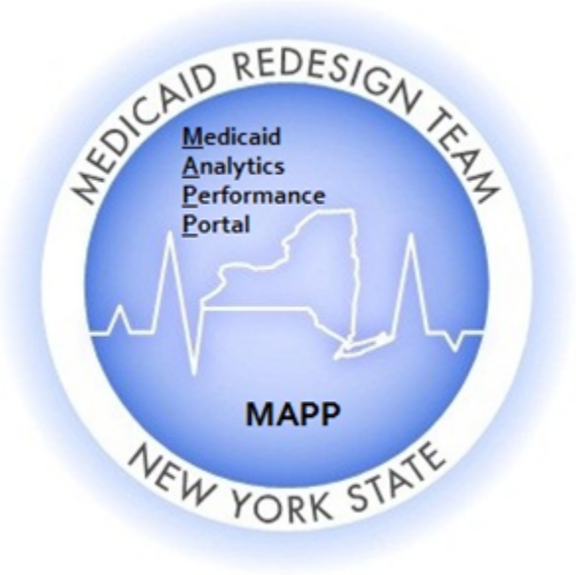
New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP PPS Organizational Application



Adirondack Health Institute

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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: **23_SEC000_AHI_Lead Financial Viability Document_FINAL.pdf**

Description of File

AHI_Lead Financial Viability Document_FINAL

File Uploaded By: ahidsrip
File Uploaded On: 12/22/2014 06:13 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: ch569810
Last Updated On: 12/22/2014 03:28 PM

Certified By:	ch569810	Unlocked By:	
Certified On:	12/22/2014 03:32 PM	Unlocked On:	
Lead Representative: Cathy Homkey			

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

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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	Reduce avoidable hospital and emergency department use by 25% over 5 years.	The overarching goal of the AHINCPPS is "to create an effective, integrated health care delivery system for preventive, medical, behavioral, and long term care services to all communities throughout New York's North Country." This is the same goal that the North Country Health System Redesign Commission was charged with at their inception by then New York State DOH Commissioner, Nirav R. Shah, MD, MPH. To the extent such integration is achieved, there will be less reliance on high-cost hospital-based services and greater reliance on home and community based services. This shift results not only in systemic cost savings, but in more positive patient experiences and greater quality of life.
2	Increase the proportion of care that is provided under a value-based payment methodology.	At present, health care providers and administrators are challenged to manage organizations that continue to rely heavily on fee-for-service payments. The full incentive effect of value-based payment methodologies will not be realized until a greater proportion of care is reimbursed under such models. More widespread proliferation of value-based payment is necessary to reach the quality and cost goals that health care system transformation seeks to achieve.
3	Increase the # of primary care providers that are recognized Patient Centered Medical Homes.	The North Country Health System Redesign Commission, and the Community Needs Assessment, both point to a need to strengthen the North Country's primary care system in terms of capacity, quality, and access. More widespread adoption of the PCMH model is one strategy to build a stronger primary care system; the model specifically addresses quality and access. The AHI North Country PPS will build on the gains made in primary care via the Adirondack Medical Home Pilot. Specifically, the PPS will expand on the current level of NCQA PCMH Certification in the region by including additional practices, and supporting all practices to meet NCQA 2014 Level 3 standards.
4	Increase primary care capacity.	The region suffers from a lack of a strong primary care infrastructure. There is a shortage of primary care physicians, lower per 100,000 population in all counties, except Warren, than NY State and the US. The primary care provider shortage is further evidenced by the large number of HPSA designations in the AHI North Country PPS. The entire counties of Clinton and Fulton, and various areas of Essex, Franklin, Hamilton, St. Lawrence, Washington and Warren are designated primary care HPSAs. Workforce development strategies, and targeted primary care expansion will both be necessary to achieve this goal.
5	Connect a wider range of providers to RHIOs and/or	The region benefits from widespread connectivity to RHIOs, however, it is

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#	Goal	Reason For Goal
	regional population health management technology.	mainly hospitals and primary care providers that leverage RHIOs, data warehouses, registries, and/or other population health management technologies. Currently, many providers (e.g., behavioral health, long-term care, home care) lack connection to RHIOs or other shared platforms that could be used not only to share information, but to support regionally adopted clinical guidelines and care pathways. A Regional Health Information Technology plan will be developed and implemented, to increase communication and coordination across the full care continuum.
6	Increase options for home and community-based care.	People prefer to receive care at home or in their community, whenever possible. Given that the service are of the AHI North Country PPS is largely rural, it is particularly for patients and families when care is needed at a hospital in a major population center. Care provided in the home, or community, contributes to more positive patient experience of care and greater quality of life. Many selected projects contribute to this goal, including Hospital to Home Collaborative Solutions, among others.
7	Ensure the full care continuum participates in health system transformation.	To achieve reductions in avoidable hospital use, providers from the full continuum of care, along with community-based organizations, will need to work collaboratively to achieve common goals. The AHINCPPS is establishing Regional Health Innovation Teams, one for each of the North Country's "Naturally Occurring Care Networks", that work together top plan, implement, monitor, and improve performance at the micro-system level.

***Formulation:**

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

The PPS is formulated to empower regional entities (Regional Healthcare Innovation Teams, or RHITs) to work collaboratively to identify community health needs and disparities, set priorities, and implement evidence-based strategies to address them. Through NYS DOH Rural Health Network funding, AHI has established a forum for public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations, such as the United Way, to conduct a regional community health needs assessment and prioritization process. The RHITs build on this work by planning and implementing projects, and then monitoring and improving performance in a rapid-cycle fashion. RHITs develop plans and recommendations that are endorsed by the leadership of the PPS (currently the Interim Steering Committee; at the time of incorporation, the body is the Leadership Board). The AHINCPPS has adopted a Delegated Governance Model, to effectively engage and empower this multi-stakeholder coalition.

***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.

AHI is establishing the AHI North Country Performing Provider System (AHINCPPS), an integrated network of providers and community-based organizations that will serve all or parts of nine counties (Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, & Washington) in northern New York State. The AHINCPPS' 5-year vision is to realize the primary recommendation of the North Country Health Systems Redesign Commission (NCHSRC), "to ensure that New Yorkers in the North Country achieve high quality care, better health outcomes, and lower costs, both now and into the future". The future state will provide patients with a fully integrated approach that centers on preventive and primary care services, offers ample home and community-based options, and relies on high quality acute and long-term care facilities when they are needed most. The system of the future rewards cross-continuum collaboration and quality, and provides both patients and care-givers with a secure, sustainable , safety net.

***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;

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- 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	Article 29F and Proposed Regulations	(1) 2.a.i is implicated and it is a general concern regarding the PPS program. 2.a.i project requirements (9-10) are implicated because negotiating with private entities increases anti-trust risk. (2) There are ongoing anti-trust concerns for the PPS. AHI requests that the proposed regulations be adopted so that COPA can be applied for. The waiver would facilitate implementation of an integrated system by providing certainty as to the activities that the PPS may undertake without state action. (3) The PPS considered waiting for COPA, but due to the requirements of working with Medicaid MCOs, at the outset, the PPS felt the need for immediate clarity. (4) The PPS would only be undertaking activities within the bounds of the requirements promulgated by DOH for the DSRIP Program, these activities do not directly implicate patient safety.
2	10 NYCRR 405.1(c)	(1) The integrated delivery system of 2.a.i is generally implicated, but project requirement 10 is specifically implicated. (2) The PPS requests a waiver because the PPS will adopt certain policies on behalf of PPS Partners and will make certain decisions regarding the provision of healthcare to patients in the PPS. The PPS should be specifically exempted from this requirement because its activities with PPS Partners will not rise to the level of operating Partner facilities. The requirement for establishment would be overly burdensome and will delay the timely formation of the PPS. (3) The PPS considered requesting an expedited establishment review, but it was rejected because the activities of the PPS should be deemed to fall below the establishment threshold. (4) Patient safety will not be impacted because the PPS will not be responsible for the day to day operation of any partner and the partners' established operator will still need to formally adopt any policies any make decisions regarding patient care. In addition, any policies pertaining to patient safety could be reviewed by applicable agencies.
3	10 NYCRR 600.9(c)	(1) 2.a.i is implicated and it is a general concern regarding the PPS program. (2) The PPS and its Partners and Affiliates will receive certain distributions of funds pursuant to the DSRIP program that could be construed as fee splitting. The PPS requests an waiver of the requirement that an entity that splits fees needs to have establishment approval. (3) There are no feasible alternatives. (4) Patient safety will not be impacted because the PPS will not be responsible for the day to day operation of any partner and the partners' established operator will still need to formally adopt any policies and make decisions regarding patient care.

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#	Regulatory Relief(RR)	RR Response
4	Public Health Law § 18(6); Mental Hygiene Law § 33.13(c); Education Law 6530(23), Article 32 Privacy	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vii. project requirement 10; 2.d.i. project requirement 17; 3.a.i. project requirement 4; 3.a.ii. project requirement (2, 8, and 11); 3.a.iv. project requirement 9; 3.g.i. project requirement 6; and 4.b.ii project requirement 4. (2) Without a regulation PPS Partners and Affiliates will be subject to lawsuits from patients regarding uses and disclosures of healthcare information. The PPS requests that a regulation be promulgated that allows the PPS to obtain a single consent for treatment, payment, and healthcare operations uses and disclosures to settle liability under New York law. The regulation could specifically cite the DOH consent form being developed. (3) The PPS could utilize the consent form that DOH is drafting; however, without the issue addressed in binding law there will be outstanding liability questions with regard to inter-PPS disclosures. (4) Patient safety and patient privacy would not be implicated because the PPS, partners, and affiliates will sign business associate agreements or confidentiality agreements regarding patient information and will utilize any consent form DOH proposes.
5	10 NYCRR 600.1; Parts 670; Parts 700	(1) All projects. (2) The PPS requests that DOH, OMH, and OASIS create an integrated program for review of Public Need and Financial Feasibility for all PPS projects requiring CON or Prior Approval Review because requiring multiple agency review will make implementing the projects slower and more expensive. (3) The PPS considered complying with current requirements for review by each applicable agency, but feels that multiple agency review will delay implementation of the project. (4) Patient safety will not be implicated because a single agency or integrated review will still have significant oversight over the project.
6	Request for Bi-Weekly Video Conferences to accommodate necessary approvals	(1) All projects. (2) The PPS requests that the Public Health and Health Planning Council schedule a bi-weekly videoconference meeting to accommodate required approvals emanating from approved PPSs. The PPS requests that the Behavioral Health Services Advisory Council schedule a monthly videoconference meeting to accommodate required approvals emanating from approved PPSs. (3) No, due to volume this seems necessary. (4) Patient safety will not be implicated because the review is accelerated not eliminated.
7	10 NYCRR 708.3(e); 10 NYCRR 708.4; 10 NYCRR 710.1(c)(4)(iv); 10 NYCRR 710.1(c)(5)(iv)	(1) 2.a.iv. project requirement 1. All projects involving bed and service relocations between Partners. (2) The PPS requests an accelerated review requirement for bed and service relocations between PPS Partners. The bed and service relocations should only require letter notification to DOH and the review should be deemed to occur after 15 days. There is authority for this in 10 NYCRR 710.1(c)(4)(iv) which allows for certain changes to be made without an application and for limited review under 10 NYCRR 710.1(c)(5)(iv). The 180 day review period in 10 NYCRR 708.3(e) could be shortened to 15 days. This requires eliminating the specific 10 NYCRR 708.4(a) review criteria and substituting whether the relocations fit into the PPS's overall plan. (3) No, due to volume this seems necessary. (4) Patient safety will not be implicated because the review is accelerated not eliminated.

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#	Regulatory Relief(RR)	RR Response
8	10 NYCRR 401.3(g)	(1) If 2.a.i. is successful it will reduce the overall number of patients being admitted as inpatients. This may cause certain facilities or components of facilities to close. (2) The PPS requests that the 90-day timeline for DOH to consider facility closure be reduced to 30 days to facilitate timely closures where it is necessary due to the PPS achieving its goals. (3) Utilizing a longer period was considered; however, due to the amount of change in the delivery of healthcare that DSRIP will bring about, closing a facility quickly in order to more efficiently allocate resources may be necessary. (4) Patient safety will not be impacted because the PPS has an effective governance structure with multiple providers that will have analyzed the closure within regional committees and, with all interests and effected parties involved, undertaken a medically sound, open, and deliberative approach to ensuring that services have been effectively moved to other facilities.
9	10 NYCRR §§ 710.1(2), 710.1(3)(i)(q), 710.1(5)(iv)(g).	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vii. project requirement 10; 2.d.i. project requirement 19; 3.a.i. project requirement 4; 3.a.ii. project requirement (2, 8, and 11); 3.a.iv. project requirement 9; 3.g.i. project requirement 6; and 4.b.ii project requirement 4. (2) All of these project require use of HIT technologies and interoperability, this will require investment in new EHR technologies, capital and vendor services. The waiver is necessary so that the PPS and all partners do not need further review or approval from the Department regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP project. (3) No alternatives were identified. To facilitate rapid implementation in DSRIP Y1, all partners and Newco must be in a position to make rapid changes in HIT. (4) This provision does not pertain to patient safety.
10	Scope of practice	(1) All Projects dealing with integration of services will face scope of practice issues. (2) The PPS requests that DOH exercise its authority to formally approve each PPS and its treating partners in order to become exempted from these scope of practice provisions for the professions of: • Social Work (Education Law, Article 154), • Psychology (Education Law, Article, 153), • Mental Health Practitioners (Education Law, Article 163). The authority for this is Section 9 of Chapter 420 of the Laws of 2002, as amended by chapter 132 of the laws of 2010, relating to the profession of social work; Subdivision a. of Section 17-a of chapter 676 of the laws of 2002, as amended by chapters 130 and 132 of the laws of 2010, and as further amended by chapter 57 of the laws of 2013, in relation to the profession of psychology and the four professions described as mental health practitioners. The PPS also requests the extension of this scope of practice exemption beyond its July 1, 2016 sunset date. (3) There are no other feasible solutions. (4) The PPS and Partners will develop protocols for practitioner treatment of patients. These protocols and policies could be submitted to DOH for comment.
11	10 NYCRR 600.2	(1) All projects that plan to utilize the integrated outpatient services regulations.

