (HPSAs). The City of Buffalo has a high need designation. The ratio of Medicaid population to safety net physicians is excessively high (over 4,500:1) in some counties.
Primary care PCMH status: Only 21% (110) out of 512 primary care locations in the region are currently NCQA recognized as PCMH facilities. In MCC 36% (85) out of 235 primary care locations are currently NCQA recognized as PCMH facilities.
Primary care mid-level workforce in PCP settings: Only 22% (306) of the PCPs in the region are mid-level providers (PA or NP). Most mid-level providers are currently working in specialty or hospital settings.
Care management personnel in PCP safety net settings: In certain settings, there are inadequate primary care personnel devoted exclusively to the care management and integration of patients with behavioral health services.
Behavioral health/primary care integration: With a few exceptions, there is little meaningful integration of behavioral health with primary care due in large part to the structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training, etc.). Behavioral health conditions have a profound effect of the medical management of chronic complex disease.
Workforce implications to achieve behavioral health/primary care integration: The six emerging health home agencies have just started and have limited presence in some areas. In addition, there is a need to create new functionality in the primary care safety net setting dedicated to this integration. Additional licensed mental health counselors (not presently credentialed by health plans) and licensed social workers may be needed. In behavioral health settings serving seriously mentally ill, it may be more effective to embed PCPs in these targeted locations.
Shortage of psychiatrists and psychologists: There is a severe shortage of psychiatrists and psychologists compared to NYS. On average, NYS has almost twice as many psychiatrists and psychologists per beneficiary compared to WNY. Orleans County has no psychiatrists, and most other small rural counties have no pediatric psychiatrists.

***Gaps 2:**
Include data supporting the causes for the identified gaps, such as the availability, accessibility, affordability, acceptability and quality of health services and what issues may influence utilization of services, such as hours of operation and transportation, which are contributing to the identified needs of the community.

Availability: There is significant fragmentation in service locations for primary care and behavioral health clinicians, as evidenced by large areas designated as HPSAs and by geographic gap analysis. Of all urban and rural areas, 100% are above the region's poverty rate (15%) are designated shortage areas. WNY has a 28% lower PCP visit rate and a lower proportion of beneficiaries (60%) with a PCP visit compared to NYS (64%).
Accessibility: In the "community conversation" focus groups, a key finding was that delays in care are barriers to patient engagement in the primary care system. This includes how far in the future an appointment may be, as well as how long the patient waits to be seen.
Affordability: In "community conversation" focus groups, a key finding was that out-of-pocket costs are a significant barrier to healthcare for lower-income consumers.
Quality: In the community health needs survey, when asked to select from a list of suggested improvements to the primary care delivery system, two of the most common answers were "better follow-up care," and "more responsive staff." In the focus groups, a key finding was that communication is a problem for Medicaid patients who may not fully understand a doctor's instructions or explanations, either because the doctor speaks too technically, because the patient speaks another language, or because the doctor "talks down" to the

patient. More generally, provider sensitivity to cultural differences is seen as a need. Many focus group participants also felt that the quality of care provided to Medicaid enrollees is perceived by some as inferior in quality to the care that people receive when they are otherwise insured.
Hours of operation: In the health needs survey, when asked to select from a list of suggested improvements to the primary care delivery system, the most common answer was "shorter time to schedule appointments," followed by "longer hours of operation."
Transportation: In the focus groups, a key finding was that transportation is a pervasive problem. Many low-income households lack access to a vehicle, public transit services in the region are weak or nonexistent, and use of Medicaid-funded services requires significant advance notice. An analysis of proximity to providers indicates that many patients, Medicaid and non-Medicaid, have trouble accessing the health system due to a number of issues.

***Gaps 3:**

Identify the strategy and plan to sufficiently address the identified gaps in order to meet the needs of the community. For example, please identify the approach to developing new or expanding current resources or alternatively to repurposing existing resources (e.g. bed reduction) to meet the needs of the community.

(1) Resolve excess capacity: We will work collaboratively to decertify unused, unstaffed beds in hospitals and residential healthcare facilities, while seeking beneficial ways of repurposing the space for new essential services.
(2) Enhance primary care through:
- (a) Rapid practice transformation to PCMH 2014 Level 3 using evidence-based TRANSLATE model to achieve PCMH recognition
- (b) Behavioral health/primary care integration: Create new functionality within safety net PCPs; offer evidence-based behavioral health training for PCP providers; aid targeted behavioral health settings to co-locate primary care services or train providers in supporting patient self-management; accelerate integration of emerging health home agencies into the infrastructure

(3) Enhance coordination: Explore mechanisms for meaningful integration by overcoming structural barriers (regulatory, confidentiality, lack of interoperability, lack of cross-training, etc.). Improve coordination among partners through mandated use of EMRs and RHIO. Enhance interoperability by focusing on six areas: (a) care coordination for high-risk patients in transitions; (b) hospital care: prevent readmissions and avoidable admissions; (c) emergency care: prevent non-emergent use; (d) referral to subspecialists; (e) medication safety; and (f) interoperability with behavioral health and community supports.
(4) Strengthen ED: To reduce improper ED use, we will incorporate services for care coordination, linkages to primary care, and access to social services at these sites. EDs will be linked to other providers through the RHIO.
(5) Workforce training and recruitment: Our organizations and employees need to be trained to participate in the new model. Standard training protocol will be developed for new roles. When possible, excess staff from reductions will be redirected to fill new positions. We will also work with AHEC partners to influence primary career choice, place mid-levels and physicians in safety net PCP settings, and recruit specialists into shortage areas.
(6) Access and overall health: Prevention campaigns, education and support programs, and better access to rehabilitative services are needed to improve overall community health. Problems of access and transportation will be addressed through enhanced coordination such as telemedicine services in underserved areas.

Section 3.7 - Stakeholder & Community Engagement:

Description:

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

***Community 1:**

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

A three-part engagement process was designed to ensure that the CNA clearly understood the voice of the consumer. These elements included a robust community health needs survey, facilitated conversations with community groups, and an ambitious series of interviews with providers across the region.
Community health needs survey: The survey was adapted from the Behavioral Risk Factor Surveillance System survey, which seeks information from consumers on their healthcare experiences and health status as well as basic demographic information. Two open-ended questions were included: one asking what the respondent believes is the most important health problem in the community, another asking

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what they believe is the most critical health system need. The community health needs survey was deployed online, and a hardcopy version was distributed in healthcare settings across the region with the assistance of partner organizations. In aggregate, the more than 7,000 responses track roughly with the age demographics of the region, population of constituent counties, and the ratio of Medicaid to non-Medicaid insured individuals.
Focus groups (community conversations): Outreach to hear the voice of the customer also included a series of 16 "community conversations" with Medicaid enrollees and others. These small group discussions, involving up to a few dozen participants in each, provided an open-ended opportunity for residents to reflect on their experiences in the healthcare system and suggest some improvements. The sessions were facilitated by the P2 Collaborative of Western New York and produced in collaboration with provider organizations and community groups across the eight counties.
Key informant provider interviews: Interviews included a wide range of frontline healthcare providers to gain valuable insights into the dynamics of healthcare provision on the ground. The panel included hospital administrators, ED staff, urgent care providers, primary care doctors in a range of settings, mental health providers, discharge planners, care managers, wellness educators, plus providers who focus on maternal and infant care, childhood asthma, tobacco cessation, addiction treatment and more. All 45 interview subjects were suggested by representatives of the PPSs.

***Community 2:**

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

Three community engagement approaches were used to gather extensive qualitative data that provided dimension and human context to the numbers, providing us with the means to explain some of the dynamics at play in our healthcare system today:
Community health needs survey: Completed by more than 7,000 people
Focus groups: 16 "community conversations" engaging people served by the system to better understand those patient perspectives
Key informant provider interviews: A series of 42 interviews with providers from every part of the region and every phase of the healthcare system, from primary care to mental health and behavioral care to ED settings

***Community 3:**

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

Community health needs survey key findings: Those insured by Medicaid were three times more likely to report ill health in the past month and more than three times more likely to be smokers. Roughly half of all respondents reported being overweight or obese. When asked to select from a list of suggested improvements to the primary care delivery system, the most common answer was "shorter time to schedule appointments," followed by "longer hours of operation," "better follow-up care," and "more responsive staff."
Community conversations key findings: Transportation is a pervasive problem. Use of Medicaid-funded services requires significant advance notice. The quality of care provided to Medicaid enrollees is perceived by some as inferior in quality to the care that people receive when they are otherwise insured.
Provider interview key findings: Patients who fail to appear for scheduled appointments make it hard to maximize the benefit from scarce resources. Capacity is a key issue across primary care, specialist care, and mental and behavioral healthcare. Better coordination of care is identified as a pressing need across the system.