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#	Regulatory Relief(RR)	RR Response
		(2) The PPS requests in numerous locations that DOH adopt the proposed integrated outpatient services regulations so that the PPS can adopt those regulations. In the interim, the PPS requests that for all projects where it has indicated a desire to utilize these regulations DOH grant an waiver or approval under 10 NYCRR 600.2 to allow the PPS to begin the process of undertaking the selected projects in the interim in situations where primary care services will be provided at a facility licensed by OASIS or OMH. (3) If the regulations are not finalized before the implementation of the project begins, then it will be difficult to begin the project without this waiver. The delay to the project of multiple licensure will be difficult. (4) Patient safety would not be implicated because this would merely be a temporary waiver until the project is approved under the integrated outpatient services regulations.
12	10 NYCRR 405.19 (g)	(1) All projects that plan to utilize observation beds.
13	(2,5 (b)); 10 NYCRR 710.1(c)(2) or (3)	(2) The PPS requests a waiver to increase number of observation beds and a waiver physical space and location and Construction requirements for those beds regardless of cost. The PPS will comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011. (3) The PPS does not believe there are alternatives to this proposed waiver. (4) The PPS does not believe that this poses a patient safety concern.
14	10 NYCRR 400.9 (c)(1) and (d).	(1) All projects that are impacted are the use of telemedicine to make decisions about transferring residents from SNFs when physicians, nurses and other clinical staff with the necessary training to make the transfer decision are not available. (2) 10 NYCRR 400.9(c)(1) requires the personal, alternate or staff physician requests or agrees to the admission, transfer or discharge from a skilled nursing facility. The reasons for the waiver request is to allow transfer decisions to be evaluated in a timely way by health care professionals with the necessary expertise to facilitate transfers as needed, and avoid preventable transfers undertaken because of the unavailability of health care professionals at the SNF to evaluate the resident and make a transfer decision by utilizing tele-health and telemedicine services. (3) The PPS does not believe that there are feasible alternatives. (4) Information that supports why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s) would not risk patient safety is that telemedicine will be used to assure that physicians with necessary credentials and training will be consulted regarding the transfer decision in consultation with nursing home staff to assure that the physician has access to available clinical information to inform the transfer decision.
15	10 NYCRR § 98-1.5(b)(6)(vii)	(1) 2.a.i. project requirement 8; 2.d.i. project requirements 6 and 10; 3.a.ii project requirement 3. (2) The PPS will contract with Medicaid Managed Care Organizations as an integrated system and establish value based payment arrangements. This could require licensure as an IPA under 10 NYCRR 98-1.5(b)(6)(7). The PPS requests a waiver of the restriction on MCOs contracting with unlicensed entities for IPA services and recognize that the PPS may perform some IPA services. The PPS requests that it be exempt from the definition of an IPA under 10 NYCRR 98-1.2 (w). (3) The PPS considered seeking IPA licensure, but feels that IPA licensure is inappropriate for a PPS which performs a wide variety of non-IPA services. (4) Patient safety will not be impacted because the PPS is a highly regulated entity where multiple providers with healthcare expertise will be involved in establishing policies to focused on maintaining and improving

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#	Regulatory Relief(RR)	RR Response
		quality of care in the PPS. DOH could impose certain requirements on the MCO contracts.
16	Public Health Law § 4901(9)(c)	(1) 2.a.i. project requirement 9. (2) The PPS requests that regulations be promulgated indicating that the PPS is not a utilization review agent due to the Public Health Law § 4901(9)(c) exception. The Public Health Law provides that agents acting on behalf of the state and local government for services provided pursuant to title XIX of the federal social security act are not utilization review agents. The PPS will be analyzing utilization and medical necessity of various treatments, especially inpatient hospitalization, and could be deemed a utilization review agent. (3) The PPS considered simply adopting a literal reading of the exception and deeming itself exempt, but feels clarity is necessary given the mission of reducing avoidable hospital use by 25%. (4) Patient safety will not be impacted short term because the PPS will not be making utilization determinations for the MCO immediately and long term safety will not be impacted because the PPS will be changing the utilization model to provide care in other locations. The PPS could provide DOH for comment and retroactive approval its policies regarding medical necessity determinations.
17	Public Health Law § 18(6); Mental Hygiene Law § 33.13(c); Education Law § 6530(23); Article 32 Privacy.	(1) 2.a.i. project requirement 11; 2.d.i. project requirements 11 and 13; 4.a.iii project requirement 4 the PPS intends to share PPS data elements gathered from across the PPS with trainers in MEB health promotion. (2) It would be a treatment purposes disclosure for the PPS to disclose information to healthcare providers within the PPS. However, it is not a treatment purposes disclosure to disclose information to engage patients in the integrated delivery system through outreach. As such, the consent form DOH is currently drafting needs to be a HIPAA compliant "authorization" for these activities. The consent form should only need to be obtained once to allow the PPS to conduct all activities required under the project plans. However, an authorization needs to be specific as to the entity the information is to be released to. Therefore, DOH will need to consult with CMS in drafting the authorization to determine if reference in the consent to an online list of PPS Partners and Affiliates will be sufficient for an authorization. (3) There do not appear to be other feasible options. (4) The PPS does not see this as a patient safety issue and to address any safety concerns the PPS would suggest that the DOH consent form contain a location for the PPS to insert a web address listing all Partners and Affiliates to whom the patient is authorizing MEB related disclosures.
18	10 NYCRR §§ 405.2(e)(3), 405.4(b)(4), 94(b)(2-3)	(1) 2.a.ii project requirement 8 dealing with behavioral health screening protocols. (2) The PPS requests that providers be allowed to be credentialed at the PPS level. Effective PPS preventative care screening will require providers with appropriate credentials to be available in facilities that do not currently credential providers of that type. This will enable the creation of a single community wide practitioner base and waiver of these various state agency requirements. Administrative delays relating to multiple credentialing processes of the State and MCOs can impede a PPS's ability to provide access to care. (3) The PPS considered entering into contractual arrangements to serve as a credentialing agent for each entity, but that would create an administrative burden of negotiating numerous contracts. (4) The PPS does recognize that there are patient safety concerns in credentialing. As such it suggests that DOH, OMH, and OASIS could provide a combined list of elements for valid PPS wide credentialing that the PPS must include in its protocols. In the alternative, the PPS could

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#	Regulatory Relief(RR)	RR Response
		submit its credentialing policies to a combined review team with representatives of DOH, OMH, and OASIS for comment and retroactive approval.
19	10 NYCRR §§ 400.11(a) and 700.3(a)(1-2); 700.3(c).	(1) 2.a.ii project requirement 8 dealing with behavioral health screening protocols. (2) The PPS requests that the requirements of specific screening tools and specific staff training be waived to allow PPS providers to use alternate screening assessment tools approved by the PPS and to permit staff with alternate training to complete such assessments. (3) The PPS considered training all providers on the regulatory screening tools, but doing so would impose an undue administrative burden on the PPS due to cross disciplinary care approach of the PPS and an increased emphasis on behavioral health screening. (4) PPS providers will still complete the PASSR and take medically appropriate actions to work toward proper placement and level of care through policies and procedures. Clinton County: CVPH in Plattsburgh, expand outpatient behavioral health, substance abuse, pharmacy access This facility is located more than 50 miles away from the closest population center and Medical Village Franklin County: Adirondack Medical Center in Saranac Lake, expand outpatient behavioral health, substance abuse, and outpatient services add medical detoxification This facility is the only full service hospital in the Adirondack Park, it is over 50 miles from the closest proposed Medical Village and the closest hospital is almost 40 miles away and it is a Critical Access Hospital Essex County: Moses Ludington Hospital in Ticonderoga, relocate and expand primary care and access to ambulatory services Warren County: Glens Falls Hospital, expand access to crisis stabilization services and medical observation (1) 2.a.ii project requirement 8 dealing with behavioral health screening protocols. (2) The PPS requests that the requirements of specific screening tools and specific staff training be waived to allow PPS providers to use alternate screening assessment tools approved by the PPS and to permit staff with alternate training to complete such assessments. (3) The PPS considered training all providers on the regulatory screening tools, but doing so would impose an undue administrative burden on the PPS due to cross disciplinary care approach of the PPS and an increased emphasis on behavioral health screening. (4) PPS providers will still complete the PASSR and take medically appropriate actions to work toward proper placement and level of care through policies and procedures. Clinton County: CVPH in Plattsburgh, expand outpatient behavioral health, substance abuse, pharmacy access This facility is located more than 50 miles away from the closest population center and Medical Village Franklin County: Adirondack Medical Center in Saranac Lake, expand outpatient behavioral health, substance abuse, and outpatient services add medical detoxification This facility is the only full service hospital in the Adirondack Park, it is over 50 miles from the closest proposed Medical Village and the closest hospital is almost 40 miles away and it is a Critical Access Hospital
20	10 NYCRR § 710.1(c)(1-5,7) - add or change method of service	(1) 2.a.iv project requirement 1. (2) The PPS requests a waiver of the requirements of department approval of changes to the extent and kind of services to be provided at PPS Partner Article 28 facilities. The PPS requests a waiver of the factors for determining public need and the specific review process. The PPS requests a waiver of the requirement determination of public need and prior review and approval. The PPS requests that such approval be deemed

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#	Regulatory Relief(RR)	RR Response
		granted upon review and approval of this application and any supplemental filings regarding specific projects. This is necessary in order to convert outdated and unneeded hospital infrastructure and programs into other types of hospital based programs within a medical village. The process of applying for department approval would be time consuming especially given the number of requests within the next several years. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
21	10 NYCRR §§ 401.3(e), 670.1 (a-b), 710.1(c)(1)(v). - add or reduce bed capacity	(1) 2.a.iv project requirement 1. (2) The PPS requests waiver of need for new CON and need methodology for determination of public need and prior review and approval of decreases in bed capacity. The PPS proposes that approval of the DSRIP Project application be deemed approval of any bed reduction contained therein. However, the PPS requests that if prior review is required only that DOH only require letter notification going forward. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
22	10 NYCRR 401.3(g) - reduce or eliminate a service	(1) 2.a.iv project requirement 1. (2) The PPS requests that DOH reduce the notice period of 401.3(g) from 90 to 30 days. The reduced period will address the need to rapidly change and reconfigure services. This is necessary to allow changes to healthcare delivery in a timely fashion due to the high volume of such requests throughout the state. (3) There were no feasible alternatives. (4) The PPS does not see a patient safety concern because all decisions will be made deliberatively by experts in regional health care delivery and will be supported by the Community Needs Assessment data.
23	10 NYCRR 405.9 (f)(3)(ii)	(1) 2.b.viii project requirement 1. (2) The PPS requests a waiver of hospital-specific review criteria for post-hospital discharge planning needs and to permit PPS created rapid response teams to conduct the discharge review analysis for the facility. This is necessary because otherwise the Hospital will be required to have a duplicative service or review of decisions. This will permit PSS approved policies to be utilized and permit PPS rapid response teams to implement those policies. (3) The PPS considered having a hospital provider ratify the decision of the Rapid Response Team with regard to the necessary home care services, but that would duplicate an already existing service. In addition, it is not necessary because the Hospital will have the opportunity to review and participate in the development of the rapid response team protocols (4) Patient safety will not be impacted because hospitals will have representatives on the rapid response team and the rapid response team may be more familiar with available home care services than hospital personnel.
24	10 NYCRR 761.2 (b), 760.4, and 760.5.	(1) 2.b.viii project requirement 1. (2) The PPS requests a waiver allowing an automatic amendment to the operating certificate of any Home Health Agency within the PPS changing the service area, required under 10 NYCRR 761.2 (b), to include the entire PPS geographic area. Specifically, the PPS would like to expand the geographic service area to include additional areas located within the PPS area as needed based on the CAN analysis for accomplishing DSRIP objective without showing public need and methodology.

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		(3) The PPS considered simply requesting each Home Health Agency to expand its service area, but that could lead to confusion. As such, the PPS feels that having the Service Area defined in whole or in part as the PPS would be more efficient. This will allow all home health agencies in the PPS to see patients as is practically and medically appropriate without artificial boundaries preventing care. (4) The PPS does not see a patient safety issue because this simply provides an expedited process for what would be a necessary step for Home Health Agencies working in the PPS.
25	18 NYCRR 505.20(b)(3); 18 NYCRR 540.5.	(1) 2.b.viii project requirement 1. (2) The PPS requests a waiver of the requirement that the hospital have staff members responsible for discharge planning and arranging alternate care. The PPS requests that the Rapid Response Team be allowed to perform this function for the hospital. The PPS requests that this satisfy the requirements for the Hospital to obtain prior authorization under 18 NYCRR 540.5. (3) The PPS considered having a hospital provider ratify the decision of the Rapid Response Team with regard to the necessary home care services, but that would duplicate an already existing service. (4) Patient safety will not be impacted because hospitals will have representatives on the rapid response team and the rapid response team may be more familiar with available home care services than hospital personnel.
26	14 NYCRR 36.4(a)(1)	(1) 2.b.viii project requirement 1. (2) The PPS requests a waiver of the requirement that the hospital have staff members responsible for discharge planning and arranging alternate care. The PPS requests that the Rapid Response Team be allowed to perform this function for the hospital. (3) The PPS considered having a hospital provider ratify the decision of the Rapid Response Team with regard to the necessary home care services, but that would duplicate an already existing service. (4) Patient safety will not be impacted because hospitals will have representatives on the rapid response team and the rapid response team may be more familiar with available home care services than hospital personnel.
27	10 NYCRR 766.4(b)	(1) 2.b.viii project requirement 2; 3.a.ii project requirement ii. (2) The PPS requests that a waiver be granted expanding the ability of RNs, NPs, and PAs to write orders for admission and discharge of treatment in the home care setting. This is necessary because the PPS will be expanding the use of home care and the rate of necessary orders may outpace M.D. capacity. (3) Other options include providing a clarification as to the role of supervision by an M.D. over N.P.s and P.A.s in this context, but a limited expansion of scope for certain protocol driven orders is appropriate in this context especially with regard to orders regarding readmission for certain specific indicators. (4) The PPS acknowledges that there are certain patient safety concerns with this request, but if readmission decisions are made using PPS created protocols agreed to by relevant providers the risk will be mitigated.
28	10 NYCRR 763.7(a)(3)	(1) 2.b.viii project requirement 2 (2) The PPS requests that a waiver be granted expanding the ability of NPs, and PAs to write orders for treatment in the home care setting. The PPS requests that the requirement of signature be waived so that electronic review by an authorized practitioner can be utilized. The PPS also requests

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		that the NPs and PAs be treated as authorized practitioners regardless of supervision or countersignature by an MD. This is necessary for PPS activities because the PPS will be expanding the use of home care faster than the rate at which MD's can supervise and write orders. (3) Other options include providing a clarification as to the role of supervision by an M.D. over N.P.s and P.A.s in this context, but a limited expansion of scope for certain protocol driven orders is appropriate in this context especially with regard to orders regarding readmission for certain specific indicators. (4) The PPS acknowledges that there are certain patient safety concerns with this request, but if readmission decisions are made using PPS created protocols agreed to by relevant providers the risk will be mitigated.
29	10 NYCRR 405.9 (b)(2)	(1) 2.b.viii project requirement 3 (2) The PPS requests that a waiver be granted to allow the protocol to be applied to Medicaid patients only. Otherwise a literal reading of the regulation would lead to a situation where a patient could claim that he or she was denied admission into the hospital due to source of payment. (3) There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. (4) The PPS does not see this as a patient safety issue, but limitations could be imposed that guide medical necessity determinations by the PPS. To further reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
30	10 NYCRR 405.9 (f)(7)	(1) 2.b.viii project requirement 3 (2) The PPS requests that a waiver be granted to allow the PPS to allow it and its providers to only apply its protocol to Medicaid patients and thus, include source of payment as one of the factors considered in the decision to discharge to home care. (3) There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. (4) The PPS does not see this as a patient safety issue, but limitations could be imposed that guide medical necessity determinations by the PPS. To further reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
31	10 NYCRR 405.9(a)	(1) 2.b.viii project requirement 3 (2) The PPS requests a waiver of this regulation because it requires a transfer agreement. The PPS feels that the PPS clinical protocol could take the place of a transfer agreement in many situations because local health care providers, including hospitals and skilled nursing facilities will have signed on to the protocol. (3) The PPS could reference transfer agreements in its protocol. However, existing transfer agreements may limit the flexibility of the protocol and the PPS would not be a party to those agreements. Further, those transfer agreements likely have provisions that will conflict with the PPS protocol. (4) The PPS acknowledges that there are certain patient equity concerns, but to reduce the patient safety concern, clinical governance will include competent professionals to ensure that transfer protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.

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32	14 NYCRR 504.5	(1) 2.b.viii project requirement 3 (2) The PPS requests a waiver of this regulation so that it can develop a protocol that includes appropriate placement of patients leaving transitional care. This is necessary because this protocol is too inflexible for behavioral health services in an integrated delivery system. (3) The PPS could utilize certain parts of this regulation in its protocol, but the entire regulation is too inflexible for the PPS to develop an effective protocol that includes behavioral health transitional care. (4) This regulation does not directly effect patient safety. However, to reduce patient safety concerns the clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care. Moreover, such protocols may be submitted to OMH for prior review.
33	8 NYCRR 63.10(b)(2)	(1) 2.b.viii project requirement 7. (2) The PPS requests a waiver of this regulation so that a facility can be affiliated with a pharmacist through the PPS and a pharmacist can be credentialed for medication management as part of PPS wide credentialing. The regulation currently poses an impediment to this because it has strict requirements for clinical experience and facility affiliation. (3) The alternative is for the PPS to limit practice of medication management by pharmacists to only those providers with the regulatory experience requirements. The PPS feels that a better solution is to allow flexibility for the PPS to credential these providers in order to create an integrated delivery system that includes pharmacists. (4) The PPS recognizes patient safety concerns with the practice of medication management by pharmacists, but feels these concerns can be addressed by having protocols approved by the clinical quality and governance committee and having a process for oversight over pharmacists practice.
34	Propose Regulations on Telehealth and Telemedicine	The PPS requests that DOH finalize the proposed telehealth and telemedicine regulations.
35	10 NYCRR 401.3 (a)(1-3) and 710.1 (b) (c)(1-5, 7) - Change physical plant	(1) 2.a.iv project requirement 1 for each Medical Village; 3.a.i. - North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care, Adirondack Health's new Lake Placid Health and Wellness Center, Nathan Littauer hospital co-location with Family Counseling Center, Behavioral Health Services North (BHSN) and HHHN in Plattsburgh and Center for Well-Being in Morrisonville; 3.a.iv - Plattsburgh project; 4.a.iii project requirement 2. (2) The PPS requests that DOH grant a waiver of the requirement for determinations of public need and prior review and approval for construction projects contained in the DSRIP Project application. To the extent review is deemed necessary, the PPS requests that DOH only require limited review or architectural review only. (3) There are no feasible alternatives due to volume of applications. (4) The PPS does not feel that this regulation is a patient safety regulation.
36	10 NYCRR §§ 710.7(b-c) 710.7 (d) - Expedited Construction	(1) 2.a.iv project requirement 1 for each Medical Village; 3.a.i. - North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care, Adirondack Health's new Lake Placid Health and Wellness Center, Nathan Littauer hospital co-location with Family Counseling Center, Behavioral Health Services North (BHSN) and HHHN in Plattsburgh and Center for Well-Being in Morrisonville; 3.a.iv - Plattsburgh project; 4.a.iii project requirement 2. (2) The PPS requests that a waiver of the requirement that DOH advise the

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#	Regulatory Relief(RR)	RR Response
		PPS in writing that it can commence construction under 10 NYCRR 710.7 (d) and instead deem the submission under section 710.7(b-c) of the regulations complete after 15 days. This is necessary to ensure the ability to rapidly commence construction and renovation projects within the 3 year implementation period for DSRIP. (3) There were no feasible alternatives. (4) The PPS does not feel that this regulation is a patient safety regulation.
37	10 NYCRR 710.9 - Waive pre-opening inspection	(1) 2.a.iv project requirement 1 for each Medical Village; 3.a.i. - Franklin County: North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care, Essex County: Adirondack Health (AH) is developing a new Lake Placid Health and Wellness Center, Nathan Littauer hospital will co-locate BH with Family Counseling Center (FCC), Clinton County: Behavioral Health Services North (BHSN) and HHHN, Behavioral Health Services North (BHSN) and HHHN will partner to bring PCPs into the Center for Wellbeing (CWB); 3.a.iv Plattsburgh project; 4.a.iii project requirement 2. (2) The PPS requests that DOH expedite the pre-opening inspection and survey to within 15 days and allow the facility to remain open while non-patient areas are under review. This is necessary to ensure the ability to rapidly begin operation once renovation and building projects are complete. (3) There were no feasible alternatives. (4) The review process by DOH of this application will include patient safety requirements to be achieved.
38	10 NYCRR 703.6 - Construction Standards of Part Time Clinic	3.a.i. - North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care, Adirondack Health's new Lake Placid Health and Wellness Center, Nathan Littauer hospital co-location with Family Counseling Center, Behavioral Health Services North (BHSN) and HHHN in Plattsburgh and Center for Well-Being in Morrisonville; 3.a.iv - Plattsburgh project; 4.a.iii project requirement 2. (2) The PPS requests that DOH treat extension clinics and diagnostic and treatment centers as a part time clinics under 10 NYCRR 710.6 for purposes of review the construction and operating standards for each project. The waiver is necessary to aid the PPS during the transition phase. (3) There were no feasible alternatives. (4) The PPS recognizes that DOH may have patient safety concerns. As a result, the PPS requests that this be a time limited waiver simply to allow transition to diagnostic and treatment center and extension clinic standards for new integrated clinics.
39	Petition to CMS regarding co-location	The PPS requests that DOH petition CMS to allow DOH to waive CMS colocation requirements when it is deemed in the best interests of promoting the objectives of DSRIP.
40	14 NYCRR 599.4(r)	(1) 3.a.i the Franklin County: North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care; 4.a.iii project requirement 2. (2) The PPS will not utilize the proposed integrated service provider regulations because this will be a true shared space project and the Malone Health Center primary care will not be an established operator responsible for patient care by North Star Behavioral Health. The PPS requests a waiver of the requirement, under 14 NYCRR 599.4(r), increasing the number of mental health visits that a diagnostic and treatment center can conducting before it is required to be licensed. Instead, the PPS requests a more flexible approach that looks at the primary purpose for the facility. (3) The PPS considered licensure, but it would be unduly burdensome. (4) Patient safety will not be impacted because North Star Behavioral Health will be conducting the Mental Health screenings.

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#	Regulatory Relief(RR)	RR Response
41	10 NYCRR 401.1(g); 10 NYCRR § 710.1(c)(3)	(1) 3.a.i the North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care is an established provider that is moving its facility to a more central location; 4.a.iii project requirement 2. (2) The new extension clinic would generally be subject to administrative review under 10 NYCRR § 710.1(c)(3) and 401.1(g) the PPS requests that upon approval of this application the administrative review process be waived and the PPS be authorized to submit construction plans. (3) The PPS considered re-licensure, but feels that since this is simply a move to a more central location it would be unduly burdensome. (4) Patient safety will not be impacted because the review of the Project application establishes community need.
42	Integrated Provider – Proposed regulations	(1) 3.a.i Essex County: Adirondack Health (AH) is developing a new Lake Placid Health and Wellness Center; 4.a.iii project requirement 2. (2) The PPS will utilize the proposed integrated services provider regulations and apply to add mental health services at a new extension clinic. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible. (4) The PPS does not feel that this poses a patient safety issue.
43	10 NYCRR § 710.1(c)(3) - Establishment of Extension Clinic	(1) 3.a.i Essex County: Adirondack Health (AH) is developing a new Lake Placid Health and Wellness Center; 4.a.iii project requirement 2. (2) The new extension clinic would generally be subject to administrative review under 10 NYCRR § 710.1(c)(3) and 401.1(g) the PPS requests that upon approval of this application the administrative review process be waived and the PPS be authorized to submit construction plans. (3) There were no other feasible possibilities. (4) Patient safety will not be implicated because the project application is adequate review of the need for the project.
44	14 NYCRR 599.4(r)	(1) 3.a.i the Franklin County: North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care; 4.a.iii project requirement 2. (2) The PPS will not utilize the proposed integrated service provider regulations because this will be a true shared space project and the Malone Health Center primary care will not be responsible for patient care by Clinton County Mental Health and Addiction Services. The PPS requests a waiver of the requirement, under 14 NYCRR 599.4(r), increasing the number of mental health visits that a diagnostic and treatment center or extension clinic can conduct before OMH licensure is required for that space. (3) The PPS considered licensure, but it would be unduly burdensome. (4) Patient safety will not be impacted because North Star Behavioral Health, an OMH approved provider, will be conducting the Mental Health screenings.
45	10 NYCRR 401.3 (d)	(1) 3.a.i the Franklin County: North Star Behavioral Health (NSBHS) integration with Malone Health Center primary care; 4.a.iii project requirement 2. (2) The PPS requests a waiver of 10 NYCRR 401.3 (d) to permit the lease of Article 28 approved space to North Star Behavioral Health (NSBHS) without meeting the requirements of 10 NYCRR 401.1. This is necessary

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#	Regulatory Relief(RR)	RR Response
		because otherwise it could be deemed necessary for Malone Health Center to obtain an operating certificate over the treatment provided by NSBHS. This would unnecessarily delay the timely commencement of operations at Malone Health Center. (3) There are no other feasible options. (4) Patient safety will not be impacted because North Star Behavioral Health (NSBHS) is an experienced behavioral health provider that will be responsible for patient care.
46	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.i. - Hudson Headwaters Health Network will integrate services at all of its 15 primary care sites, expending on the existing pilot it has had success with at the main Queensbury primary care clinic. Four of these sites will receive behavioral health services via tele-medicine; 4.a.iii project requirement 2. (2) The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
47	14 NYCRR 599.4(r)	(1) 3.a.i. – Four Hudson Headwaters Health Network sites will receive behavioral health services via tele-medicine; 4.a.iii project requirement 2. (2) The PPS intends to utilize the proposed tele-psychiatry regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests a waiver of the 2000 visit per year requirement for these lower volume HHHN sites that are using telemedicine services. Providing regulatory certainty on this issue will allow HHHN to proceed with attempting to increase volume of behavioral health care provided without concern for the number of visits per year. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
48	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.i. - Glens Falls Hospital (GFH) will integrate behavioral health into four hub PCP practices; 4.a.iii project requirement 2. (2) The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
49	14 NYCRR 599.4(r)	(1) Nathan Littauer hospital will co-locate BH services at three of its primary care centers (Gloversville, Decker, and Perth). Family Counseling Center (FCC) will provide BH services; 4.a.iii project requirement 2. (2) The PPS will not utilize the proposed integrated service provider regulations because this will be a true shared space project and the Nathan Littauer hospital will not be responsible for patient care by Family

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		Counseling Center. The PPS requests a waiver of the requirement, under 14 NYCRR 599.4(r), increasing the number of mental health visits that a diagnostic and treatment center or extension clinic can conduct before OMH licensure is required for that space. (3) The PPS considered licensure, but it would be unduly burdensome. (4) Patient safety will not be impacted because Family Counseling Center is an experienced behavioral health provider that will be responsible for patient care.
50	10 NYCRR 401.3 (d)	(1) 3.a.i Nathan Littauer hospital will co-locate BH services at three of its primary care centers (Gloversville, Decker, and Perth). Family Counseling Center (FCC) will provide BH services; 4.a.iii project requirement 2. (2) The PPS requests a waiver of 10 NYCRR 401.3 (d) to permit the lease of Article 28 approved space to Family Counseling Center without meeting the requirements of 10 NYCRR 401.1. This is necessary because otherwise it could be deemed necessary for Nathan Littauer Hospital to obtain an operating certificate over the treatment provided by FCC. This would unnecessarily delay the timely commencement of operations at Nathan Littauer Hospital. (3) There are no other feasible options. (4) Patient safety will not be impacted because Family Counseling Center is an experienced behavioral health provider that will be responsible for patient care.
51	10 NYCRR 401.2 (b)	(1) 3.a.i HHHN will provide primary care services to patients at BHSN's center for wellbeing. (2) The PPS requests a waiver of the limitation that an operating certificate only permits activities on one site and requests that HHHN, a licensed Article 28 FQHC, be allowed to send primary care physicians to BHSN's site. This is necessary in order to ensure the smooth integration of primary care physicians working in Article 28 hospitals and extension clinics into the Behavioral Health context. (3) No alternatives are feasible for this project. (4) Patient care will not be impacted because HHHN will remain responsible for adequately credentialing its providers.
52	14 NYCRR 587.4 (7)	(1) 3.a.i HHHN will provide primary care services to patients at BHSN's center for wellbeing. (2) 14 NYCRR 587.4 (7) defines a provider of service as an entity that is responsible for operation of a program. The remainder of that part imposes certain requirements on providers of services for the operation of outpatient programs. The PPS requests a waiver of the definition of a provider of service to exclude primary care practices, like HHHN, from complying with the requirements of that subpart applicable to providers of services when co-located with a bona-fide provider of services. (3) The responsibilities of a provider of services could be split between the co-located institutions, but due to the limited responsibilities of HHHN for the primary care component this would be inappropriate. (4) This will not affect patient safety.
53	14 NYCRR 587.20 (a)	(1) 3.a.i HHHN will provide primary care services to patients at BHSN's center for wellbeing. (2) There is a requirement that there be psychiatric coverage in any outpatient program. 14 NYCRR 587.20(a) contains an ability to waive this requirement when there is no psychiatrist available, there is an appropriately trained physician, and there is a showing of need. The PPS requests an expansion of the waiver allowing physician coverage solely on the basis of a showing of need as presented in the Project Application. This is necessary in order to enlarge the scope of services at the facility and to allow limited mental health treatment by the providers of the primary care practice. In addition, it is needed regionally due to the shortage of psychiatrists. (3) The other alternative is use of DSRIP funding to recruit psychiatrists, but

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#	Regulatory Relief(RR)	RR Response
		the issue with doing so is that it will take time. It was rejected in favor of requesting this waiver allowing limited coverage by physicians and allowing the coverage to begin during the training period for the provision of mental health services. (4) There is a risk to patient safety in having non-psychiatrists provide coverage in a behavioral health clinic. However, this can be addressed by limiting scope of practice and developing care protocols. This protocols could be submitted to DOH.
54	10 NYCRR 401.2 (b) DOH provider at non-DOH facility	(1) 3.a.i GFH will provide primary care services to patients at its own behavioral health clinics. (2) The PPS requests a waiver of the limitation that an operating certificate only permit activities on one site and requests that GFH, a licensed Article 28 Hospital, be allowed to send primary care physicians to its behavioral health clinics to perform primary care services. This is necessary in order to aid the smooth integration of primary care physicians working in Article 28 hospitals and extension clinics into the Behavioral Health context. (3) No alternatives are feasible for this project. (4) Patient care will not be impacted because GFH will remain responsible for adequately credentialing its providers and the providers will be working within GFH.
55	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.i. - Glens Falls Hospital (GFH) will integrate primary care into its behavioral health clinics. (2) The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
56	14 NYCRR 587.20 (a)	(1) 3.a.i GFH will provide primary care services to patients at its own behavioral health clinics. (2) There is a requirement that there be psychiatric coverage in any outpatient program. 14 NYCRR 587.20(a) contains an ability to waive this requirement when there is no psychiatrist available, there is an appropriately trained physician, and there is a showing of need. The PPS requests an expansion of this waiver allowing physician coverage solely on the basis of a showing of need as presented in the Project Application. This is necessary in order to enlarge the scope of services at the facility and to allow limited mental health treatment by the providers of the primary care practice. In addition, it is needed regionally due to the shortage of psychiatrists. (3) The other alternative is use of DSRIP funding to recruit psychiatrists, but the issue with doing so is that it will take time. It was rejected in favor of requesting this waiver allowing limited coverage by physicians and allowing the coverage to begin during the training period for the provision of mental health services. (4) There is a risk to patient safety in having non-psychiatrists provide coverage in a behavioral health clinic. However, this can be addressed by limiting scope of practice and developing care protocols.
57	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.i. - Community, Work & Independence (CWI), Inc. will integrate PCPs into its Foothills behavioral health clinics. (2) The PPS intends to utilize the proposed integrated outpatient services