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

[Millennium Collaborative Care PPS (ECMC)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	The Greater Buffalo United Ministries	An association of churches located in or near all of the Black and Latino neighborhoods in Greater Buffalo.	GRUM churches blanket the east side of Buffalo where health disparities are the most pronounced in the region.
2	Niagara Falls Memorial Medical Center (NFMMC)	Full-service 171-bed regional medical center, extensive inpatient and outpatient services, designated stroke center, comprehensive range of	Represents stakeholders in Niagara and Orleans Counties. Hosted "Community Conversation" focus group.

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[Millennium Collaborative Care PPS (ECMC)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		surgical services.	
3	Mt. St. Mary's Neighborhood Health Center	Provides primary healthcare services, serves as a medical home to one of the poorest neighborhoods in Niagara Falls. Features primary care physicians, obstetricians/gynecologists, and pediatricians.	Represents stakeholders in western Niagara County. Hosted "Community Conversation" focus group.
4	Group Ministries	Human services organization that provides HIV-related programming/services, re-entry mentoring, women's services programming, and substance abuse non-clinical counseling. Linkage agreements with various organizations in the City of Buffalo to provide referrals to clients in need of any services not provided.	Represents inner city Buffalo minority faith community. Hosted "Community Conversation" focus group.
5	Eastern Niagara Hospital - Lockport	General medical and surgical hospital in Lockport, NY, with 140 beds.	Represents stakeholders in eastern Niagara County. Hosted "Community Conversation" focus group.
6	The Resource Center	Comprehensive agency composed of community leaders and family members providing services to persons with all types and levels of disabilities.	Represents developmental disability stakeholders in Chautauqua County. Hosted "Community Conversation" focus group.
7	Mercy Comprehensive Care Center (Catholic Health)	Primary care center in Buffalo that provides OB/GYN care, midwifery, diagnostic testing, ultrasounds, and x-rays. Achieved highest PCMH recognition from the NCQA. Comprehensive stroke center.	Represents stakeholders in Erie County. Hosted "Community Conversation" focus group.
8	WCA Hospital	Southwestern New York's largest not-for-profit healthcare provider, extensive range of inpatient and outpatient acute and rehabilitation services.	Represents stakeholders in Chautauqua County. Hosted "Community Conversation" focus group.
9	Community Health Center of Buffalo (FQHC)	FTCA deemed Federally Qualified Health Center that provides access to quality and affordable healthcare to all members of the community regardless of their ability to pay.	Represents stakeholders in inner city Buffalo (Erie County). Hosted "Community Conversation" focus group.
10	Calvary Tabernacle Food Pantry	Faith-based provider of monthly and emergency food distribution for community members.	Represents stakeholders in Orleans County. Hosted "Community Conversation" focus group.
11	Bethany Lutheran Church	Evangelical Lutheran church that provides site for the Olean Food Pantry. Involved in many community outreach projects.	Represents stakeholders in Cattaraugus County. Hosted "Community Conversation" focus group.
12	Patient Voices Network	Partnership among a group of patients from Jefferson Family Medicine and Jericho Road Family Practice, providers, and the University at Buffalo's Department of Family Medicine.	A patient-run advocacy group representing inner city Buffalo (Erie County) patients with complex chronic conditions.
13	Buffalo Urban League	Community outreach organization that advocates and provide services for minorities and disadvantaged individuals to secure economic self-reliance, power, and civil rights.	Represents stakeholders in inner city Buffalo and Erie County. Hosted "Community Conversation" focus group.
14	St. Vincent's Clinic (Catholic Health)	Provides primary and gynecological care. Offers blood testing with no appointment.	Represents stakeholders on the east side of Buffalo (Erie County). Hosted "Community Conversation" focus group.
15	Towne Garden Pediatrics (Kaleida Health)	Pediatric primary care providers who provide sick and well care to children in the City of Buffalo.	Represents pediatric stakeholders in inner city of Buffalo (Erie County). Hosted "Community Conversation" focus group.
16	Our Lady of Victory Family Care Center	Primary care center affiliated with Mercy Hospital.	Represents stakeholders on south

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[Millennium Collaborative Care PPS (ECMC)] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
	(Catholic Health)	Recognized at highest level of PCMH by the NCQA, provides healthcare services for the entire family.	side of Buffalo and Lackawanna (Erie County). Hosted "Community Conversation" focus group.
17	Tuscarora Nation House	Multi-use house for the Tuscarora Indian Nation, primarily used as a medical center for the nation providing dentistry, general healthcare, and Community Health Workers under the direction of NFMMC.	Represents Native American stakeholders in rural Niagara County. Hosted "Community Conversation" focus group.

Section 3.8 - Summary of CNA Findings:

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

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

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

[Millennium Collaborative Care PPS (ECMC)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for delivery system integration across the spectrum of care	Excess bed capacity (1,240 inpatient beds not in use region-wide, 499 excess SNF beds). More than 40% community-level consent with RHIO. Primary care gaps. Large portions of inner city and rural areas are primary care HPSAs. Only 21% of 512 primary care locations are NCQA PCMH recognized. Structural barriers between medical system and behavioral health system. WNY has half the psychiatrists and psychologists per beneficiary as does the State. Lack of interoperable HIE among healthcare settings. Lack of behavioral health integration with primary care. Behavioral health gaps. Care management inadequate across settings (hospital/ED to PCP, to behavioral health, to community supports).	>Dashboard Domain 2 & 3 metrics >NYS Prevention Agenda for Population Domain 4 metrics >SPARCS Data (assessments not in Domain 2, 3, or 4) >CDC Mortality Data >Census >NYS BRFFS Survey >Health Needs Survey (n= 7000) >16 community conversations >Key Informant Interviews- a series of 42 provider in
2	Need for accessible primary care as alternative to ED	ED currently the preferred source of care for uninsured and Medicaid beneficiaries without access to primary care: 35,053 potentially preventable ED visits per year; current rate is	> Dashboard Domain 2 & 3 metrics > SPARCS Data (assessments not in

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[Millennium Collaborative Care PPS (ECMC)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		37.6/100; goal rate for 25% reduction would be 28.2/100. Most EDs have no triage function for dealing with non-emergent care needs. Most have little follow-up with PCP to prevent repeat ED visits.	Domain 2, 3, or 4) > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
3	High readmission rates due to poor transitions between settings	Currently many patients with chronic conditions are readmitted within 30 days because there was no support to assist their transition to community, home, primary care, or hospice: 2,042 potentially preventable readmissions per year; current rate is 5.8/100; goal rate for 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community healthcare system have been identified as important factors.	> Dashboard Domain 2 & 3 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
4	High hospital transfer rates from SNF	Many SNF patients are transferred to hospitals for conditions that could have been identified early and pre-empted before emerging to acute problems. Over half of the counties in WNY have SNF-to-hospital admission rates higher than the State's 14.81/1,000 SNF beneficiaries.	> Dashboard Domain 2 & 3 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > Census > Key Informant Interviews- a series of 42 provider interviews
5	High readmission rates due to poor collaboration with home care and PCMH	Currently many patients with chronic conditions are readmitted within 30 days because home care was not evaluated and arranged under supervision of the PCP. 2,042 potentially avoidable readmissions per year; current rate is 5.8/100; goal rate for 25% reduction would be 4.4/100. Lack of care coordination during transitions, low health literacy, language issues, and lack of engagement with the community healthcare system have been identified as important factors. Transition supports such as home care services not well deployed.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
6	High avoidable chronic disease admissions in underserved, low access areas	Many complex patients in underserved areas often do not go to a PCP in their county and do not have nearby access to specialist. Region lacks a robust public transportation system. Vehicle ownership is fundamental for adequate access to care, but in WNY, 12% of households do not own a vehicle. Remote patient care supports such as telemedicine	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics >SPARCS Data (assessments not in

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[Millennium Collaborative Care PPS (ECMC)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		is not well deployed. Some specialists, such as psychiatrists, are missing in rural areas and the State has twice as many per beneficiary as WNY.	Domain 2, 3, or 4) > Census > NYS BRFFS Survey >Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
7	Need for patient activation/engagement to integrate UI/NU/LU into community care	Currently, the only contact the uninsured have with the health system is through the ED. Engaging this population and connecting them to community care can improve health and reduce inappropriate ED use. The rural counties have high uninsured rates. Cattaraugus County has the highest proportion of uninsured in WNY (11.8%), slightly higher than the State average. There is little integrated functionality in crisis intervention community settings geared to activate and connect the uninsured and non-utilizing population to the healthcare delivery system.	> Salient Performance Data System > SPARCS Data (assessments not in Domain 2, 3, or 4) > Census > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
8	High cardiovascular disease (CVD) prevalence and leading cause of death	Currently many patients with cardiovascular conditions or risks do not consistently receive evidence-based care in primary care settings. CVD/ heart related conditions are the (a) leading cause of death, (b) leading cause of premature death, (c) leading cause of hospitalization, and (d) leading cause of preventable hospitalization for the general population and moreso for African-Americans.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
9	Poor perinatal indicators for low income population	Many women and their children on Medicaid do not consistently receive adequate prenatal or well child care. 12.1% of births are preterm, above the NYS Prevention Agenda goal of 10.2%. The maternal mortality rate is 26.8/100,000 births, above the Prevention Agenda goal of 21/100,000. The 69.5% of children who have had the recommended number of well child visits in government sponsored programs is below the State goal of 76.9%. Medicaid well care visits in the first 15 months are done 87.4% of the time. Medicaid low-weight births (<2,500 grams) happen 9.6% of the time. Inadequate prenatal care for Medicaid women occurs 22.2% of the time. High-risk pregnancies occur for Medicaid mothers 10.9% of	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > CDC Mortality Data > NYS BRFFS Survey >Health Needs Survey (n= 7000) > 16 community conversations > Key Informant

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[Millennium Collaborative Care PPS (ECMC)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		the time. 33.2% of live births are unintended pregnancies, well above the Prevention Agenda goal of 23.8%.	Interviews- a series of 42 provider interviews
10	Palliative care shared decision-making not occurring when most appropriate	Often, patients and families have not been engaged in palliative care options prior to reaching end-stage intensive care unit care that is not informed by quality-of-life wishes. "Community Conversations" focus groups key findings called for integration of hospice and expansion of palliative care shared decision-making in more settings.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > CDC Mortality Data > NYS BRFFS Survey >Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider int
11	Mental, emotional, and behavioral well-being not addressed for the general population	Promotion of community well-being is fragmented at the local level and is not orchestrated at the regional level. In WNY, 11.7% of the general population are adults with poor mental health, above the NYS Prevention Agenda goal of 10.1%. The percent of adult binge drinking in the general population is 18.9%, above Prevention Agenda goal of 18.4%. The suicide death rate in the general population is 11.4/100,000, far above the Prevention Agenda goal 5.9/100,000.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
12	Tobacco use tied to leading causes of premature death and preventable hospitalizations	Currently patients who use tobacco are not consistently offered cessation assistance in primary care settings. The percent of cigarette smoking among adults is 20.8%, above the NYS Prevention Agenda goal of 15%. Smoking-related conditions are the top five causes of death and premature death in every county (heart followed by lung).	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews >42 provider interviews
13	Poor premature birth indicators for the general population	Premature birth rates in the general population is tied to inadequate prenatal care, risk reduction, and management of high-risk pregnancy. 12.1% of births are preterm, above the NYS Prevention Agenda	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4

Millennium Collaborative Care PPS (ECMC) (PPS ID:48)

[Millennium Collaborative Care PPS (ECMC)] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		goal of 10.2%. Medicaid low-weight births (<2,500 grams) happen 9.6% of the time. Inadequate prenatal care for Medicaid women occurs 22.2% of the time. High-risk pregnancies occur for Medicaid mothers 10.9% of the time. 33.2% of live births are unintended pregnancies, well above the Prevention Agenda goal of 23.8%.	metrics > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
14	Need for behavioral health community crisis stabilization services	Currently many patients with behavioral health problems end up in acute care for extended periods of time because they lack support and assistance in the community at times of crisis. Limited integration in crisis intervention community settings that is geared to activate and connect the uninsured and non-utilizing high-need population to the healthcare delivery system. Most crisis services have limited coordination across the region, and there is virtually no interoperability with the RHIO.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > SPARCS Data (assessments not in Domain 2, 3, or 4) > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews
15	High cardiovascular disease (CVD) prevalence and leading cause of death	Currently many patients with cardiovascular conditions or risks do not consistently receive evidence-based care in primary care settings. CVD/ heart related conditions are the (a) leading cause of death, (b) leading cause of premature death, (c) leading cause of hospitalization, and (d) leading cause of preventable hospitalization for the general population and moreso for African-Americans.	> Dashboard Domain 2 & 3 metrics > NYS Prevention Agenda for Population Domain 4 metrics > CDC Mortality Data > NYS BRFFS Survey > Health Needs Survey (n= 7000) > 16 community conversations > Key Informant Interviews- a series of 42 provider interviews

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
48_SEC038_Millennium_PPS_CNA.pdf	12/22/2014 10:46:33 AM	Millennium Community Needs Assessment

Millennium Collaborative Care PPS (ECMC) (PPS ID:48)

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: **Erie_Section4_Text_MCC_Project_Plan_Application_48.docx**

Description of File

MCC project plan application

File Uploaded By: jstaylor

File Uploaded On: 12/22/2014 03:13 PM

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

Currently Uploaded File: **Erie_Section4_ScopeAndScale_AS SUBMITTED 12-22 - DSRIP Project Plan Application _Scale & Speed UPDATED _ 20141205.xlsx**

Description of File

Scale and speed application as of 12/22/2014

File Uploaded By: santiag7

File Uploaded On: 12/22/2014 11:03 AM

Millennium Collaborative Care PPS (ECMC) (PPS ID:48)

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.

The MCC PPS expects that 1.7% (211) of the 12,644 health workforce staff across the partner facilities in the WNY region will be impacted by redeployment or retraining in either inpatient, ED, or SNF settings.
Hospital inpatient workforce impact: Using Cost Reports to consistently extract information for every hospital in the MCC PPS, the CNA determined the PPS inpatient occupancy rate is 72%, which means on average there are 490 beds (out of 1,726 licensed beds) not in use. Presumably the deactivation of unused beds that are largely unstaffed (about 390) would not have workforce reduction implications, especially if reuse of facilities were possible using redeployed staff. The CNA estimated that MCC inpatient facilities have about 3,600 Medicaid preventable admissions annually (including preventable readmissions as well as adult and pediatric avoidable admissions). A

25% reduction over five years would be a reduction of 900 admissions per year. Using FTE per admission statistics from the Cost Reports for each facility, we estimate this would impact a total of 117 existing FTEs across the 10 MCC acute care hospital settings. The FTE impact by category of worker would be approximately: 30 RNs, 6 LPNs, 10 CNAs, 28 Medical Assistants, 18 Therapists (MSWs etc.), 14 Medical Coders, and 11 other allied health professions.
Hospital ED workforce impact: CNA estimated that the 12 MCC ED facilities have about 71,000 Medicaid preventable ED visits annually. A 25% reduction over five years would be a reduction of 17,500 ED visits per year. Using FTE per visit statistics from the Cost Reports for each facility, we estimate that this would impact a total of 32 existing FTEs across the 12 MCC ED settings. The FTE impact by category of worker would be approximately: 8 RNs, 2 LPNs, 3 CNAs, 7 Medical Assistants, 5 Therapists (MSWs etc.), 4 Medical Coders, and 3 other allied health professions.
SNF workforce impact: There are 41 nursing home facilities in the MCC PPS. Projected estimates of WNY public need for SNF beds indicate an excess of 275 beds (out of 5,607) in these facilities. Presumably deactivation of unused beds that are largely unstaffed (about 200) would not have great workforce reduction implications, especially if reuse of facilities were possible using redeployed staff. Assuming some excess beds are unstaffed, the CNA estimated this would impact 62 existing FTEs across the 41 MCC SNF settings. The FTE impact by category of worker would be approximately: 6 RNs, 13 LPNs, 27 CNAs, 10 Therapists, and 6 other allied health professions.
Regionally, healthcare employees are represented by a broad mix of unions, including NYSNA, CWA, CSEA, 1199 SEIU, and AFSCME, and there are also many who are not represented by unions. This challenge creates complexity in our implementation approach and suggests that we need to keep our frontline staff engaged in the process directly or through their union representatives. The system needs to remain flexible (to a degree) to incorporate unanticipated needs. The development of regional strategies will be of particular importance to ensure consistency of approach and outcomes.