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		center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
58	14 NYCRR 587.20 (a) request waiver of psychiatric coverage	(1) 3.a.i CWI will provide primary care services to patients at its own behavioral health clinics. (2) There is a requirement that there be psychiatric coverage in any outpatient program. 14 NYCRR 587.20(a) contains an ability to waive this requirement when there is no psychiatrist available, there is an appropriately trained physician, and there is a showing of need. The PPS requests an expansion of this waiver allowing physician coverage solely on the basis of a showing of need as presented in the Project Application. This is necessary in order to enlarge the scope of services at the facility and to allow limited mental health treatment by the providers of the primary care practice. In addition, it is needed regionally due to the shortage of psychiatrists. (3) The other alternative is use of DSRIP funding to recruit psychiatrists, but the issue with doing so is that it will take time. It was rejected in favor of requesting this waiver allowing limited coverage by physicians and allowing the coverage to begin during the training period for the provision of mental health services. (4) There is a risk to patient safety in having non-psychiatrists provide coverage in a behavioral health clinic. However, this can be addressed by limiting scope of practice and developing care protocols.
59	10 NYCRR 405.9 (b)(2)	The regulation requested for waiver is 10 NYCRR 405.9 (b)(2). The Projects requested for: 2biv; 2bvii; and 3aii to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to reduce ED and inpatient hospital usage. There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
60	10 NYCRR 405.9 (f)(7)	The regulation requested for waiver is 10 NYCRR 405.9 (f) (7). The Projects requested for: 2biv; 2bvii; and 3aii to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to discharge patients to the appropriate post-acute setting. There are not alternatives to this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
61	10 NYCRR 405.9 (f)(3)(ii)	The regulation requested for waiver is 10 NYCRR 405.9 (f) (7). The Projects requested for: 2biv to permit providers to implement PPS-approved protocols for care transitions and care pathways, protocols to manage patients in appropriate settings and implement project goals to discharge patients to the appropriate post-acute setting. There are not alternatives to

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#	Regulatory Relief(RR)	RR Response
		this request since the source of patient is a factor in identifying patients who may be included in certain programs. To reduce the patient safety concern, clinical governance will include competent professionals to ensure that protocols are safe and appropriate and staff will be trained to focus on patient safety and Quality. Outcomes will be closely monitored to ensure that implementation does not have an adverse impact on patient care.
62	14 NYCRR 589.5(h)	(1) 3.a.iv project requirement 1 - Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center and also a satellite ambulatory detox at the Malone Crisis Stabilization Center. All other integrated providers of ancillary outpatient detox services are also impacted by this regulation and as such the PPS requests a general waiver of this regulation. (2) 14 NYCRR 822-3.1(11)(h) provides that programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service. This means that if a patient is already "admitted" or enrolled in an OASAS outpatient provider then, a satellite facility providing ancillary detox services is unable per the billing regulations, to bill for services. So, for example, if a patient is in the Malone Outpatient Program with St. Joseph's Rehab, and comes to/or is referred to the Crisis Stabilization Center in Malone for ancillary detox, the Crisis Stabilization Center would be unable to "admit" them to this separate outpatient satellite program. Given that the goal of the PPS is to expand access to such outpatient services to avoid inpatient treatment episodes the PPS requests that these regulations be waived. (3) There are no other feasible alternatives as this limits the ability to provide services to patients. (4) The PPS recognizes that there may be patient safety concerns. However, these concerns can be addressed by having effective OASAS approved protocols and having providers share records to prevent the provision of duplicate or excess care.
63	14 NYCRR § 599-1 - Proposed Integrated Services Center Regulations	(1) 3.a.ii. - Mental Health Association in Essex County will expand its existing one mobile crisis worker and one respite bed in Elizabethtown to add additional mobile crisis workers and 4 short-term crisis respite/ambulatory detox beds. (2) The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. The use of the regulations is necessary to allow the OASIS and OMH services to be provided in the same location. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
64	14 NYCRR §§ 589.5(h)(6)(i-ii)	(1) Mental Health Association in Essex County will expand its existing one mobile crisis worker and one respite bed in Elizabethtown to add additional mobile crisis workers and 4 short-term crisis respite/ambulatory detox beds. (2) The PPS requests a waiver of the requirements to seek prior approval from OMH for major changes in the program and physical location of a crisis stabilization program. This is necessary because in order to timely commence the increase in services at the Essex county site. (3) No alternatives are feasible for this project. (4) This will not impact patient safety because Mental Health Association in Essex County is an established provider that already has one bed.

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65	10 NYCRR 401.3 (d)	(1) 3.a.ii Citizen Advocates Inc. (CAI), North Star Behavioral Health (NSBH) will establish a full service 24 hour Crisis Stabilization Center (CSC) in the former Alice Hyde Hospital Nursing Home 1st floor. (2) Currently, the PPS believes that the property is still owned by Alice Hyde Hospital. As such, Alice Hyde will be leasing space to a provider with an OMH license. The PPS requests a waiver of 10 NYCRR 401.3(d) permitting the lease of its Article 28 space without meeting requirements of 10 NYCRR 401.1 et. seq. (3) The PPS is not aware of another option to accomplish this project. (4) This waiver will not impact patient safety because Citizens Advocates Inc. is an experienced provider that will be licensed on its own to provide services within the space at Alice Hyde Hospital.
66	14 NYCRR 551.6 (c)(1)(i)	(1) 3.a.ii Citizen Advocates Inc. (CAI), North Star Behavioral Health (NSBH) will establish a full service 24 hour Crisis Stabilization Center (CSC) in the former Alice Hyde Hospital Nursing Home 1st floor. (2) 14 NYCRR 551.6 (c)(1)(i) requires Prior Approval review of new projects for established providers in new locations. The PPS requests a waiver for prior approval review of this project upon approval of this Project Application. (3) The PPS considered requesting an expedited review, but felt that this was more appropriate due to the fact that the project will have already been approved.
67	14 NYCRR § 599-1	(1) 3.a.ii. - Mental Health Association in Essex County will expand its existing one mobile crisis worker and one respite bed in Elizabethtown to add additional mobile crisis workers and 4 short-term crisis respite/ambulatory detox beds. (2) This project will be collocated in a hospital, but it will also provide a mix of crisis stabilization services and withdrawal management services. The PPS intends to utilize the proposed integrated outpatient services center regulations once those regulations are promulgated. The PPS requests that those regulations be finalized as soon as possible. The PPS requests that approval of this project application be deemed approval of the integrated services center application under 14 NYCRR § 599-1.15(f). In the alternative, the PPS requests that any multiple agency reviews be consolidated into a single review process to expedite the authorization for this project. The use of the regulations is necessary to allow the OASIS and OMH services to be provided in the same location. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
68	14 NYCRR 551.6 (c)(1)(i)	(1) 3.a.ii. - crisis stabilization beds will be developed and housed at Glens Falls Hospital. (2) Glens Falls Hospital is currently licensed by OMH with both outpatient clinics and inpatient beds. 14 NYCRR 551.6 (c)(1)(i) requires Prior Approval review of new projects for established providers. The PPS requests a waiver for prior approval review of this project upon approval of this Project Application. The PPS requests this regulation to accelerate the process of implementing this project. (3) No alternatives are feasible for this project. (4) Patient safety will not be impacted due to compliance with the proposed regulations.
69	14 NYCRR 590.3; 14 NYCRR 590.4;	(1) 3.a.ii project requirement 9. (2) The PPS is going to establish a central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers. Currently, a hospital authorized under 9.39 is the only entity authorized to establish admission and discharge triage criteria as a Comprehensive Psychiatric Emergency Program. The PPS requests a waiver of this provision allowing the PPS Partners to develop

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		joint protocols for admission and discharge of psychiatric patients in a similar manner as a 9.39 hospital in a Comprehensive Psychiatric Emergency Program. (3) The PPS considered the alternative of simply having one of its constituent hospitals to house a Comprehensive Psychiatric Emergency Program. However, due to the size of the PPS, the PPS feels that a broader ability for PPS constituents to jointly administer a triage program is important. (4) While the regulation pertains to patient safety, the adoption of protocols that are approved by medical professionals regarding triage would take the place of hospital oversight.
70	14 NYCRR 810, 814, 814.7, 816, 822-2, 822-4	Developing detox services including ambulatory detox, short-term respite beds for detox patients, and an outpatient SUD site with integrated PCP team. Additional respite beds will be developed to serve crisis stabilization patients through project 3.a.ii—with overlap between patients, co-location will be beneficial to share costs and staff. This is a new facility and will require capital costs to repurpose, 7 RNs (3 shifts, 24/7), 7 certified recovery coaches (some part-time), 3 Credentialed Alcoholism & Substance Abuse Counselors (CASAC), 1 Social Worker, 0.5 medical director, 1 NP, and 4 admin/food service staff. The program will also need transportation services, appropriate referral protocols from local EDs, as well as linkages to inpatient services. The partners have identified an existing facility in Schuyler Falls that will be re-purposed.
71	14 NYCRR 810.6(a)(1)	(1) 3.a.iv project requirement 1 - BHSN will be creating an ambulatory detoxification clinic next to its OMH clinic in Morrisonville New York. (2) 14 NYCRR 810.6(a)(1) allows for administrative review of all applications for certification of certified services. An ambulatory detox facility is a certified service. The PPS requests a waiver of the requirement of administrative review and requests that certification be granted for this certified service based on this project application. (3) The PPS considered submitting the project for administrative review. However, the process of reviewing the project application is very similar to administrative review and will allow the PPS to proceed with the project more quickly and without the need for further filings. (4) The PPS feels that this is a low risk for patient safety issues because BHSN is already a licensed provider that providers a wide variety of similar programs.
72	14 NYCRR 814.7	(1) 3.a.iv project requirement 1 - BHSN will be creating an ambulatory detoxification clinic next to its OMH clinic in Morrisonville New York. (2) The PPS requests a waiver of the shared space requirements under 14 NYCRR 814.7. Putting two facilities in the same vicinity is beneficial because it will enable sharing of costs and staff. Moreover, the detox facility will utilize the services of primary care teams. Thus, to accomplish the goals of integration, the PPS requests that these regulations be waived for this project. The PPS also requests that OASIS petition CMS to allow it to further waive certain federal shared space requirements. (3) Given the goals of integration there are no other feasible alternatives. (4) This is not a patient safety issue.
73	14 NYCRR 800.2(a)(3) and 810.3	(1) 3.a.iv project requirement 1 - BHSN will be creating an ambulatory detoxification clinic next to its OMH clinic in Morrisonville New York. (2) The clinic will utilize the services of primary care teams. 14 NYCRR 822-2 provides that Chemical Dependence Outpatient and Opioid Treatment Programs are chemical dependence services. The PPS requests a waiver of the definition of provider of chemical dependence services 800.2(a)(3) and 810.3 as it applies to primary care teams practicing in this co-located facility. There is authority for this under 800.3(a) (3) The PPS considered whether the Integrated Outpatient Services regulations would be sufficient, but determined that these regulations do not

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#	Regulatory Relief(RR)	RR Response
		apply to a situation where a small team of primary care providers practices in an OASIS facility on an ongoing, but intermittent basis. (4) This will not impact patient safety because the detoxification component of the integrated facility can operate under the regulations without the primary care component meeting the same regulatory requirements.
74	14 NYCRR 810.6(a)(1)	(1) 3.a.iv project requirement 1 - by Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center. (2) 14 NYCRR 810.6(a)(1) allows for administrative review of all applications for certification of certified services. An ambulatory detox facility is a certified service. The PPS requests a waiver of the requirement of administrative review and requests that certification be granted for this certified service based on this project application. (3) The PPS considered submitting the project for administrative review. However, the process of reviewing the project application is very similar to administrative review and will allow the PPS to proceed with the project more quickly and without the need for further filings. (4) The PPS feels that this is a low risk for patient safety issues because BHSN is already a licensed provider that providers a wide variety of similar programs. Moreover, the DOH has had sufficient opportunity to review this application.
75	14 NYCRR 810.5(a)(1)	(1) 3.a.iv project requirement 1 - the Malone Outpatient Clinic Center will house ambulatory detox services run by Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS). (2) 14 NYCRR 810.5 requires full establishment for a provider that will establish any service where that provider has not been previously certified by OASIS to provide substance use disorder services. As Malone Outpatient Clinic Center will likely be a diagnostic and treatment center it will need to have an OASIS establishment to comply with 10 NYCRR 401.3 (d). As such, the PPS requests a waiver of these regulations as to the housing of this project by Malone Outpatient Clinic Center. (3) The PPS considered utilizing the integrated service provider proposed regulations. The issue is that this is a true co-location project where Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will be responsible for the ambulatory detoxification component. (4) The PPS does not anticipate an impact on patient safety.
76	14 NYCRR 800.2(a)(3) and 810.3	(1) 3.a.iv project requirement 1 - by Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center. (2) The clinic will utilize the services of primary care teams. 14 NYCRR 822-2 provides that Chemical Dependence Outpatient and Opioid Treatment Programs are chemical dependence services. The PPS requests a waiver of the definition of provider of chemical dependence services 800.2(a)(3) and 810.3 as it applies to primary care teams practicing in this co-located facility. There is authority for this under 800.3(a) (3) The PPS considered whether the Integrated Outpatient Services regulations would be sufficient, but determined that these regulations do not apply to a situation where a small team of primary care providers practices in an OASIS facility on an ongoing, but intermittent basis. (4) This will not impact patient safety because the primary care component will not be performing detoxification services.
77	14 NYCRR 814.7	(1) 3.a.iv project requirement 1 - Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center (2) The PPS requests a waiver of the shared space requirements under 14 NYCRR 814.7. Co-locating these services with outpatient services is beneficial because it will enable sharing of costs and staff. Moreover, the

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#	Regulatory Relief(RR)	RR Response
		detox facility will utilize the services of primary care practitioners. Thus, to accomplish the goals of integration the PPS requests that these regulations be waived for this project. The PPS also requests that OASIS petition CMS to allow it to further waive certain federal shared space requirements. (3) Given the goals of integration there are no other feasible alternatives. (4) This is not a patient safety issue.
78	14 NYCRR 810.6; 14 NYCRR 810.13 (c)(2)	(1) 3.a.iv project requirement 1 - Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center and also a satellite ambulatory detox at the Malone Crisis Stabilization Center. (2) Because Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will already have been established as an operator by OASIS an additional site of operation will only require administrative review under 14 NYCRR 810.6. The PPS requests that this be waived pursuant to the approval of this Project Plan. Similarly 14 NYCRR 810.13 (c)(2) allows satellite facilities, but requires that the operator be located within 1 county. The PPS requests that this requirement be waived for this project and for the entire PPS to allow greater ability to create satellite programs. (3) The PPS does not see a feasible alternative. (4) The PPS does not see a risk to patient safety because the program will be overseen by the same providers who will boost support for both projects in the Malone area simultaneously.
79	10 NYCRR §§ 401.3(e), 670.1 (a-b), 710.1(c)(1)(v).	(1) 3.a.iv project requirement 1 – reduction in inpatient beds at the Adirondack Health Medical Village and the establishment of 5 inpatient beds by St. Joseph's Rehab and Treatment Center. (2) The PPS requests waiver of the requirement for a new CON and need methodology for determination of public need and prior review and approval of decreases in bed capacity. Currently, Adirondack Health plans to reduce its inpatient bed capacity by 5 for inpatient detox beds. The PPS proposes that approval of the DSRIP Project application be deemed approval of any bed reduction contained therein. However, the PPS requests that if prior review is required that DOH only require limited review going forward. (3) There were no feasible alternatives. (4) The PPS does not see this as a patient safety regulation, but to the extent it is the CAN process has established the needed bed capacity in the region and the PPS Partners have taken a deliberative and medically sound approach to analyzing this change in beds.
80	10 NYCRR 401.3 (d)	(1) 3.a.iv project requirement 1 – reduction in inpatient beds at the Adirondack Health Medical Village and the establishment of 5 inpatient beds by St. Joseph's Rehab and Treatment Center. (2) The space where St. Joseph's Rehab and Treatment Center will run the outpatient beds is within property that will be otherwise licensed as an Article 28. As such, Adirondack Health will be leasing space to a non-DOH licensed provider. The PPS requests a waiver of 10 NYCRR 401.3(d) permitting the lease of its Article 28 space without meeting requirements of 10 NYCRR 401.1 et. seq. (3) The PPS is not aware of another option to accomplish this project. (4) This waiver will not impact patient safety because St. Joseph's Rehab and Treatment Center is an experienced provider that will be licensed on its own to provide services within the space at Alice Hyde Hospital.
81	14 NYCRR 810.6(a)(1); 14 NYCRR 810.13 (c)(2)	(1) 3.a.iv project requirement 1 – reduction in inpatient beds at the Adirondack Health Medical Village and the establishment of 5 inpatient beds by St. Joseph's Rehab and Treatment Center. (2) Because St. Joseph's Rehab and Treatment Center already is an established operator by OASIS an additional site of operation will only require administrative review under 14 NYCRR 810.6. The PPS requests that this be waived pursuant to the approval of the Project Plan. Similarly 14 NYCRR 810.13 (c)(2) allows satellite facilities, but requires that the

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#	Regulatory Relief(RR)	RR Response
		operator be located within 1 county. The PPS requests that this requirement be waived for this project and for the entire PPS to allow greater ability to create satellite programs. (3) The PPS does not see a feasible alternative. (4) The PPS does not see a risk to patient safety because the program will be overseen by the same providers who will boost support for both projects in the Malone area simultaneously.
82	14 NYCRR 810.5	(1) 3.a.iv project requirement 1 – reduction in inpatient beds at the Adirondack Health Medical Village and the establishment of 5 inpatient beds by St. Joseph's Rehab and Treatment Center. (2) 14 NYCRR 810.5 regulation requires full establishment for a provider that will establish any service where that provider that has not been previously certified by OASIS to provide substance use disorder services. As Adirondack Health is an Article 28 hospital it will need to have an OASIS establishment to comply with 10 NYCRR 401.3 (d). As such, the PPS requests a waiver of 14 NYCRR 810.5 as to the housing of this project at Adirondack Health. (3) The PPS considered utilizing the integrated service provider proposed regulations. The issue is that this is a true co-location project where Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will be responsible for the ambulatory detoxification component. (4) The PPS does not anticipate an impact on patient safety because this project will have been reviewed as part of the project application and establishment is not a patient safety regulation.
83	14 NYCRR 822-5.13(c)	(1) 3.a.iv project requirement 4. (2) The PPS requests that a waiver be applied to all providers identified and linked with the PPS to provide opioid medical maintenance of the requirements rom portions of Part 822 pertaining to counseling, and recordkeeping requirements. This is provided for in 14 NYCRR 822-5.13(c), but the PPS requests that the waiver be applied as a matter of course or that bulk notifications to OASIS be deemed sufficient. (3) The PPS did not find any other feasible options. (4) This waiver does not effect patient safety because the PPS will develop careful criteria for outpatient medication management and the waiver is a component of the current regulatory scheme.
84	14 NYCRR 822-5.13(b)	(1) 3.a.iv project requirement 4. (2) The PPS requests that a waiver be allowed for the specific requirements of this section pertaining to minimum OMM criteria. This will allow the program to be further expanded where it is appropriate. (3) The PPS did not find any other feasible options. (4) This waiver does not effect patient safety because the PPS will develop careful criteria for outpatient medication management and the waiver is a component of the current regulatory scheme.
85	14 NYCRR 816.5(c)	(1) 3.a.iv project requirement 5. (2) 14 NYCRR 816.5(c) contains requirements applicable to all chemical dependence withdrawal and stabilization services and specifically requires that there are certain policies and procedures that must be adopted by the governing body. The PPS requests a waiver of this requirement for programs under the PPS allowing those programs to adopt the PPS withdrawal management protocols without the need to have the governing body adopt the protocols. The governing body could instead adopt the PPS program by resolution. (3) The PPS considered having each governing body adopt each protocol, but felt that doing so would delay adoption and result in duplicative efforts. (4) The PPS does not feel that this presents a patient safety issue because the protocols would be developed by mental health professionals, would be uniform throughout the PPS, and the individual entities would have an opportunity to provide input on the protocols.
86	14 NYCRR 800.2(a)(3) and 810.3	(1) 3.a.iv project requirement 5

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		(2) The community based withdrawal management and detoxification protocols may be utilized by primary care physicians that either have a presence in outpatient programs as part of a primary care team or are simply part of the PPS that have a high volume of patients that could benefit from use of the protocol. The PPS requests a waiver from 14 NYCRR 800.2(a)(3) and 810.3 to make clear that such primary care physicians would not be deemed Opioid Treatment Programs. (3) The PPS considered whether the Integrated Outpatient Services regulations would be sufficient, but determined that these regulations do not apply to a situation where a small team of primary care providers practices in an OASIS facility on an ongoing, but intermittent basis. (4) This will not impact patient safety because the primary care component will not have any detriment on the detoxification component of the integrated facility.
87	10 NYCRR Part 790.16 (a-e); 10 NYCRR 792.1(c)	(1) 3.g.i. project requirement 2. (2) 10 NYCRR Part 790.16(a-e) mandates that there must be a determination of public need for a Hospice programs. This need methodology should be eliminated to facilitate PPS wide coverage. Similarly, the requirement to list a specific service area under 10 NYCRR 792.1(c) should be waived for each Hospice service working with the PPS to allow PPS wide service. (3) The PPS considered applying for service areas contiguous with the PPS, but the PPS size may change over time. This would impose an unnecessary burden for Hospice providers. (4) The PPS does not feel that this poses a patient safety risk because the DOH would still be able to determine the Hospice operating area by looking to the PPS operational area.
88	14 NYCRR 822-3.1(11)(h)	(1) 3.a.iv all projects. Specifically, Citizen Advocates (CAI) and North Star Behavioral Health Services (NSBHS) will run an ambulatory detox facility at the Malone Outpatient Clinic Center and also a satellite ambulatory detox at the Malone Crisis Stabilization Center. All other integrated providers of ancillary outpatient detox services are also impacted by this regulation and as such the PPS requests a general waiver of this regulation. (2) 14 NYCRR 822-3.1(11)(h) provides that programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service. This means that if a patient is already "admitted" or enrolled in an OASAS outpatient provider then, a satellite facility providing ancillary detox services is unable per the billing regulations, to bill for services. So, for example, if a patient is in the Malone Outpatient Program with St. Joseph's Rehab, and comes to/or is referred to the Crisis Stabilization Center in Malone for ancillary detox, the Crisis Stabilization Center would be unable to "admit" them to this separate outpatient satellite program. Given that the goal of the PPS is to expand access to such outpatient services to avoid inpatient treatment episodes the PPS requests that these regulations be waived. (3) There are no other feasible alternatives as this limits the ability to provide services to patients. (4) The PPS recognizes that there may be patient safety concerns. However, these concerns can be addressed by having effective OASAS approved protocols and having providers share records to prevent the provision of duplicate or excess care.
89	14 NYCRR 599.14(f); 14 NYCRR 588.5(e)	(1) 3.a.i and 3.a.iv all projects. Specifically, patients receiving outpatient treatment for mental health services at other providers or locations may be referred for treatment at the Crisis Stabilization Center. All other integrated providers of outpatient mental health services are also impacted by this regulation and as such the PPS requests a general waiver of this regulation. (2) 14 NYCRR 599.14(f) provides that a clinic may not be reimbursed for services provided to an individual currently enrolled in another licensed

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		mental health outpatient program for which Medicaid reimbursement is being made, unless certain exceptions apply. 14 NYCRR 588.5(e) provides that upon admission to a specific outpatient program, reimbursement shall be made for participation in that program only, unless certain exceptions apply. It further specifies that in no event shall a recipient be concurrently admitted to a clinic treatment program, a continuing day treatment program and an intensive psychiatric rehabilitation treatment program. The PPS requests that this provision be waived to allow "admission" in multiple outpatient clinics or under multiple "programs" so that a patient's care can be spread across those clinics according to PPS approved protocols. This is critical to the goal of reducing inpatient psychiatric hospitalization because it will allow patients to receive care in the most convenient location as consistent with PPS protocols and the level of care available. (3) There are no other feasible alternatives as this limits the ability to provide services to patients. (4) The PPS recognizes that there may be patient safety concerns. However, these concerns can be addressed by having effective OMH approved protocols and having providers share records to prevent the provision of duplicate or excess care.
90	Education Law §§ 6512, 6513, 6509(9), 6509-a.	(1) 2.a.i. and all projects dealing with creating an integrated delivery system. (2) The PPS requests that a regulation be promulgated clarifying that the activities of a PPS would not constitute the practice of medicine. In particular, the PPS requests clarification that the creation of a single system of credentialing within the PPS does not constitute the corporate practice of medicine. (3) The PPS considered applying for ACO licensure, but the activities of the PPS may not rise to the level of ACO activities because it may not seek out capitated payment arrangements at the PPS level. (4) Patient safety will not be impacted because the PPS has an effective governance structure with multiple providers that will be overseen by DOH and other agencies.
91	10 NYCRR § 401.3(a)	(1) 2.a.i. project requirements (4-7); 2.a.ii. project requirements (4-6); 2.a.iv. project requirements (4-6); 2.b.vii. project requirement 10; 2.d.i. project requirement 19; 3.a.i. project requirement 4; 3.a.ii. project requirement (2, 8, and 11); 3.a.iv. project requirement 9; 3.g.i. project requirement 6; and 4.b.ii project requirement 4. (2) The PPS requests a waiver to forgo prior review, regardless of cost, for acquisition, installation, and modification, and any capital outlay associated with purchase of EHR for PPS Partners. (3) The PPS considered going through the application process, but feels it would delay the reorganization of EHR within the PPS. (4) This provision does not pertain to patient safety.

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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.

AHI North Country Performing Provider System, LLC ("AHINCPPS") will be formed under the DSRIP Program that will begin operating under the Delegated Governance Structure. The AHI Board of Directors and Members worked closely with legal counsel to deliberate on the organizational structure best suited for the complex transformation of the North Country's health care delivery system. AHI will be the sole Member of AHINCPPS with certain powers reserved to it in the LLC Operating Agreement. Once formed and active, AHINCPPS will effectively engage over 400 DSRIP partners, including community stakeholders. The Delegated Governance model provides a more efficient implementation structure to manage a large number of partners across a rural setting and enable AHINCPPS to meet the goals of DSRIP. The model also allows for representation across the continuum of care on the Leadership Board based on well-defined criteria. The "Leadership Board" shall be comprised of Partners that have signed Participation agreements, Affiliates, community members, and beneficiaries. AHINCPPS will leverage the expertise of the regional Partners and Affiliates through nominations from the partner organizations to serve on various committees of the company. All Partners and Affiliates will continue to have an opportunity to provide input into the projects to be carried out by AHINCPPS through the Project Advisory Committee ("PAC"). A board of managers will govern

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the AHINCPPS, LLC referred to as the Leadership Board. The Leadership Board will provide oversight and strategic direction of PPS activities, maintaining a transparent governance process, exercising fiduciary duties and ensuring meaningful participation in the composition and control of AHINCPPS. Three types of managers will exist. 1.) Member Managers: AHI is a not-for-profit corporation directed by a Board of Directors and with certain powers reserved to Community Provider Inc., Adirondack Health, Glens Falls Hospital, and Hudson Headwaters Health Network. These members provide the capital to AHI and thus will have a role in financing the initial operations of the PPS. As such, these members are analogous to Capital Contributing Partners. 2.) Attributed Lives Managers: The entities with the most attributed patients will be represented on the Leadership Board. 3.) Nominated Managers: These positions shall include reps from across the continuum of care, inclusive of Behavioral Health, Home Health, Skilled Nursing Facilities, Community Based Reps, Individual Physicians, working with beneficiaries of the PPS.
AHI is well-positioned to serve as PPS Lead and Program Management office based on over 20 years of organizational experience convening stakeholders, collecting, analyzing and publishing data and developing and implementing programs to support the healthcare needs of the Adirondacks. AHI will build on its experience with the Adirondack Rural Health Network, Adirondack Medical Home Demonstration, AHI Health Home network, Hudson Mohawk Area Health Education Center and NYSOH Navigator programs to continue to support the State Health Innovation Plan (SHIP) and Prevention Agenda (PA) and promote the Triple Aim of better care, better population health and lower health care costs through stakeholder collaboration, data-driven prioritization and regional strategies for addressing health disparities. As the lead entity and fiduciary, the reserved powers provided to AHI in this model will support the functioning of AHINCPPS in a similar manner going forward.

The committees of the corporation (discussed in further detail below) are a critical component to its success. To a great degree, the committees will be responsible for effectively leveraging the human capital of the PPS Partners and Affiliates to make decisions for the PPS allowing for efficient governance and transparent representation.

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: **23_SEC021_AHINCPPS_LLC_OrganizationalStructure.pdf**

Description of File

AHINCPPS_LLC_OrganizationalStructure

File Uploaded By: ahidsrip

File Uploaded On: 12/22/2014 06:11 AM

***Structure 2:**

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

Once AHINCPPS is formed, the roles of the Leadership Board and the Members, and AHI shall be divided into three categories: (1) actions delegated to the Leadership Board that it may take on its own; (2) actions the Leadership Board may take with ratification by AHI; and (3) actions AHI may take on its own.

For routine decisions and decisions which directly impact the provision of care by AHINCPPS Providers and Affiliates, it is most efficient to have those decisions delegated to the Leadership Board outright. The actions delegated to the Leadership Board include:
1. Implementing the project plan and monitoring the milestones and metrics;
2. Hiring, removing, and supervising the employees, other than the CEO;
3. Creating committees and delegating authority to committees;
4. Approving any clinical policies and procedures for participants;
5. Appointing and replacing Nominated Managers;
6. Setting and approving terms and fees for the provision of services by or to the LLC; and
7. Coordination of services and expansion of the network.

In many instances, the special knowledge and experience of AHI will be helpful to have prior to the board adopting a plan of action. The actions requiring AHI Ratification include:
1. Community assessment of need, identify DSRIP strategies consistent with that need, developing project plans incorporating those

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strategies;
2. DSRIP funds distribution plan;
3. Grant applications;
4. Annual strategic planning;
5. LLC annual operating and capital budget and any change (greater than $500,000 per line item) to a budget previously approved;
6. Entering into any payer or managed care contract;
7. Individual expenditures in excess of twenty percent (20%) of the budget; and
8. All actions not explicitly reserved to the Leadership Board or AHI.

In a limited set of circumstances, the interest of AHI and AHI's members may be directly impacted by a decision of the PPS. In addition, certain Powers are reserved to AHI in order to break any deadlocks within the PPS. The actions reserved to AHI include:
1. Creation or undertaking any debt, long-term borrowing, or any encumbrance;
2. Admittance of a new Member and setting or accepting capital contributions on behalf of that new Member;
3. Any amendment to the Articles of Organization, Participation Agreements, and Operational Policies and Procedures necessary for legal compliance or to continue to receive the DSRIP funding;
4. Any amendment to Project Plans or Distribution Plans necessary to continue to receive DSRIP funding;
5. Any amendment to the articles of organization deemed necessary or appropriate by AHI;
6. Any decision to merge, consolidate, dissolve, or sell all or substantially all assets of the Company;
7. Hire and remove the President or CEO of the Company with or without cause; and
8. Appoint Member Managers, Attributed Lives Managers, and initial Nominated Managers.

***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.

Because the Partners and Affiliates will need to implement quality and clinical practices, it is critical that decisions regarding quality and clinical practices be made by the Partners and Affiliates. The Leadership Board will be delegated authority to make clinical and quality decisions, but it will delegate that authority at the outset to a Clinical Governance and Quality Committee.

With regard to its quality role, this committee will develop quality measures and systems. It will also conduct quality improvement planning in alignment with its clinical advisory role. Further, it shall periodically receive reports regarding quality assurance functions, as well as reports regarding efforts to improve all services at the Corporation.

With regard to its clinical advisory function, the committee's on-going role will be to identify gaps in care, identify opportunities to enhance value, share lessons learned from providers that have successfully executed improvement strategies, conduct training and provide strategic planning for providers that are struggling with the principles of care coordination and patient centered care (i.e. clinicians working as part of efficient teams, setting up workflows for clinicians with clear direction on roles and new responsibilities within practices, helping medical directors to run practices with business savvy, etc.).