***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.

MCC PPS expects that impacts would be minimized through redeployment, retraining, retirement, and promotions over the course of the DSRIP project period and that we will be able to avoid layoffs. Existing staff will have the opportunity to learn new skills in order to support their patient population. Retraining will be necessary to ensure that staff possesses skills necessary to fulfill their new roles. Redeployment will be based on interest, skill level, and seniority as determined by the facility's HR processes and union contracts.
When required, recruitment will be conducted following current HR practices, which will include interviewing and selection of the best available candidate. If required, the PPS will recruit from outside the respective partner organization, including affiliated PPS partner organizations.
Insights from our work with labor representatives highlighted the need for workers', labor representatives', and academic institutions' involvement on the development of mechanisms to reduce the time it takes for completing various certifications and to develop a mechanism to give employees credit for existing skills sets to reduce training time. The MCC PPS is committed to following through with these efforts through the operation of a Workforce Development Work Group and by collaborating with community partners on strategies to minimize the negative impact for employees.
It is well documented that skilled workforce shortages exist across the healthcare system as demand increases and the workforce ages. For example, an April 2014 article in the Buffalo News states that, "Health care facilities in Western New York and across upstate are facing a shortage of doctors, with hospital officials saying it's particularly challenging to recruit primary care physicians, according to a new survey by a statewide hospitals association" ("Doctor Shortage Found in WNY, Upstate" by Stephen T. Watson, http://www.buffalonews.com/city-region/medical/doctor-shortage-found-in-wny-upstate-20140403). In addition, a 2013 report, New York's Health Care Sector: A Changing, Growing Workforce, developed by the Healthcare Association of New York State noted that recruitment for nurse managers, RNs, clinical lab technicians, medical coders, and physical therapists continue to be the most difficult occupations to recruit. Some (or all) of these positions will be affected by DSRIP project implementation.
Through the Workforce Development Work Group, the MCC PPS will continue to review and assess the impact of potential workforce shortages moving forward and will identify specific ongoing strategies when needed. The shortages could affect implementation of the projects by reducing the number of staff who will be negatively impacted. A second potential scenario would be that the staffing shortage would be reduced (a positive impact) as projects move forward. A third potential ramification could be that workers might not be available to recruit/retrain/redeploy to fill positions needed for DSRIP projects.

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***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	25%
Retrain	20%
New Hire	55%

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.

Due to reductions in beds and inpatient Medicaid utilization, the MCC PPS estimates that 95 of the 211 FTEs impacted will be retrained from either inpatient, ED, or SNF settings.
(a) Hospital inpatient retraining: Due to bed reductions and reductions in Medicaid preventable admissions, we estimate we would retrain 10 of the 117 existing FTEs that would be impacted across the 10 MCC acute care hospital settings. We expect that inpatient RNs would be retrained to become Care Transition Coordinators. Care coordination from hospital to home is one of the features of our planned IDS. The remaining FTEs impacted would be redeployed.
(b) Hospital ED retraining: Due to reductions in Medicaid ED visits, we estimate that we would retrain all 32 existing FTEs who would be impacted across the 12 MCC ED settings. We expect most impacted FTEs would be retrained to become part of ED triage project teams.
(c) SNF retraining: Due to bed reductions, we estimate we would retrain 53 of the 62 existing FTEs impacted across the 41 MCC SNF settings. We expect that impacted RNs would be retrained as INTERACT Champions and that about 40 LPNs and CNAs would be retrained as part of the CHW/Navigator workforce needed by various projects. Any MSWs will be retrained to join safety net PCP locations as behavioral health counselors.
We anticipate that retraining of all impacted personnel will be voluntary.
The first step in the retraining process in DY0 is to finalize appointment of remaining members to the Workforce Development Work Group. The work group will be comprised of appropriate managers, staff, union representatives, HR personnel (or facility training/employee development staff), AHEC representatives, curriculum developers from area colleges and universities, and other subject matter experts who are capable of reviewing and finalizing job titles and descriptions for newly created positions and identifying training and methods required. This will be completed regionally for consistency and consensus among PPS affiliates. Organizational differences will be considered by work group members as the group moves forward into implementation. The work group is also charged with identification of specific cost-effective resources required in accordance with the training needs assessment, collaborating with identified partners in the delivery, ensuring regulatory compliance of training programs selected, and aligning curricula with needs.
The MCC PPS will partner with existing academic training providers to offer specialized trainings using standard curricula where appropriate for transitioning staff. Utilizing union input, discussions will be undertaken to address the request for credit for existing skill sets, leading to faster certification for positions where it is required. Labor unions will participate in the process throughout the project and with the Workforce Development Work Group, ensuring compliance with existing labor union agreements.
During DY0, the PPS will hold an overview conference to present the DSRIP program and employment opportunities open to all staff. While planning for retraining of existing staff will begin in DY0, the majority of job-specific retraining efforts are expected to begin in DY1 and continue as workforce reductions are required throughout the life of the project. Should an employee experience a barrier to completion of retraining, they will be referred to the HR department and/or union for review. Some potential barriers mentioned by union officials when consulted at the regional meeting included cost of training, out-of-work time required for training which is not on-the-job

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training, and length of time for certain certifications. These issues will be regionally addressed on an ongoing basis through the workforce budget and the Workforce Development Work Group.

***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.

The MCC PPS does not anticipate that retraining will significantly change employee wages or benefits. Discussions with union representatives indicated that this is a concern as positions move from the traditionally higher-paying hospital setting to community-based services. The MCC PPS expects that as demand for personnel to fill community-based jobs increases, salaries and benefits may increase commensurately in those settings. The MCC PPS will monitor this situation through the Workforce Development Work Group and develop strategies to address the issue moving forward.

***Retraining 3:**

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

The MCC PPS does not anticipate employees will refuse retraining. However, should an employee refuse retraining, they will be referred to the HR department and/or union pursuant to union agreements. The PPS will work with frontline staff through the Workforce Development Work Group to allow staff to have input into how staffing gaps in the workforce across the region should be addressed. This strategy will minimize the need for disciplinary action, which would only be considered as a last resort.

***Retraining 4:**

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

Labor representatives from PPS-affiliated organizations, including CWA, 1199 SEIU, SEIU Training Fund, NYSNA, and CSEA were presented the strategy on December 9, 2014, at a regional workforce strategy meeting. They commented on the strategy and participated in the development of this retraining strategy. Discussion points focused on a review of available resources for training along with strategies for ongoing communication and involvement in implementation of the plan. Labor representatives indicated a willingness to participate in further in-depth analysis of the needs and design through participation in project committees moving forward.

***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	90%
Partial Placement	10%

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.

Due to reductions in beds and in inpatient Medicaid utilization, the MCC PPS estimates that 116 of the 211 FTEs impacted across the MCC settings will be redeployed from inpatient, ED, or SNF settings.
(a) Hospital IP redeployment: Due to bed reductions and reductions in Medicaid preventable admissions, we estimate that we would redeploy 107 of the 117 existing FTEs that would be impacted across the 10 MCC acute care hospital settings. We expect that inpatient RNs, LPNs, CNAs, and MSWs could be redeployed to become part of new primary care teams being developed at selected behavioral health outpatient locations. Inpatient Medical assistants, therapists, medical coders, and other allied health professionals would be redeployed elsewhere across the MCC system, since many of these job categories are in short supply.

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(b) Hospital ED redeployment: None required. All 32 existing FTEs that would be impacted across the 12 MCC ED settings would be retrained to become part of the ED triage project team at each facility.
(c) SNF redeployment: Due to bed reductions, we estimate that we would redeploy 9 of the 62 existing FTEs that would be impacted across the 41 MCC SNF settings. We expect that those impacted would be therapists and other allied health professionals. They would be redeployed elsewhere across the MCC system.
The MCC PPS anticipates that redeployment of staff will take place in the form of: employees moving to the same position in a different department, location, or schedule; employees transitioning to an entirely new position within the organization; and employees transitioning to new employment categories (e.g., from full-time to part-time, flexible hours, etc.). An MCC PPS Workforce Development Work Group will ensure regional consistency of communications with all PPS providers, provide a single point of contact to resolve workforce issues, and oversee the process from a regional perspective. After identification, individual employees who are required to be redeployed will be counseled by a staff person from the HR department. Employees will not be penalized for choosing an alternative option to redeployment. At the counseling meeting, pursuant to all facility collective bargaining agreements in effect, the redeployed employee will be offered:
(1) The opportunity to transfer to any available openings for which they are qualified; this may include transfer to a position created by this project or to another opening in the same job title, class, retaining their seniority, salary and benefits as specified within facility collective bargaining agreements in effect.
(2) If current practice allows for inter-organizational transfer between affiliated facilities, this option may also be offered to the redeployed employee.
(3) The opportunity to meet with an independent job coach.
(4) The opportunity to accept a voluntary layoff or retirement (if applicable).
(5) Wherever possible, permanent employees will be retained as opposed to replacement by subcontractors and/or per diem employees.
MCC is comprised of multiple entities, unionized and non-unionized. Each organization will work with labor representatives (intra- or inter-entity) throughout the project in relation to redeployment. Employees will be allowed to exercise their union rights for representation at any point in this process. Union officials were invited to provide input into this plan. MCC will utilize (or develop) an internal job bank in order for employees to learn about new positions, responsibilities, pay grade, hours, etc. and understand what positions will become available.

***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.

Employee wages and benefits may be affected in accordance with existing collective bargaining agreements. For example, if a full-time employee chooses to move to part-time instead of redeployment, salary and benefits will be adjusted accordingly. It is the PPS's intention to coordinate this activity through the HR units of facilities with regional oversight as needed. The PPS will provide employees with a packet which offers a comparison between the current position and redeployed position, salary, benefits, role, responsibility, and training requirements. The PPS will work with HR and the Workforce Development Work Group to finalize the list of employees who may be redeployed and facilitate job placement coaching and referrals where appropriate. The Workforce Development Work Group will coordinate the redeployment process, with labor representative consultation, to understand and document to what extent redeployment will impact staff compensation and benefits.

***Redeployment 3:**

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

Redeployment will be voluntary. The MCC PPS does not anticipate employees will refuse redeployment. However, should an employee refuse redeployment option they will be referred to the HR department and/or union for review. The PPS will work with frontline staff through the Workforce Development Work Group to allow staff to have input into how the staffing gaps in the workforce across the region should be addressed.

***Redeployment 4:**

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

MCC is comprised of multiple entities, unionized and non-unionized. Labor representatives from PPS-affiliated organizations, including 1199 SEIU, SEIU Training Fund, CWA, NYSNA and CSEA were presented the strategy on December 9, 2014, at a regional workforce strategy meeting and offered an opportunity to comment and participate in the development of the redeployment plan. The discussion highlighted a sense that the projects will create a change in titles and descriptions with new opportunities for employees to be redeployed

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rather than cause significant job loss. Work group consideration of resources available and the impact of required training needs will remain a priority for the PPS moving forward. The MCC PPS will continue to work with labor representatives (intra- or inter-entity) throughout the project in relation to redeployment. Employees will be allowed to exercise their union rights for representation at any point in this process. Union officials were invited to provide input into this plan.

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.

At this point the MCC PPS anticipates 251 new hires to address structural gaps identified by the CNA as rapidly as possible in the following areas: (a) PPS organizational capacity across a continuum of partners; (b) gaps in interoperability; and (c) gaps in primary care infrastructure, behavioral health integration, and other workforce gaps.
(a) PPS organization capacity across a continuum of partners: 24.5 new hire FTEs. This administrative team will consist of the Executive Director, Administrative Director, Chief Medical Officer, Clinical Integration Officer, Chief Reporting Officer, Population Health Manager, Clinical Manager, Compliance Officer, Continuing Education Manager, Finance Director, and other administrative resources. This team will be responsible for resolving excess bed capacity; activating a continuum or providers in the IDS including medical, behavioral, and community; care management integration; contracting with Medicaid MCOs to include value-based payments; transitioning to a provider incentive-based compensation model; and engaging patients in the IDS at all levels.
(b) Gaps in interoperability: 25 new hire FTEs. This team will consist of the IT Project Manager, IT Support Liaisons, and HIE Analysts. This team will be responsible for EHR connectivity to RHIO's HIE for all safety net primary care locations; HIT integrated population health management in all safety net primary care locations; and project performance reporting.
(c) Gaps in primary care infrastructure, behavioral health integration, and other workforce gaps: 201.5 new hire FTEs. This collection of new hires addresses the following gaps identified by the CNA that are necessary for various projects:
3 physicians: psychiatrists to address severe shortage of psychiatrists in high-need unserved areas
4 behavioral health providers: clinical psychologists to address shortage of behavioral health clinicians in high-need unserved area
74 social workers: to provide critical behavioral health care management in various projects: 2.b.iii. ED Care Triage for At-Risk Population; 3.a.i. Integration of Primary Care and Behavioral Health Services; and 3.a.ii. Behavioral Health Community Crisis Stabilization Services
33 nurse practitioners: to fill primary care infrastructure gaps in the 2.a.1. IDS and 3.a.i. Integration of Primary Care and Behavioral Health Services projects
87.5 other new hires: an array of community-based resources such as Community Health Workers/Navigators who are essential across most of the projects

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	25
Physician	3
Mental Health Providers Case Managers	3
Social Workers	74
IT Staff	25
Nurse Practitioners	33
Other	88

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.

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Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	570,000	285,000	142,500	85,500	57,000	1,140,000
Redeployment	556,800	278,400	139,200	83,520	55,680	1,113,600
Recruiting	1,506,000	451,800	301,200	225,900	150,600	2,635,500
Other	4,320,000	2,160,000	1,296,000	648,000	432,000	8,856,000

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

MCC is committed to collaborating with other organizations and tapping resources of existing state programs wherever applicable. MCC and the Catholic Medical Partners PPS are already working together on workforce strategy and trainings to promote regional consistency. The MCC Workforce Development Work Group will assist in defining the ongoing strategy to identify and utilize the wide range of state and federal programs available to support healthcare worker training/retraining efforts.
Further examples of collaboration in support of staff development will be a subcontract with the Erie Niagara AHEC (ENAHEC) for development of health literacy and cultural competency trainings, prime elements of the project. In addition, MCC intends to enter into a subcontract with the WNY Rural AHEC (R-AHEC) for coordination of a portion of the workforce retraining and job coaching functions of the project. This subcontract, in addition to the existing Health Workforce Retraining Initiative (HWRI) contracts in place with various PPS affiliates, will allow the PPS to access additional state programs such as the HWRI-funded data analytics project which will focus on key areas of DSRIP including the Healthcare Reform Act, PCMH, and effective implementation of EHRs.

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 developing the workforce strategy, MCC PPS organized a Workforce Development Work Group. MCC PPS has and will continue to reach out to a variety of stakeholders to populate the work group. Work group membership reflects MMC's policy of inclusion by including management, project teams, unions, employees, AHEC, community members, area colleges and universities and various subject matter experts.
A system-wide communications plan was organized and implemented, which includes a website (www.millenniumcc.org) and an online communication newsletter (Millennium Collaborative Care Weekly WNY DSRIP Partner Update). These communication resources were created to enhance communication and coordination throughout the project among partners, stakeholders, and consumers.

***Engagement 2:**

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

Input was solicited from major labor unions representing the workforce: 1199 SEIU, CWA, AFSCME, NYSNA, and CSEA through the development of the CNA and a meeting with labor representatives. At the meeting, labor representative from the following unions attended: NYSNA, CWA, CSEA, 1199 SEIU, and SEIU Training Fund. Representatives provided valuable insight and were offered ongoing roles in the development of effective workforce strategies. Each labor union will continue to be active in the process as we move forward.
WNY R-AHEC was engaged to work collaboratively with partners in development of retraining strategies. R-AHEC consulted with a variety of sources, including the statewide AHEC system staff, UB Primary Care Institute, Union Workforce Coordinators, DSRIP project staff, and community members in the development of these strategies.

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***Engagement 3:**

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

In many cases, the day-to-day lives of the frontline workers will be altered by changes proposed in DSRIP projects, so it will be both necessary and beneficial to engage them throughout the planning and implementation phases. To this end, frontline workers will continue to contribute their time and insights by participating on several PPS work groups and committees (e.g., Primary Care, Behavioral Health/Substance Abuse, Pediatrics/Perinatal, Post-Acute Care). The PPS will engage them in ongoing dialogue through project newsletters, meetings/stakeholder sessions, social media, and website interaction.

***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.

stakeholder engagement plan to maintain interest and participation in all PPS operations and governance. For example, the engagement plan will feature communication strategies to ensure that work group members are kept well-informed about meeting schedules and activities. The PPS will define a communication schedule and standard templates for ensuring consistent messaging among all components of the PPS.
Structural barriers to engagement such as distance, weather, and multiple locations may be a factor in engagement and/or meeting attendance. These barriers will be addressed, as they have successfully been during application development (notably throughout the WNY snowstorms in late November), through the use of technological resources such as video conferencing, web conferences, call-in meetings, e-surveys of employees and partners, and web-based trainings when applicable.

Section 5.8 - Domain 1 Workforce Process Measures:

Description:

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

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

Please click here to acknowledge the milestones information above.

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

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

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

This section is broken into the following subsections:
- 6.1 Data-Sharing & Confidentiality
- 6.2 Rapid-Cycle Evaluation

Scoring Process:

This section is worth 5% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 6.1 is worth 50% of the total points available for Section 6.
- 6.2 is worth 50% of the total points available for Section 6.

Section 6.1 – Data-Sharing & Confidentiality:

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

***Confidentiality 1:**
Provide a description of the PPS' plan for appropriate data sharing arrangements among its partner organizations.

Appropriate data sharing among MCC PPS partners will be a key factor in reducing costs, providing better outcomes, and improving patient care. It is essential that the PPS establish appropriate safeguards to protect patient confidentiality. The PPS will develop a strong IT Data Committee which lends itself to collaboration with PPS partners to appropriately share and protect data. The program will be sanctioned and overseen by the Executive Team. All PPS partners will be responsible for adhering to all policies and procedures developed by the IT Data Committee. The Compliance Officer and IT Data Committee will be responsible for enforcement of policies and procedures by all PPS partners. The IT Data Committee will be responsible for understanding how the PPS uses patient data and will assess current state of EMR adoption and level of maturity of data security. Using NYS and Federal regulations, mandatory controls to mitigate risk will be instituted.