***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.

Given the large number of providers involved in AHINCPPS, the Delegated Governance Structure will likely allow the greatest extent of legal integration possible. To facilitate adapting to change, the Leadership Board will have a Governance Committee that will be charged with overseeing the performance of the LLC and recommending operational strategies and structural changes based on the evolution of the projects, changes in leadership, the number and types of partners, as well as transformation towards value based reimbursement methodologies. It is anticipated that the operating agreement may need to be modified to: change the board structure; add new committees, and potentially delegate authority to committees as the PPS moves towards a high-performing integrated delivery system.

The LLC structure generally allows rapid changes in the structure of the organization; any recommendation for a change in governance structure will be discussed in the PAC and brought to the attention of DOH, if necessary.

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The provider network will become more integrated in two ways. First, the Governance Committee and the Clinical Governance and Quality Committee will seek out new providers to join the PPS within the region. Second, over time the goal is that the PAC will express its goals and issues to the Regional Committees and Project Committees so that all Partners and Affiliates will become more integrated into the AHINCPPS through these committees.

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.

Within section 2.1, we uploaded one file containing 3 pages that represent the PPS governing structure & process.
Page 1. PPS Organizational Structure
Page 2. Governance Members
Page 3. PAC Structure

Page 2 specifically outlines the members of the PPS governing body, as well as the roles and responsibilities of each member.

As portrayed in the PPS Organizational Structure, there will be a number of Standing, Project, and Regional Committee's that will be serving in an advisory capacity to the Leadership Board. The Standing Committee's will include:
o Executive,
o Governance,
o Audit, Compliance and Finance,
o Clinical Governance and Quality,
o IT & Data Sharing,
o Workforce,
o Community and Beneficiary Engagement Committee,

The Project Advisory Committee (PAC) Structure includes Regional Committee's comprised of members that participated on 5 Regional Healthcare Innovation Teams (RHITs) and Work Groups that contributed toward the development of project plans in the application phase. Project Committees will also be formed. It is recognized that the roles and responsibilities of each member will be further developed and defined within each committee's charter and scope.

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

Currently, AHI is in the process of forming the LLC, adopting the operating agreement, and choosing the initial board members. In the interim, an "Emerging PPS Steering Committee" (SC) has been established. Many of the Steering Committee members are individuals who previously participated in a Project Advisory Committee which determined the initial set of projects to include in the Project Design Grant Application this past spring. The SC is charged with endorsing the AHI DSRIP Project Plan Application (including the overall financial model, and the project selection, plans, and budgets), as well as the PPS Capital Restructuring Financing Program application. The functions of this interim structure will be transitioned to the AHINCPPS.

The governing body will be created in 3 steps. First, the Members of AHI will select their Managers to sit on the board. Second, AHI will conduct an analysis to see which Partners brought in the most patients to the organization. Each Partner with the most patients attributed to the PPS will select an individual to serve as its representative on the board. The Members' Managers will then pass a resolution nominating that representative to the Leadership Board. Third, in the first year the Members' Managers and the Attributed Lives Managers will consult with the PAC and then use best efforts to nominate appropriate Nominated Managers from the PAC. In the second year, the PAC will provide candidates for the Nominated Managers and then the entire Leadership Board will nominate those Nominated Managers. The CEO will be chosen by AHI and is a function reserved to the Member. All other officers will be chosen by the Leadership Board as a whole once it is fully constituted. The chairs of the committees, other than those who are Officers of the Company, as well as the

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committee membership, will be chosen by the Leadership Board as a whole once it is fully constituted.

***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.

AHI has demonstrated an extremely strong capacity to engage, convene and build consensus among a range of stakeholders that impact, or are impacted by, health and health care issues within the Adirondack region. To effectively achieve DSRIP goals, AHI reached into its database and invited over 400 partners including public health services, community health centers, hospitals, community mental health programs, emergency medical services, community-based organizations, community leaders and patient advocates to participate in PPS community forums. The PPS expanded its partners to include representatives from the New York State Nurses Association, Service Employees International Union, Civil Service Employees Association and the Teamsters. The PPS also includes NYSARC chapters from several counties, mental health, home health care, county offices for the aging and community health and both of the region's Area Health Education Centers.

***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 AHINCPPS organizational structure has been designed to support the board of managers with a Leadership Board that would have the power to design and manage the PPS while the Member Manager and Attributed Lives Managers would have the power to veto or approve.
As the governance was developed, PAC and Steering Committee representation was balanced and included members of the North Country Health Systems Redesign Commission (NCHSRC) as either leader of a PPS partner organization or to serve on AHI's Board of Directors. Their expertise on regional health systems redesign issues is vital in guiding the development of the PPS and the final project plan. Community based organizations will be represented on both the Leadership Board and in various committees.

***Process 5:**

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

Once the Leadership Board is formed there will be no distinctions between the powers of the various categories of managers. As noted previously, there are certain decisions that are delegated to the Leadership Board exclusively, certain decisions that require AHI member ratification, and certain decisions that the AHI Member can make on its own, but, to the extent possible, on the advice of the Leadership Board. The operating agreement provides that at the Leadership Board level:

- a quorum will be a simple majority and
- Decisions will be made by a simple majority vote.

The decisions that require Member ratification or Member actions will require approval of the Member according to its bylaws. However, the Leadership Board will have Member representatives on it to guide AHINCPPS in the direction of making decisions that will be acceptable to the Member. Moreover, most actions of the company will simply require member ratification.

***Process 6:**

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

In designing AHINCPPS, AHI chose to use a legislative branch model where the Leadership Board would have the power to design and the AHI Member would only have the power to veto or approve. Actions of Committees will require Leadership Board approval. In order to bring a recommendation to the Leadership Board, the Committee must approve the action by a majority vote of a quorum of its members. If consensus cannot be reached at the Leadership Board or on a Committee, issues will be sent to Committees, Special Committees, or the PAC to workshop the issue. Deadlocks at the committee level will be referred to the Leadership Board. As a final step, AHINCPPS would consult the appropriate regulatory body for guidance on actions necessary to continue the DSRIP program or other legally necessary actions. In that case, the Member has the ability to take any action necessary for legal compliance or to continue the DSRIP funding for AHINCPPS.

***Process 7:**

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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.

In order to facilitate the understanding of the above structure, all Partners will sign a participation contract which lays out the criteria for the selection of Nominated Managers and Attributed Lives Managers. The Nominated Managers will be responsible for communicating to the categories of providers they represent within the PAC to effectively act on behalf of their interests on the PPS Leadership Board. The Leadership Board will be responsible for ensuring effective communication and engagement with the community. Leadership Board and Committee meetings will be posted to an online calendar. Also, descriptions of the major projects and decisions that the Leadership Board has agreed to undertake will also be on the PPS website. Where legally permissible, all meeting materials will be posted on the PPS website for easy access and transparency of activities for Partners, Affiliates, and the community. Finally, open invitations to webinars and periodic meetings will be setup by the PPS.

***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 AHINCPPS governance structure has been designed to ensure community and beneficiary representation on the board or within the committee structure. A community or beneficiary representative will represent one vote on the Leadership Board. AHINCPPS will also have a Community Engagement Committee. This committee will be charged with developing strategies to communicate AHINCPPS's population health improvement activities to the community. The committee will also develop strategies to market and advertise the activities and services of the PPS to target populations in a HIPAA compliant manner.

Throughout the life of the DSRIP program there will be regional town hall meetings, community focus forums, and dissemination of information through AHI's various programs and initiatives.

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.

AHI established a PAC early in the planning process.. In April of this year, we held 3 informational meetings, open to the all interested stakeholders, at various locations across the service area. Over 150 individuals representing 70+ unique organizations attended. These contacts formed the basis of a distribution list that was subsequently built to ensure all health care and community organizations were included. This list received a survey requesting PAC nominations.
The survey resulted in a group of 25 people that formed the first iteration of the PAC. Membership was based on nominations, with the additional consideration of ensuring geographic representation. Membership included hospitals, pediatrics, primary care, prevention agencies, behavioral health, public health, long-term care, home care, and substance abuse treatment providers. The PAC was charged with producing DSRIP project recommendations for the Project Design Grant application. In May and June, the PAC met three times and discussed the project options and made recommendations based on: community health needs, potential number of Medicaid beneficiaries affected, feasibility, regulatory issues, and cost.

In September, we held two large forums, one in Lake Placid and one in Queensbury. All potential partners, and their selected workforce representatives, were invited. At these meetings, we proposed the establishment of five Regional Health Innovation Teams (RHITs), and proposed transitioning the early PAC group into an "Interim Steering Committee" (SC). The RHITs are local planning groups that make recommendations to the Interim Steering Committee, which in turns makes recommendations to the AHI Board and Members. Together, the RHITs and the Interim Steering Committee provide the PPS with the PAC function. To facilitate decision-making, the 27 member initial PAC was pared down to a 20 member SC. The group includes executives from hospital (5), primary care (2), public health and/or prevention (4), behavioral health (4), long-term care, home and community-based services (5). Note that the hospital systems in this region are also major providers of primary care services. In addition, we will continue to hold large stakeholder forums to ensure communication across other sectors (education, business, etc.) that are not represented in the RHITs and the SC.

***Committee 2:**

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

As described above, the PAC has already transitioned to an Interim Steering Committee (SC). We changed the name of the group from "PAC" to "Interim Steering Committee" to emphasize the group's strong role in guiding decision-making. The SC is charged with endorsing the Project Plan Application (including the overall financial model, and the project selection, plans, and budgets), as well as the AHI PPS Capital Restructuring Financing Program application. Given that the PPS is not yet incorporated, technically the SCs role is advisory, however, the AHI Board and Members have to date approved all SC recommendations. When the PPS is incorporated, we anticipate the SC will largely become the Leadership Board.

In addition to the SC, the PPS benefits from recommendations and advisement from the Regional Health Innovation Teams described previously (RHITs) and from public stakeholder forums. The AHI North Country PPS will continue to host public regional forums at least twice annually.

***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 first iteration of the PAC quickly transitioned to the Interim Steering Committee (SC). The SC met five times over the course of the past two months. AHI's CEO and Board of Directors, in consultation with legal counsel, prepared the proposed Governance models and organizational structures, which SC discussed and ultimately endorsed. The SC reviewed the CNA and approved final project selections to align with the CNA.

We also involved the much broader groups that met in September (all partners and their workforce representatives), in development of the organizational structure and the CNA. At these meetings, we proposed the establishment of an LLC, and outlined the structure of the five Regional Health Innovation Teams (RHITs) and Interim Steering Committee (SC). Attendees also reviewed preliminary CNA results, discussed, and contributed to the final version (a summary slide set is available on our website).

***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.

We ensured sufficient representation through the nomination process described previously, that resulted in the formation of the initial PAC. Given the need to keep the PAC (and eventually the Interim Steering Committee) to a reasonable number to facilitate decision-making, we felt it was important to provide more opportunities for direct representation in the planning and implementation process. As such, we established the Regional Health Innovation Teams (RHITs) to provide another forum for involvement that would ensure engagement with a broader set of providers and stakeholders. The RHITs are local planning groups, each of which includes representation from across the care continuum in the "naturally occurring care network" they represent. The composition of the RHITs is not final, during the process of developing detailed implementation plans, we anticipate additional RHIT members will be identified and invited to join.

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.

Lottie Jameson, V.P. of Regional Planning and Development for Adirondack Health Institute, will be the designated interim compliance official for the PPS. AHI maintains a compliance program in accordance with New York State Social Services Law 363-d and has submitted the required annual compliance program certifications with OMIG since the inception of the program. Currently, Ms. Jameson oversees the AHI compliance program.

During the first quarter of 2015 recruitment efforts will begin for an experienced Compliance Officer that has no ties to any AHINCPPS partners. The position will be submitted by the Member Managers to the Leadership Board to identify the Compliance Officer for

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AHINCPPS. The Compliance Officer will report to and have a direct line of communication to the Leadership Board.

***Compliance 2:**

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

A PPS-specific compliance program plan that is consistent with OMIG's requirements is under development and will include mechanisms for identifying and addressing compliance problems related to PPS' operations and performance. The Compliance Officer will develop this plan in conjunction with the Audit, Compliance, and Finance Committee that will be formed as part of the PPS governance team. This combined charge will include the adoption and implementation of the compliance program tailored to DSRIP and ensuring that the PPS complies with the applicable COPA requirements.

The Audit, Compliance, and Finance Committee in conjunction with the Compliance Officer will hire and supervise one or more Compliance Managers that will be tasked with auditing Partners on program performance and reporting. This responsibility ensures that providers are accurately reporting DSRIP project metrics/milestones. The Compliance Plan will also consist of a prospective audit process for provider organizations that have been identified for more focused reviews prior to reporting to DOH.

***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.

The compliance plan that is under development will also contain an education and training component. The PPS Compliance Training Program being developed will initially leverage existing compliance training programs from AHI and its member organizations. Additionally, existing training programs within other PPS member organizations will be referenced in the development of the plan to ensure that it is tailored to the needs of the community and adequately serves the PPS population.

***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.

The Compliance Plan will contain a whistleblower policy that will have a hotline where employees, Partners, Affiliates, community members and patients can report compliance issues. The whistleblower policy will be circulated to all Partners for distribution when they sign their Participation contract. AHINCPPS will provide Partners and Affiliates with draft language to post on their websites that will briefly describe the AHINCPPS compliance program and the methods in which a compliance report may be submitted. Compliance reports may be submitted to any employee or supervisor of a Partner organization, Affiliate, and/or DOH. The Compliance Officer's number and the hotline number will also be posted on the AHINCPPS website.

Instructions will be provided to PPS member organizations that stress the importance of submitting all received reports to the Compliance Officer for investigation. The Compliance Officer will also monitor the hotline as is necessary and prudent based on average call volume. If a report pertains to Clinical or Quality issues, then the Compliance Officer shall report the issue to the Clinical Governance and Quality Committee to take appropriate actions.

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.

AHINCPPS Finance Committee charter and membership is being developed in conjunction with the formation of the AHINCPPS. In the interim the PPS Finance Workgroup was formed.

AHINCPPS Finance Committee tasks include:

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• Develop and approve policies and procedures for oversight and accountability of funds flow, budgeting and reporting of financial and non-financial metrics.
• Measuring and monitoring performance of the PPS and partners, setting specific target metrics for identifying financial issues requiring escalation to the Executive body and monthly reporting to the Executive Board.
• Develop formal process to identify and address financially fragile partners and partners at risk for becoming fragile.
• Collaborate on pay-for-performance initiatives, contract negotiations, restructuring and capital planning with appropriate committees and partners.

AHINCPPS Leadership Board tasks include:
• Ensure Finance Committee provides relevant, timely information
• Resolving issues escalated by the Finance Committee with specific tasks identified for financially fragile partners.

***Organization 2:**
Please provide a description of the key finance functions to be established within the PPS.

AHINCPPS Finance Committee (AHI SC Finance Workgroup in interim) is responsible for ensuring the procedures below are in place and effective and in compliance with the governance documents, in specific decision making and delegation of authority. Key fiscal procedures to be established to process and ensure internal controls related to:
• Working capital including cash receipts and disbursements including approval limits
• Contractual obligations, including contract review and compliance
• Data and reporting accuracy and protection of personal health information
• Define and track the financial metrics set for the PPS and partners
• Administer and report on DSRIP funds allocation and distribution
• Compliance with internal PPS and external reporting requirements and standards
• Employee compensation, including compliance with IRS regulation and Executive Order #38

AHINCPPS LLC will receive DSRIP funds beginning April 1, 2015

AHI, Inc., has specific fiduciary responsibility to the AHINCPPS as outlined in the governance documents

***Organization 3:**
Identify the planned use of internal and/or external auditors.

Audit/compliance committee

An independent external audit firm will be engaged to audit compliance of the finance functions related to DSRIP on an annual basis. Audit results to be provided to the Finance Committee for review and communicated with the Executive Committee. Identified issues or concerns will be addressed timely and procedures updated as required to ensure ongoing compliance.