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

The IT Data Committee will be responsible for leveraging existing and/or establishing new policies and procedures which will define the responsibilities of how PPS partners will share and protect patient data. This includes but is not limited to business associate agreements, data use agreements, and master participation agreements. All PPS partners will be responsible for adhering to policies and procedures developed by the IT Data Committee and integrating those policies, procedures, and protocols into their daily operations. Through the use of appropriate tools, the IT Data Committee and Compliance Officer will monitor adherence to established standards.
The Compliance Officer and/or designee will be responsible for oversight of a Change Review Board (CRB) composed of clinical, management, and technical staff from PPS members. The CRB will be responsible for reviewing, approving, and communicating changes to all supporting systems, and monitoring tools, policies, and procedures.

***Confidentiality 3:**
Describe how the PPS will have/develop an ability to share relevant patient information in real-time so as to ensure that patient needs are met and care is provided efficiently and effectively while maintaining patient privacy.

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In order to share data to make meaningful decisions, it is important that an EHR be made available, at group discount pricing, to all PPS partners that do not already have one. By leveraging the current technology investment in population health and workflow tools, the PPS will offer, at a minimal cost to the practice plan, an effective EHR solution coupled with process engineering consultation, training, and education. Through current state analysis, any PPS partner's electronic processes requiring alignment will be addressed through a mitigation strategy assessment.
Identified gaps including patient confidentially and inability of members to adhere to technical and operational components of the data sharing model will be addressed by the IT Data Committee through a remediation strategy.
The IT Data Committee will establish the patient consent process guided by the safeguards illustrated in the NYSDOH Opt-Out model for ACOs. Development of clear and concise rules concerning the collection and tracking of patient consent to share their patient data through the PPS will be essential. Education and communication of the consent and its impact to the patient will be provided uniformly across all participating PPS members. The PPS, through the IT Data Committee, will be responsible for ensuring routine education on the confidentiality and appropriate use of patient data. Access control and patient consent metrics for process improvement will be made available to all PPS partners and tracked through the Compliance Officer and IT Data Committee. Required metrics, including analytics and performance measures, will include staff education and regular reviews of participation levels.

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.

MCC PPS and its partners, under strong provider leadership, will set direction for day-to-day operations and establish goals for addressing long-term population health metrics. Board of Managers Standing Committees will use the following principles to establish their criteria: process optimization/standardization, responsibilities and accountabilities, organizational culture, and outcome measurement/monitoring. The Physician Steering Committee, Physician Performance Sub-Committee, Governance Committee, and Executive Team will designate appropriate personnel and/or committees to establish metrics, identify data collection criteria, develop communication/education strategies, monitor/manage results, and remediate for unrealized targets. Rapid cycle evaluation (RCE) must be driven by providers. The IT Data Committee and its designee will ensure timely, accurate, reliable data is available, and grassroots providers/caregivers will be empowered to enhance performance metrics based on experience and expertise. We aim to change the culture of all MCC partners to include this information as part of their daily activities and thus realize our long-term goal of population health management.

***RCE 2:**
Outline how the PPS intends to use collected patient data to:

- Evaluate performance of PPS partners and providers
- Conduct quality assessment and improvement activities, and
- Conduct population-based activities to improve the health of the targeted population.

The Physician Performance Sub-Committee, Finance Committee, and IT Data Committee will evaluate and select a population health management/risk stratification and workflow tool to evaluate and monitor adherence to the criteria established by the committees. To evaluate the effectiveness of the PPS and ensure we are meeting designated targets, we will utilize an approach of continuous and systematic data collection and rapid feedback including the remediation strategy Plan-Do-Study-Act (PDSA) cycle. The selected population health management tool will provide key medical record-based data to care providers swiftly and efficiently utilizing state-of-the-art web portal technologies. MCC will also reinforce appropriate use of these tools by all MCC members through a continual in-servicing program. This information will be utilized by MCC and its membership to improve the health outcomes of the targeted population in addition to reducing healthcare costs.

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***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 portal-driven tool will be utilized by the Physician Performance Sub-Committee, Finance Committee, and their designees to produce regular and ad hoc reports addressing results from defined metrics and quality outcomes. Metrics will be developed to manage key factors including cost reduction, outcomes improvement, and patient care quality, with a particular focus on care transitions and chronic conditions. Defined metrics can be changed based on direction from established Committees. All changes will follow the change control methodology established by the Change Review Board. Inherent capabilities to drill down to patient-specific results will be made available to the MCC partners based on need. In addition, data will be available in a secured dashboard for real-time analysis and review. These reports will include analysis and interpretation and will be delivered to the Executive Team and their designee regularly who will create action plans with defined deliverables and due dates.

***RCE 4:**

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

MCC will provide reliable, accurate, and timely data metrics directly to caregivers, information they can use to improve patient outcomes, provide quality care, and reduce healthcare costs. The Clinical Integration Officer will integrate an appropriate population management solution into clinician/business owner workflows. A support team charged with successful delivery of the PDSA strategy will provide process engineering consultation, training, and education to MCC partners. This team of clinicians and IT professionals seasoned in population health management will integrate relevant data metrics into provider champion and partner staff workflows. Working with provider champions, Physician Performance Sub-Committee, and Clinical/Quality Committee, the support team will implement changes and develop well-defined measureable indicators. Based on this and RCE, committees will determine whether various processes should be adapted, adopted or abandoned, facilitating a closed-loop cycle.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

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

Scoring Process:

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

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

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

In the CNA community health needs survey, when asked to select from a list of suggested improvements to the primary care delivery system, one of the most common answers was "more responsive staff." In the "Community Conversation" focus groups, a key finding was that communication is a problem for Medicaid patients who may not fully understand a doctor's instructions or explanations, either because the doctor speaks too technically, because the patient speaks another language, or because the doctor "talks down" to the patient. More generally, provider sensitivity to cultural differences is seen as a need.
Medicaid patients in WNY represent various levels of education, cultures, economic experiences, and social networks. Challenges include a current lack of consistent cultural competency training at all levels, the erroneous assumption that healthcare staff is already culturally competent, and the general exclusion of home healthcare aides and family/friend caregivers from cultural competency training. The CNA provides evidence that the Medicaid population served by the PPS desire providers who treat them with respect and do not talk down to them. In order to establish a culturally connected community that will be reflected through all of the groups, cultural competency and health literacy training will be provided.

***Competency 2:**

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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.

MCC will develop a culturally competent responsive system of care as follows:
(a) Identify cultural competence champions: Providers, staff, and community members throughout the IDS who are willing to learn about the culture and communication norms of their community in order to improve the overall health of the community.
(b) Measure success: Develop a culturally responsive assessment framework including a planning template where the team will identify standards they will work on, gaps to be resolved, action/strategies, target outcomes, review dates, links to toolkits, and annual performance assessment
(c) Conduct demographic evaluation of employees: Organizations affiliated with the IDS profile their workers to identify races, languages spoken, and education levels
(d) Complete similar demographic evaluation of neighborhoods served: PPS organizations compare the community profile to their workforce to determine cultural fit and identify underrepresented segments of their organization
(e) Cross-cultural training: A professional development program will be required for everyone. Methods of delivery will include face-to-face group sessions and train-the-trainers. Webinars/live video conferencing and podcasts will serve as tools to refresh and sustain the training.
(f) Quality improvement: The PPS will implement an audit and feedback component using methods such as rapid-cycle improvement. Activities may include, but are not limited to, identifying project impacts, sharing "lessons learned," opportunities to scale up initiatives to a broader patient population, and key challenges associated with the expansion of the project, including special consideration for the safety net population.

***Competency 3:**

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

Built into four specific projects, the PPS will use an RFP process to solicit proposals from community-based organizations (CBOs) for Community Health Workers (CHWs)/Navigators who will be deployed as coaches in high-risk target areas or as part of care teams dealing with culturally or linguistically diverse high-risk patients. CBOs will be identified and included in the process to jointly identify concerns, set priorities, and plan for action to achieve and maintain cultural competence. Securing buy-in of the diverse groups represented in this PPS is a challenge that requires equal representation and an equal voice. One of the standing advisory committees to the MCC Board of Managers is a CBO Task Force that will address these matters. Its members will represent various cultures in the PPS community. They will work with providers and staff to establish a vision and context that will represent and reach out to each respective group to secure their buy-in and participation.

Section 7.2 – Approach to Improving Health Literacy:

Description:

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

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

***Literacy:**

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

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

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Program.

Building an effective IDS requires that everyone responsible for patient care understands that improving health literacy includes reading ability and understanding and communicating health information. A core component of project 2.a.i. (Integrated Delivery System) is to engage patients at all levels. The Executive Director, Administrative Director, and their team will be accountable for this. The IDS project's Action Plan #5 is to build patient engagement in all core components. This action plan will be aligned with all Board of Managers Standing Committees. Related to this is a strategy that will mutually establish core principles that will guide all PPS member organizations. Cultural/linguistic competency and health literacy sensitivity will be key themes of the guiding principles.
The PPS strategic plan focuses on providing communication to patients in clear, plain language that is neither offensive nor demeaning. Whenever possible, that communication will be in the patient's primary language. It includes improvement of the patient experience as evidenced by improvement in nurse/physician communication scores and overall program scores on patient assessment tools. The PPS will inventory and assess existing tools and methods currently used for communication at every point of patient contact.
Our communication will reflect the patient's level of understanding. The new tools will help patients connect to healthcare services and reliable community resources, understand dosages and test results, and communicate with healthcare providers. Special emphasis will be placed on communicating with patients with developmental disabilities and those suffering from mental illness. We will include the community in this process, asking for guidance and input.
These improvements will be introduced through PPS-led initiatives to promote health literacy. Our goal is to build a bridge that everyone who chooses can cross to enjoy a healthier life. The plan includes initiatives that reflect the people living in target areas, measuring the outcomes, making necessary changes for improvement, and then proceeding with the process in each community.
CBOs will be included in the process to achieve a communication design that improves usability of healthcare services. There are several instruments that can measure health literacy. However there is evidence that the instruments themselves can be a cause of continued distress. For some patients, REALM and TOFHLA will provide some measurement. However neither test is a comprehensive assessment of an individual's capacity; they both measure selected domains that are markers for a person's overall capacity. Many Medicaid patients have a great deal of apprehension about taking tests of this sort, which in fact can lead to their not seeking or continuing care. In response to these patients' concerns, we would use a shorter and more patient-friendly approach. We would train providers and staff to educate patients on universal precautions, avoid miscommunication by using plain language in all oral and written communication, and confirm understanding with all patients by having them repeat back their understanding of the diagnosis and treatment plan. We would measure efficacy of this approach by measurement of improved adherence and improved health of the patient.

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

Description:

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

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

Please click here to acknowledge the milestones information above.

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SECTION 8 – DSRIP BUDGET & FLOW OF FUNDS:

Section 8.0 – Project Budget:

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

This section is broken into the following subsections:
8.1 High Level Budget and Flow of Funds
8.2 Budget Methodology
8.3 Domain 1 - Project Budget & DSRIP Flow of Funds Milestones

Scoring Process:

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

Section 8.1 – High Level Budget and Flow of Funds:

***Budget 1:**
In the response below, please address the following on the DSRIP budget and flow of funds:

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

The allocation of DSRIP funds for MCC is tied to the established budget. There are six budget categories, or types of expenditures, in the budget plan: 1) project implementation and administrative costs; 2) costs for services not covered or reimbursed by the Medicaid program; 3) revenue loss replacement; 4) incentive payments; 5) contingency fund for unexpected expenditures; and 6) miscellaneous. The distribution plan allocates significant funds to project implementation to assure a successful implementation and to anticipated revenue loss that providers will experience as the projects are placed into action. The plan also provides incentive, or bonus, payments for providers who achieve project goals as well as sufficient funds to protect safety net providers and those who are financially fragile. DSRIP funds will be allocated to each region based on the number of attributed Medicaid lives using the average monthly lives by county from the NYSDOH website. MCC is geographically challenged, with three major service areas or sub-regions--Central, North, and South--covering the eight counties of WNY. Within each sub-region, funds will be allocated based on targeted lives related to each project, initially by project budgets defining costs and goals for each participating provider. Priority will be given to projects pertaining to population health management, readmission reductions, and primary care initiatives in specialty care and behavioral health. The MCC Board of Managers, MCC's primary governing body, is comprised of providers and provider groups representative of the communities in the three sub-regions we serve. In addition, members of and participants on MCC committees and workgroups that are responsible for the selection and approval of DSRIP projects, goals, and metrics include providers from across the region and from all services. MCC is committed to allocating a significant portion of the PPS's DSRIP funds to safety net providers who support PCMH, behavioral health, and primary care initiatives. MCC's plan for distribution of DSRIP funds is designed to be consistent with our DSRIP objectives. The plan considers the investment, impact, and requirements of each provider and the projects they participate in, which will ensure emphasis on DSRIP objectives. Our objectives, or rules of the game, are to be: 1) transparent: all providers will understand project goals and metrics and be included in the decision-making process; 2) measurable: metrics will be established to measure results and monitor project successes, especially during implementation and incentive award phases; 3) reportable: implementation progress and achievement of goals and milestones will be

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reported regularly to all members; and 4) accountable: accountability will be established and all providers and participants will be held to high standards to assure project goals are met.

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	12%
2	Revenue Loss	10%
3	Internal PPS Provider Bonus Payments	71%
4	Other	7%
	Total Percentage:	100%

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

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

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

Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

This section is broken into the following subsections:
- 9.1 Assessment of PPS Financial Landscape
- 9.2 Path to PPS Financial Sustainability
- 9.3 Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability
- 9.4 Domain 1 - Financial Sustainability Plan Milestones

Scoring Process:

This section is worth 10% of the total points available for the Overall PPS Structure Score. The responses will be evaluated for completeness and a scoring determination will be made based upon the quality of the response.
- 9.1 is worth 33.33% of the total points available for Section 9.
- 9.2 is worth 33.33% of the total points available for Section 9.
- 9.3 is worth 33.33% of the total points available for Section 9.
- 9.4 is not valued in points but contains information about Domain 1 milestones related to Financial Sustainability which must be read and acknowledged before continuing.

Section 9.1 – Assessment of PPS Financial Landscape:

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

***Assessment 1:**
Describe the assessment the PPS has performed to identify the PPS partners that are currently financially challenged and are at risk for financial failure.

DSRIP projects could have adverse financial impacts on providers (e.g., hospitals will lose volume and revenue with fewer Medicaid admissions, readmissions, and ED visits) and negatively impact cash flow, capital needs, and operations, compromising certain financially fragile providers during transition. MCC intends to support financially fragile providers critical to maintain financial strength and long-term sustainability.
Adverse financial impacts due to increased patient volume flowing to primary care, behavioral health, and other members: Financial impact on each member will be assessed so MCC may apply equitable allocation methodology to address changes; this methodology must be structured to meet patient needs identified in CNA. MCC is making provisions to support safety net/vital access providers, especially financially fragile/challenged and critical to success of DSRIP goals.
Potential impacts on providers, positive and negative:
Loss of programs/volume due to creation of IDS could result in significant downsizing at hospitals
Implementation of patient activation activities to engage/educate/integrate UI, resulting in fewer inappropriate admissions
ED triage for at-risk population, resulting in significant reductions in ED visits and redirection of patients to appropriate community care setting
Inability of providers to handle additional volume redirected from hospitals or reduce costs to match reduced revenues for inpatient/ED services
Lower demand for SNF beds due to hospital/home care project, resulting in need to reduce/retrain staff

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Challenge of redirecting inpatient/ED funding resources to other services e.g., PCMHs, Health Homes
Risk of losing volume, revenue, cash flow; potential margin losses if program expenses are not reduced
Unintended adverse impacts on primary/secondary healthcare services for non-Medicaid patients
Other providers lack appropriate staff to manage anticipated increase in volume redirected from hospitals and nursing homes

***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.

MCC is well aware of the potential adverse financial impact DSRIP projects could have on individual providers. It is expected that hospitals will lose volume and revenue with fewer Medicaid inpatient admissions, readmissions, and ED visits, which may negatively impact cash flow, needed capital investment, and operations, thus compromising certain financially fragile providers during this transition period. Transitional compensation for revenue loss, repurposing of newly available space and beds due to program downsizing, and redeployment and retraining of staff will be priorities of the PPS. MCC's goal is to support financially fragile providers that are critical to maintain financial strength and long-term sustainability beyond the five-year DSRIP program.
MCC is also focused on possible adverse financial impacts of increased patient volumes that flow to community primary care, behavioral health providers, and other members. Many of these providers have limited financial resources to invest in additional staff and physical infrastructure required to handle the flow of patients being directed to them by DSRIP-led initiatives. The financial impact on each member, positive or negative, will be assessed so MCC may apply an equitable allocation methodology to address these changes, recognizing that an equitable allocation methodology must be structured to further DSRIP goals of meeting patient needs identified in the CNA. MCC is making specific provisions in the budget and funds flow plan to support safety net and vital access providers, especially those who are financially challenged and critical to successful implementation and continuance of DSRIP goals.
The potential impact on providers, both positive and negative, that may occur as a result of implementing MCC DSRIP projects include:
(a) Loss of programs or volume due to creation of an integrated delivery system which could result in significant downsizing of beds and services at some or all hospitals
(b) Implementation of patient activation activities to engage, educate, and integrate the uninsured, resulting in fewer inappropriate admissions
(c) ED triage for the at-risk population, resulting in significant reductions in ED visits and redirection of patients to an appropriate care setting in the community
(d) The inability of providers, especially primary care and behavioral health providers, to handle the additional patient volume redirected from the hospital setting
(e) Lower demand for SNF beds due to implementation of the hospital/home care project (2.b.viii.), resulting in the need for SNFs to adjust by reducing or retraining staff
(f) The inability of providers to reduce costs to match reduced revenues for inpatient and ED services
(g) The challenge of redirecting inpatient and ED funding resources to other services such as PCMHs and Health Homes
(h) Potential risk to providers of losing volume, revenue, and cash flow and confronting potential margin losses if program expenses are not reduced to appropriate levels to accommodate loss of revenue and cash
(i) Unintended adverse impacts on primary and secondary healthcare services for non-Medicaid patients
(j) Other providers, especially in the primary care community, lack appropriate staff to manage the anticipated increase in volume redirected from the hospitals and nursing homes to a more appropriate care setting

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.