Special audits may be initiated for identified risks or as requested by the governance of the PPS or as required for compliance with any contractual or governmental requirement.

A DSRIP Program Manager position to be created with the specific responsibilities for managing the DSRIP project such as: Managing the PPS Partner relationships and performance including validation of reported results: Monitoring DSRIP budget and funds flow; and Reviewing/approving DSRIP-related expenditures in accordance with approved policies.
The AHINCPPS finance function will provide resources to support the Program Manager and all internal and external audit reporting requirements.

***Organization 4:**
Describe the PPS' plan to establish a compliance program in accordance with New York State Social Security Law 363-d.

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A PPS-specific compliance program is under development for approval by the AHINCPPS Leadership Board with an expected completion date of April 1, 2015. At a minimum, the PPS's Corporate Compliance Plan will include the establishment of a committee responsible for the receipt/resolution of regular compliance reports and reporting to the PPS Executive Body as well as individual PPS providers, as deemed appropriate. A DSRIP Compliance Manager will be responsible for auditing PPS Partners on program performance and reporting to ensure that providers are accurately reporting DSRIP project metrics/milestones. A prospective audit process will be implemented for provider organizations that have been identified for more focused reviews prior to reporting to DOH. The DSRIP Compliance Manager will also be responsible for ensuring that the PPS complies with the DSRIP program as well as the applicable COPA requirements.

Section 2.6 – Oversight:

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

***Oversight 1:**
Describe the process in which the PPS will monitor performance.

The AHI North Country PPS (AHINCPPS) is committed to providing the highest quality care to Medicaid members and through its technology capabilities will provide its participating providers with tools to ensure needed evidence –based preventive and chronic disease management care is optimized, beneficiary engagement is achieved and care coordination resources are utilized where needed. PPS specific measures will be developed by the Clinical Governance and Quality Committee (CGQC) with both Finance and Information Technology Committee input. Additionally, aggregate reports will allow clinicians and their care team members to know what process and outcomes measures need to be achieved.

Participating Partner Agreements will outline expected minimum level of performance of the Partner required to meet AHINCPPS DSRIP goals and targets.

***Oversight 2:**
Outline on how the PPS will address lower performing members within the PPS network.

AHINCPPS will establish a Clinical Governance and Quality Committee (CGQC) to regularly review the compliance and the performance of its participating clinicians in regards to AHINCPPS quality assurance and improvement program. Where needed, this committee will work collaboratively with participating partners who are out of compliance. Where additional support is needed, AHINCPPS team members will be dispatched to provide assistance to meet expectations. It is anticipated that there interventions will enhance the partners ability to achieve expectations over time.

***Oversight 3:**
Describe the process for sanctioning or removing a poor performing member of the PPS network who fails to sufficiently remedy their poor performance. Please ensure the methodology proposed for member removal is consistent and compliant with the standard terms and conditions of the waiver.

The Operating Agreement for AHINCPPS delegates the power to enforce the terms of the Participating Partner Agreements and to add or renew partners to the Leadership Board. One of the purposes of executing a Participating Partner Agreement is to have a contractual basis to sanction or remove poorly performing providers from AHINCPPS.

The Leadership Board will delegate its role in making determinations regarding termination of these contracts to the Executive Committee and Clinical Governance and Quality Committee (CGQC).

Those committees will develop a policy regarding peer review and procedures for poorly performing Partners that provides for the following:

- the CGQC will receive reports regarding poorly performing Partners;
- the CGQC will investigate those reports, create a summary of the investigation, and schedule a time for a meeting;
- the Partner will be asked to attend the meeting and will be provided a copy of the summary;
- the meeting will be confidential;
- the CGQC will announce a decision after weighing the evidence;

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• if the CGQC requests remediation, then the Partner will have 30 days to submit a plan of action; if the CGQC requests termination of the Participating Partner Agreement, then the matter will be submitted to the Executive Committee;
• the plan of action will have a reasonable implementation period, periodic landmarks, and may include financial penalties;
• if Partner does not fulfill the plan of action or fails to submit a plan of action, then the CGQC will request termination of the Partner; and
• in an closed session, with the Partner invited to attend and advocate for him/herself, the Executive Committee will review the request for termination, the investigation summary, and any plan of action and vote by a 2/3 majority to terminate the Participating Partner Agreement or refer the Partner back to the CGQC for a new or amended plan of action.

***Oversight 4:**
Indicate how Medicaid beneficiaries and their advocates can provide feedback about providers to inform the member renewal and removal processes.

There will be several opportunities for Medicaid beneficiaries and their advocates to provide feedback about providers. AHINCPPS will utilize surveys to poll Medicaid beneficiaries about their experience with the PPS and providers. This will likely be done on a per provider basis. AHINCPPS will also have a website where Medicaid beneficiaries can submit reports regarding the quality of care of Partners. Finally, Medicaid beneficiaries will be able to utilize the compliance hotline.

***Oversight 5:**
Describe the process for notifying Medicaid beneficiaries and their advocates when providers are removed from the PPS.

If a provider is removed from the PPS, then the Participating Partner Contract will have a provision that requires the Partner to provide notice to its patients as is reasonable. For smaller providers, reasonable notice will likely be done through a letter. For larger providers, where a letter is not feasible, notice will likely be accomplished by removing references to the PPS on the Partners' website. The PPS will also have a website where all of the Partners are listed. When a Partner is removed, the PPS will promptly remove the provider from that list.

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.

AHI began this needs assessment in the summer of 2014, gleaning data from multiple data sources as suggested in the New York State Department of Health's June Guidance for Conducting Community Needs Assessment Required for DSRIP Planning Grants and Final Project Plan Applications. AHI hired JSI in November 2014 to write the needs assessment document, drawing from AHI's work to date. JSI used this same Guidance from the NY State DOH to structure the needs assessment report. To develop the tables, JSI drew on the listing of major resources and data sources contained within the Guidance, particularly datasets made available through NY DOH, BRFSS, and national datasets. Additionally, JSI drew upon the report Toward an Integrated Rural Health System: Building Capacity and Promoting Value in the North Country, developed in April 2014 by the North Country Health Systems Redesign Commission (NCHSRC). This particular report was very helpful given its recent completion, comprehensive scope, and its collaborative and publicly transparent process of development. The NCHSRD report does include Jefferson and Lewis counties but not Saratoga or Fulton Counties. When data or findings are cited from this report, a notation is included with these exceptions.
JSI was responsible for developing the data tables included in the needs assessment, interpreting this data, drawing from the NCHSRC Report, and writing the majority of the needs assessment report. The AHI NC PPS added additional information gleaned from its knowledge of the area as well as input from the multiple PAC, workgroup, and stakeholder meetings convened to put forth the AHI North Country PPS application. The AHI NC PPS also relied on a number of surveys conducted for the Community Health Assessment process in 2013. Most notably the survey conducted by the Adirondack Rural Health Network, a survey of community-based organizations, and surveys specific to needs of Saratoga and St. Lawrence Counties.

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

Quantitative data was collected from public sources through federal/state portals. Data was also collected from previous needs assessments. Following is a list of these sources:

Federal:
- Census Bureau for demographic information and grocery store, recreation, and physical facility access
- Health Resources and Services Administration, Health Professional Shortage Areas and Area Health Resource Files for provider shortages

New York State:
- Vital Statistics for premature deaths
- E-BRFSS for population health indicators
- County Prevention Agenda Data for population health indicators

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- SPARCS – for hospital admission and emergency room utilization
- County Health Assessment Indicators for population health indicators
- Medicaid Beneficiaries Chronic Disease Admissions/ER Visit Reports
- Medicaid DSRIP Dashboards for Adult/Pediatric Prevention Quality Indicators and Potentially Preventable ER Visits
-DSRIP Clinical Process of Quality Measures Chartbooks and FQHC Uniform Data System Report for select quality measures
-NYS School Survey for chemical dependency among youth
-NYS Adult Household Survey for chemical dependency among adults
-NYS Heroin Study for opiate addiction
-Office of Alcohol and Substance Abuse Services for Chemical Dependency Treatment Capacities

Local:
-Survey of community service providers to understand prevalent health issues
- Survey of residents of Saratoga County by Saratoga Hospital
- Survey of St. Lawrence County

Information from already published assessments was also compiled to confirm findings, including:
- County Health Department Assessments
- North Country Health Systems Redesign Commission. Toward an Integrated rural Health System: Building Capacity and Promoting Value in the North Country. April 2014.

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	13	9
2	Ambulatory surgical centers	1	0
3	Urgent care centers	5	3
4	Health Homes	4	2
5	Federally qualified health centers	25	2
6	Primary care providers including private, clinics, hospital based including residency programs	458	238
7	Specialty medical providers including private, clinics, hospital based including residency programs	647	277
8	Dental providers including public and private	322	15
9	Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based	13	9
10	Behavioral health resources (including future 1915i providers)	284	95
11	Specialty medical programs such as eating disorders program, autism spectrum early	1	0
12	diagnosis/early intervention	9	0
13	Skilled nursing homes, assisted living facilities	36	22
14	Home care services	15	6
15	Laboratory and radiology services including home care and community access	14	10

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#	Provider Type	Number of Providers (Community)	Number of Providers (PPS Network)
16	Specialty developmental disability services	14	7
17	Specialty services providers such as vision care and DME	175	0
18	Pharmacies	176	0
19	Local Health Departments	9	6
20	Managed care organizations	8	0
21	Foster Children Agencies	9	3
22	Area Health Education Centers (AHECs)	2	0

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

***Infrastructure 2:**

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

The Commission for Health Care in the 21st Century report and the more recent North Country Health System Redesign Commission report outline the regional reliance on institutional providers such as hospitals and nursing homes and the insufficient capacity of home and community based services. The PPS's CNA reaffirms these findings.

Providers in the PPS have engaged in a number of transformational initiatives over the past 5 years in an effort to realign capacity. The Adirondack Region Medical Home Pilot, Health Home, and Adirondacks ACO are improving access to primary and preventive care. These initiatives have had an impact as evidenced by the trend in declining hospital occupancy rates since 2011. The data shows that there continues to be a need to build on these programs and increase access to primary care. Primary care use by Medicaid beneficiaries in the PPS region tends to be slightly lower than NY State averages. In 5 counties, ER use is at least 5 percentage points higher than the NYS average, most notably in the 5 rural counties that are designated Health Professional Shortage Areas indicating a need for more capacity. Behavioral health and substance abuse organizations are not well distributed throughout the region and results from a regional survey indicate that both mental health (MH) and substance abuse (SA) are perceived as second only to obesity in emerging health issues for the region. In the PPS' service area mental diseases and disorders and substance abuse conditions accounted for 49% of inpatient admissions and 58% of ER visits. By creating crisis stabilization programs, ambulatory detoxification programs, a medical detoxification program and enhancing prevention in the communities through DSRIP will realign the capacity to address community need.

The data points to both the documented shortage of MH providers and the fragmentation between MH, SA and primary care. Based on NY State data, 68% of adults with MH disorders also have a medical disorder, and 29% of adults with a medical disorder also have a MH disorder. The PPS needs to breakdown the historical separation of these services due to regulatory restrictions for sharing health information between these types of providers, the siloed nature of funding for these two streams of care, the different facilities in which they exist, and stigma related to behavioral health disorders.
To decrease the reliance on institutional providers for care in the rural areas and transform to more preventive and home based services, the AHI North Country PPS will create four medical villages throughout the service area. Hospitals have committed to reducing 31 staffed beds in the PPS region. This number is based on a 25% reduction in Medicaid inpatient admissions. The hospitals will add or expand needed ambulatory services in the communities, including building on the 15 certified home health agencies in the area and the designated Health Homes. The Home Health Agencies will need to be strengthened to enable serving additional capacity. This will begin the process of controlling the reduction of institutional care but insure that needed services remain in the communities.

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:**

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

DSRIP PPS Organizational Application

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

#	Resource Type	Number of Resources (Community)	Number of Resources (PPS Network)
1	Housing services for the homeless population including advocacy groups as well as housing providers	40	0
2	Food banks, community gardens, farmer's markets	61	0
3	Clothing, furniture banks	0	0
4	Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges)	10	1
5	Community outreach agencies	52	6
6	Transportation services	14	1
7	Religious service organizations	64	3
8	Not for profit health and welfare agencies	129	90
9	Specialty community-based and clinical services for individuals with intellectual or developmental disabilities	21	8
10	Peer and Family Mental Health Advocacy Organizations	15	1
11	Self-advocacy and family support organizations and programs for individuals with disabilities	3	0
12	Youth development programs	21	5
13	Libraries with open access computers	45	0
14	Community service organizations	66	0
15	Education	73	0
16	Local public health programs	57	7
17	Local governmental social service programs	48	0
18	Community based health education programs including for health professions/students	14	4
19	Family Support and training	17	6
20	NAMI	0	0
21	Individual Employment Support Services	14	1
22	Peer Supports (Recovery Coaches)	54	0
23	Alternatives to Incarceration	4	1
24	Ryan White Programs	2	2
25	HIV Prevention/Outreach and Social Service Programs	14	2
26	Local or State Government Services	216	19

***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.

A key goal of the DSRIP program is to identify community-based resources and create links between health care-focused and community resources. Community resources were identified (1) by participants in the AHINCPPS's PAC, (2) by the Prevention Agenda Partner listing made available by NY State and (3) by gleaning information from individual county and hospital health needs assessments prepared in 2013. Several of the counties and hospitals conducted focus groups and/or key informant interviews with health care providers and/or consumers to supplement and augment data collection.

Focus groups and interviews identified non-medical services including organizations that provide food bank services, housing, refugee assistance, transportation, advocacy, peer support, and community health education. Other community resources named were YMCAs, churches, libraries, schools, youth programs, local universities and colleges, the military, county transportation departments, Boys & Girls Club, Community Supported Agriculture, neighborhood centers, farmers markets, police and fire departments.

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The 9 county health departments serve many functions including surveillance, service delivery, screening, health education, and health promotion. An important function is as a coalition builder for community health organizations. These established coalitions share information and resources, set priorities, and coordinate activities across the spectrum of stakeholders to achieve common goals. The coalitions can be leveraged to implement DSRIP project goals. Coalitions in the PPS region include: Comprehensive Adolescent Pregnancy Prevention Projects in 3 counties, and Tobacco Free coalitions in 7 PPS counties.

County agencies including Public Health, Office for the Aging and Social Services are stable and have been part of the PPS DSRIP planning process. The private, non-profit community based organizations are often small organizations that serve localized areas. Many rely on donations and small grants for sustainability. It has been more difficult to engage these organizations in the planning process due to their limited resources, particularly staff time. We will continue to keep them informed as we move forward with planning and help them understand the important role they can play in supporting system transformation.

The region does have a number of supportive programs and services aimed at promoting general health and wellness, including nutrition assessment, exercise, weight loss, medication access, prenatal care, parenting skills, flu shots and other vaccinations, prescription eye glasses and much more.

According to the NCHSR report, promoting awareness of these services is a challenge. For the AHI PPS, it is not changing the complement of community health care providers but creating a system so that providers understand the options and availability and can refer people in need of services or community supports. Although the New York 211 HelpLine service that has expanded to the Adirondack region has improved information sharing, there is still a need for a more robust and systematic referral program to link providers and patients with available services.

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 age distribution of children (under 18), adults (18 to 64), and older adults (age 65 plus) shows that the population in the PPS skews older than the Upstate and NY distributions. All nine counties have fewer children and five counties have more adults age 65 plus. Three counties have very high percentage of older adults, Warren at 17.3%, Essex at 18.4%, and Hamilton at 23.3% compared to Upstate at 14.6%.