MCC will develop a financial stability plan during initial implementation and startup. The financial stability plan will be developed by the Finance Committee and approved by the Board of Managers. Financial and operational metrics will be developed for each project and each provider, with specific goals and targets that must be achieved. The plan will address the shift in volume from one provider to another

and how the PPS will support providers who lose revenue due to volume loss. The Finance Committee will monitor financial reports for each major provider on a monthly/quarterly basis to identify providers who may be at risk of financial instability. Providers will submit monthly financial information to the Finance Committee. The Finance Committee will in turn review metrics such as utilization, net revenue, expense, full-time equivalents, and cash flow, to monitor sustainability of each provider as part of overall MCC DSRIP operations.
Providers not meeting financial targets and identified as at risk will be reported to the Board of Managers. The goals of MCC are to support financially at-risk providers and develop a plan for fiscal sustainability to ensure successful implementation of DSRIP in meeting patient needs with improved quality and value for those providers critical to the success of implementing DSRIP. The plan may include transitional compensation for those providers critical to the long-term success of DSRIP, and may recommend consolidation of services or restructuring to provide alternate needed services to better serve the community.
Of particular concern are providers who are projected to lose significant volumes and smaller providers who may be identified as at risk for financial instability. MCC will work with at-risk providers to develop a plan to become independently financially stable, not only during DSRIP project implementation, but beyond. At this time, MCC has not identified any at-risk providers, but will continue to review and monitor the financial stability of its members. Currently, there are no known restructuring efforts underway with any MCC members.

***Path 2:**

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

The Finance Committee will develop a financial stability plan for each project with identified targets and metrics for providers to achieve. As described in earlier, MCC will collect financial and operational data on each member provider monthly or quarterly. Those data will be reviewed and assessed by the Finance Committee to determine each MCC provider member's current and likely future sustainability based on progress towards these stated targets and metrics. During the implementation and execution stages of the project, MCC will monitor each provider's financial condition and work with providers identified (red-flagged) as not meeting their goals or at financial risk. MCC will develop a remediation plan to remedy their financial stability. Special consideration will be given to the most vulnerable providers such as safety net providers; those who lose a significant amount of volume; those who serve a disproportionate number of Medicaid, uninsured, and under-insured patients; and those who are critical to the long-term success of DSRIP goals.

***Path 3:**

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

During the DSRIP period, MCC will have developed an integrated delivery network model to incentivize and reinforce a commitment to improved quality, better access, and value in meeting the healthcare needs of Medicaid patients in the eight-county service area. We plan to execute value-based agreements and will continue to collaborate on these arrangements with the four managed care organizations (MCOs) serving WNY and other managed care providers interested in entering our market. Currently, Independent Health, HealthNow, and Universal Health have expressed interest in the DSRIP program and committed to working with MCC on payment models for the DSRIP projects.
MCC will discuss each DSRIP project with the MCOs to develop payment models such as shared savings programs that benefit not only the MCO, but the providers in the PPS. With these performance-based contracting programs in place, MCC should be able to sustain its DSRIP outcomes in the long term.

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.

ECMCC, the lead of the MCC PPS, Kaleida Health, Niagara Falls Memorial Medical Center, and Upper Allegheny Health System, along with two other participating hospitals, are well versed in payment reform initiatives and have actively led or participated in payment reform,

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including risk-based payments and limited network arrangements with local MCOs. For example, ECMCC and Kaleida Health developed a limited network arrangement with HealthNow to improve quality of care at a lower cost.
There are four Medicaid MCOs currently serving our communities, with a fifth anxious to enter the WNY market. We will continue to engage payers in this process, specifically developing a plan for services such as PCMH, cardiovascular, behavioral health, and primary care that will ultimately move to value-based payments and continuous care bundles. To assist the safety net and the most fragile providers, it is important that MCC and the MCOs agree to a shared savings payment model to support lost utilization and net revenue by the providers.

***Strategy 2:**

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

A core goal of MCC is to transform the delivery and payment system to improve the health of the community by ensuring the patients receive care at the appropriate level and to reduce the cost of delivering care. As utilization is reduced or shifted and costs exit the system, MCC will take steps to ensure that the most critical DSRIP providers and safety net providers not be harmed. The flow of funds will ensure that these providers are compensated for lost revenue for a period of time. The PPS will work collaboratively with all providers to ensure they are able to financially sustain their operations and move beyond the DSRIP period by managing less utilization and appropriately adjusting expenses to those volumes.
As stated earlier, MCC will pursue various payment models depending on the delivery model. For example, project 3.a.i. (Integration of Behavioral Health and Primary Care) will employ a value-based payment model that rewards providers with bonuses for meeting established metrics. In addition, the project 2.a.i. (IDS) will most likely employ a capitation payment method. For other projects, the PPS may establish a baseline payment and negotiate to share savings with MCOs, as appropriate. The PPS will also provide for additional payments to PCPs who meet established metrics for the PCMH program. Each of the primary service area's payment models will be tailored to the program metrics and the participating providers' needs and requirements.

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.

Please click here to acknowledge the milestones information above.

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SECTION 10 – BONUS POINTS:

Section 10.0 – Bonus Points:

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

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

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

MCC PPS has engaged key partners that possess proven population health management skill sets. For example, Optimum Physician Alliance (OPA), a mirror IPA, is a partnership between HealthNow (BCBS of Western New York) and Kaleida Health. OPA delivers patient-centered, physician-led care at a lower cost by a network of physicians working in partnership with the region's largest health system and largest health plan. OPA supports Kaleida Health's IDS, hospital, nursing home, and home care infrastructure, as well as Kaleida Health's physician network, through its systems and technology.
The population health management capabilities of OPA or a similar entity will provide participating physicians a unique opportunity to access clinical data, sophisticated information systems, innovative technology, and administrative and IT infrastructure support which would otherwise not be available. Consistent with the goals of DSRIP, clinical integration and network-exclusive health benefit plans such as those provided by OPA will promote preventive healthcare and more interaction between doctor and patient. The PPS will issue a competitive request for proposals (RFP) to acquire the services of a population health organization like OPA.
Another significant MCC partner with proven population health management skillsets is Niagara Falls Memorial Medical Center's Health Home, serving Niagara County. The Health Home is a coordinated care management program providing services to Medicaid-eligible clients with chronic conditions in Niagara County. In addition, it works closely with Health Home partners across the region to offer comprehensive care management, including family support and referrals to community and social support services.
MCC will leverage its partners' valuable and successful experience in population health management and clinical integration.

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.

MCC has neither the subject matter expertise nor the capacity required to implement the workforce strategy necessary to retrain, redeploy, and recruit employees as the PPS transforms healthcare services from inpatient settings to primary care and outpatient settings. To that end, the PPS intends to contract with a proven and experienced entity to help carry out its workforce strategy. We plan to issue a competitive RFP to appropriate local, regional, and national organizations and consulting firms to identify a vendor with particular expertise in workforce strategy and a successful track record in retraining and redeploying healthcare workers to support the PPS in its workforce development efforts. As an example, one of MCC PPS's partners, Kaleida Health, contracted with Area Health Education Center to assist in the retraining and redeployment of employees affected by the closing of the 189-bed Millard Fillmore Gates Hospital in 2012.

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

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SECTION 11 – ATTESTATION:

Attestation:

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

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

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

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

☑ ***I hereby attest as the Lead Representative of this PPS Millennium Collaborative Care PPS (ECMC) that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: ERIE COUNTY MEDICAL CTR
Secondary Lead Provider Name:

Lead Representative:	Juan Santiago
Submission Date:	12/22/2014 03:31 PM

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