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

The population in the region is predominantly White. Franklin County is the most racially and ethnically diverse, with 16 percent of its population identifying as other race/ethnicity than White, compared to 92 to 97 percent of the population in other counties identifying as White. In Franklin, 5 percent identify as American Indian/Alaskan Native, 6 percent as Black, and 3 percent Hispanic. The St. Regis Mohawk Indian Reservation is located in the northern part of Franklin and St. Lawrence counties. The approximately 3300 member/residents have access to a health center on the reservation. The other PPS counties range from 97 percent to 92.3 percent White. From 2 through 5 percent of residents in each county are identified as foreign born.

***Demographics 3:**
Income levels:

Seven of the nine AHI North Country PPS counties have lower median household incomes compared to Upstate NY. Clinton, Essex, Franklin, Fulton, Hamilton, St. Lawrence, and Washington have median household incomes below Upstate NY at $54,125. Four counties are significantly lower: Essex at $47,400, Franklin at $45,702, Fulton at $45,333, and St. Lawrence at $43,745.

***Demographics 4:**

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Poverty levels:

Economic status is a key risk factor associated with vulnerability and disparities in health care access and health status. Most of AHI North Country PPS counties have higher rates, and in some counties significantly higher rates, of poverty than Upstate NY. Seven of the nine counties in the PPS have a higher percentage of the population with incomes below 200 percent of the federal poverty level (FPL) compared to 26 percent in Upstate NY. Three counties are more than 10 percentage points above Upstate. The same three counties, Franklin, Fulton, and St. Lawrence, have notably high percentages of their populations, 18, 17, and 19 percent respectively, living in poverty (below 100 percent FPL) compared to 11 percent in Upstate NY area and 15 percent in NY state overall.

***Demographics 5:**

Disability levels:

The AHI North Country PPS has dis-proportionally more disabled than in NY State. Eight of the nine PPS counts have a higher percentage of disabled residents than NY State. The disabled population is in need of multiple health resources, and it is important in terms of quality care and cost that their health services are both accessible and well-coordinated. Proportions of disabled population range from 13 to 16 percent across the counties, with the exception of Saratoga that has 10 percent of its population as disabled, just under NY State at 11 percent.

***Demographics 6:**

Education levels:

A growing body of evidence strongly and consistently links education with health, even when other factors like income are taken into account. Six of the nine PPS counties have a higher percent of the population with less than high school education compared to 11 percent of the population in Upstate NY with less than a high school education. The range in this set of counties is from 13 to 16 percent. Even more pronounced is the difference between the PPS counties and NY State for the Population with Associate's Level Degree of Higher. Eight of the nine counties have a lower percentage of residents completing any higher education. These counties have percentages ranging from 25.5 percent to 38.8 percent compared to NY State at 41.1 percent.

***Demographics 7:**

Employment levels:

There is a lot of variability in unemployment rates for the AHI North Country PPS counties from 4.9 percent to 10.6 percent. Six of the nine PPS counties have unemployment rates above the upstate rate of 7.7 percent. Four counties have rates that are far higher at 9.3 percent to 10.6 percent, almost two to three percentage points above the Upstate rate.

***Demographics 8:**

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

The institutionalized population refers to those living in a correctional institution, nursing home(NH), and settings that exclusively house people with disabilities. There is little information about these populations generally and even less in the PPS geographic area. There are 13 correctional facilities in the PPS area (1 min, 3 max, and 9 med-security), and 31 NHs. The prison population is male and tends to be working age adults. Based on national data, disability rates are between 23-37%, mostly consisting of mental & learning disabilities. NY stats noted that 4% of inmates (2013) had been designated by NYS Office of Mental Health as seriously mentally ill. Other NY data noted that 83% of inmates (2007) had an identified substance abuse need.
The NH population is older; national rates indicate 90% of nursing home residents were 65 or older. By definition, all residents have some type of disability. Data indicates ~75% of residents receive help with 3+ activities of daily living.

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

As necessary, please include relevant attachments supporting the findings.

File Name	Upload Date	Description
23_SEC034_Project2.a.ii, Question1,AHINCPPS.docx	12/22/2014 01:34:55 PM	Section 1 narrative response of project 2.a.ii
23_SEC034_Section01,RegulatoryRelief,AHINCPPS.	12/22/2014 12:06:44 PM	Regulatory Relief document to support information populated

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File Name	Upload Date	Description
docx		in Section 01

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:

Cardiovascular disease and cancer are the two leading causes of death in the United States, New York, and AHI North Country PPS. Combined these diseases account for the vast majority of all deaths across all PPS counties. The leading causes of premature death are similar to those of mortality overall, with the first and second leading causes of premature death in AHI North Country region being cancer and cardiovascular disease across all demographic strata. Respiratory disease, unintentional injuries, diabetes, and suicide most often complete the top five causes of premature death depending on the county. Premature death rates for these top five causes all have rates higher than the Upstate NY rates, across all counties and all conditions with one exception, which is Saratoga County. The PPS spans a large mainly rural geographic area with little racial/ethnic diversity. According to the US Census, eight of the nine counties range from 97 percent to 92.3 percent White. The counties skew older than other Upstate NY counties. These factors indicate a homogeneous population leading to little variation in the causes of premature death or leading causes of death in the region.

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

The conditions causing most hospitalizations for Medicaid members are conditions classified as mental and cardiovascular diseases and disorders, 34 and 31% respectively of conditions requiring hospitalization. Behavioral health conditions (mental diseases and disorders and substance abuse) accounted for 49% of admissions.

Preventable hospitalizations for Medicaid patients are estimated by PQI (adult) and PDI (child) data. Franklin, Clinton, St. Lawrence, and Fulton show higher rates than NY State for the overall composite PQI (total preventable) and each sub-composite score (acute, chronic, diabetes, respiratory, and circulatory). Saratoga, Washington, and Warren show lower rates for the overall PQI and each composite score. Essex had an overall composite better than the state in 2011, but worse in 2012. The rates in Hamilton, given its small population, are unstable, meaning a small number of cases can cause wide fluctuations in rates.

The PDI overall composite, shows Fulton and St. Lawrence with higher rates of preventable admissions than NY State. Small numbers of hospitalized children and small populations in most counties mean these rates fluctuate widely.

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

In the PPS, county statistics indicate a range from 8 to 12% of adults with diabetes, 9 to 15% with asthma, 5 to 11% with heart disease, and 25 to 37% with high blood pressure. Treating these types of chronic conditions in primary care would reduce admissions known as ambulatory care sensitive conditions (ACSC). Select ACSC rates for PPS Medicaid members per 100,000 population range across counties as follows: diabetes - 69 to 507; COPD – 142 to 1391; hypertension – 18 to 77; and heart failure – 18 to 515. Other risk factors in the PPS that impact health status include low socio-economic status; high rates of smoking, obesity, teen births, adult binge drinking, alcohol-related motor vehicle injuries and death; poor mental health; high percentages of women receiving late or no prenatal care and births within 24 months of previous pregnancy. Preventive health metrics, notably mammograms, pap tests, dental visits, and flu shots, are worse in the AHINCPPS region than in Upstate NY. Addressing ASCS would also reduce PPV rates. All counties except Washington and Hamilton show rates higher than NY State. St. Lawrence, Essex, Clinton, Fulton and Franklin have particularly high rates.

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

The PPS population disproportionately suffers from chronic disease compared to residents of NY State. Clinton, Essex, Franklin, St. Lawrence & Warren counties have a higher percent of adult diabetes than NY State at 9%. Franklin is significantly higher at 12%. The

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percent of adult asthma is higher in 7 of 9 counties than NY State. Six of the 9 counties have a higher percent of heart disease than NY State at 8%. Clinton County is significantly higher at 11%. Eight of 9 counties have a higher percent of adults with high blood pressure than NY State.

Of the 10 most prevalent conditions for Medicaid recipients, depression & hypertension ranked 1 or 2 across counties followed by diabetes. Behavioral health conditions represent the majority of top 10 conditions. The percentage of PPS Medicaid recipients with those conditions ranked higher than the percentage of Medicaid recipients with those conditions in NY State.

Due to low numbers/confidentiality HIV rates are only reported for Saratoga County with 2.4 newly diagnosed cases per 100,000. STD rates are mixed. For chlamydia testing, 7 counties have rates below Upstate and cervical cancer screenings 5 counties perform better than Upstate.

***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:

Of three Maternal and Child Health indicators, preterm births, low birth weight, and exclusive breastfeeding, nearly all AHI PPS counties are better than Upstate NY. For the indicator Births with Late or No Prenatal Care five counties are above the Upstate NY average. Four of these counties are slightly above the Upstate NY average of 3.9%, while Hamilton County, the fifth, is significantly above the average at 10.4 percent. Six counties have percentages of cesarean births that are higher than the Upstate NY average of 36 percent. Four are within a percentage point, and the other two (Franklin and St. Lawrence counties) are just above 40 percent.

***Challenges 6:**

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

According to data from the Expanded Behavioral Risk Factor Surveillance System (BRFSS):

• 27% of Upstate NY's adults (18+) are either obese or overweight: 6 of the PPS counties have percentages higher than this, from 28% in Washington to 34% in Franklin. Seven of 9 counties have higher percentages of obese children and adolescents, from 34% in Fulton to 43% in St. Lawrence compared to an Upstate rate of 34%.

• 28% of Upstate NY's adults eat the recommended five servings of fruits and vegetables per day, and 21% get no physical activity in the past 30 days: 6 counties in the PPS have a vegetable and fruit consumption rate lower than Upstate NY and 3 counties have adult exercise rates lower than Upstate NY.

• 17% of Upstate NY's residents are current tobacco smokers: In the PPS, 8 counties had higher percentages of adults who smoke compared to Upstate, from 18% in Saratoga to 27% in Franklin and 29% in Fulton.

• 17% of adults in Upstate NY reported binge drinking (men 5+ drinks, women 4+ drinks at any 1 occasion on a regular basis): In the PPS all counties except Franklin and Washington had higher rates than the Upstate NY rate, from 18% in Warren to 28% in St. Lawrence.

***Challenges 7:**

Any other challenges:

One unique challenge is the rural, and in some areas frontier, nature of most of the PPS region. The PPS region population density is 59 persons per square mile (PPSM), with Hamilton having only 3 PPSM. A large majority of Clinton, Essex, Franklin, Hamilton, St. Lawrence and Washington counties are rural. All or portions of Essex, Hamilton, Clinton, Franklin, St. Lawrence, Warren and Washington counties are in the NYS Adirondack Park. The State owned "forever wild" forest lands are interspersed with small population centers, working lands, and homes. The geography creates long routes between small population centers that cross or circumvent rivers, lakes and the highest mountains in NY State.

The physical makeup of these rural areas will be a challenge for providing home and community based services. Public transportation is county based and struggles to serve all needs. In the rural areas residents have to travel more than 30 miles for inpatient care and OASAS-certified treatment programs. EMS transport times tend to be longer in the PPS region. Additionally severe winter weather often

makes it difficult to serve people in their homes, or for patients to attend appointments.

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**.

The data indicates that there are gaps in health care services in the AHI North Country PPS. Behavioral Health and Substance Abuse conditions are top drivers of ER visits. Chronic conditions such as Circulatory Conditions and Respiratory Conditions are major drivers of inpatient utilization. This is consistent throughout the PPS.

The overall capacity of hospital beds per 1,000 residents varies across the PPS counties but on a regional basis is lower than the NY State average. The average number of beds per 1,000 residents by county ranges from a high of 6.2 beds in Warren to 0 beds per 1,000 residents in Hamilton and Washington. The average number of beds per 1,000 residents for the PPS service area overall is 2.1 beds, which is lower than the New York State rate of 2.9 beds per 1,000.

There is considerable variation in hospital occupancy rates by county but regionally the PPS service area average occupancy rate is lower than the State average. The occupancy rates by county range from 13.5 in Essex to 74.9 in Saratoga. There are no beds in Hamilton or Washington Counties. The average occupancy rate for the 9 county service area is 51.8 compared to a New York State average of 68.5.

There are 31 nursing home in the AHI North Country PPS region with 3,715 beds (approximately 120 beds per site) and an average self-reported occupancy rate of 92.8%. According to the NYS DOH, there will be a need for 4,272 residential health care facility beds in 2016. With the currently complement of 3,715 beds across the PPS service area this indicates a potential a shortage of 557 nursing home beds. This shortage will be felt particularly in Saratoga, Clinton, Franklin and Fulton counties. St. Lawrence has a slight surplus of 45 beds, and Hamilton has no beds.

Federally qualified health centers (FQHCs), and New York State Article 28, Article 36 and Article 40 health care facilities constitute the bulk of primary care providers serving Medicaid insured and uninsured residents. Private, solo, and group primary care practices may serve some Medicaid insured patients, but are generally smaller percentages given that some providers may be hesitant about serving Medicaid patients due to lower relative reimbursement rates. Individually, these practices do not serve a significant volume of Medicaid insured individuals, but in the aggregate they play an important role in the system.

According to the NYS DOH, there are 15 Certified Health Home Agencies (CHHAs) and 6 hospices serving the PPS counties. Some of these agencies are outside of the PPS region, but serve the population of the region's counties. There are many Licensed Home Care Services Agencies (LHCSAs) in the PPS region. The counties in the AHI North Country PPS have short length of stays for Hospice care. This indicates that referrals from any and all providers are not happening in a timely way so that patients and caregivers can best benefit from this service. Anecdotal information indicates that there is a need to strengthen the home care and hospice services to ensure timely access to care.

***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.

To address nursing home capacity, in early 2015 LeadingAge NY will be releasing a study titled, "A Roadmap to a Rational, Sustainable and Replicable System of LTC Services in the Eastern Adirondacks." This study will be key to identifying the needed configuration of services in the region, assembling an action plan to re-balance the long term care and supportive services system and growing a sustainable, integrated rural health network of services in the region.

In 2013-2014, the North Country Health Systems Redesign Commission (NCHSRC) set out to assess the capacity and strength of the

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Adirondack/North Country region's primary care safety net. Their analysis concluded that sizable areas were "lacking key health and behavioral services, with a lack of transportation, and significant geographic and socio-demographic factors exacerbating problems of access. Service Providers in these communities are the safety net."

One identified challenge is a shortage of providers. This is documented through the large number of federally designated Health Professional Shortage Areas (HPSA):
- Primary Care: the entire counties of Clinton and Fulton, and various areas of Essex, Franklin, Hamilton, St. Lawrence, Washington and Warren encompassing 87 towns, 6 health center service areas, and 2 correctional facilities.
-Mental Health: There are 10 mental health HPSAs in the PPS Region - 4 full county: Clinton, Essex, Fulton and Hamilton; 3 correctional facilities; 2 health center service areas; and 1 Native American tribal designation.
-Dental: the entire county of Essex, low income populations in Essex and Warren, tribal populations in Franklin and Hamilton, and the correctional facilities in Clinton, Essex, Franklin and Washington are designated.

A review of the HRSA Health Resources Files data shows that in each of the nine counties the number of full-time-equivalent psychiatrists per 100,000 population is dramatically lower than the NY State overall figure. In three counties, there are no psychiatrists, and in four cases this rate is a small fraction of the overall NY State rate.

Additionally urgent care is limited to just the most populated areas, limiting access after hours to ERs. As in many rural areas transportation can be a barrier to access as patients may need to travel to attend appointment and public transportation is limited.

***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.

Although hospital occupancy rates are lower than the state rate, there are a number of unique issues in the AHI North Country PPS region concerning hospital capacity. Due to the very rural nature of the region the facilities are far apart, some have seasonal census fluctuations, and ensuring surge capability all need to be taken into account in looking at capacity. To start to address the changing health care needs, four hospitals in the PPS will become Medical Villages. There will be a reduction in inpatient capacity and an expansion of needed outpatient services.

The PPS will work with LeadingAge NY and the region post-acute providers to implement the strategies outlined in the study that will be released in early 2015 titled, "A Roadmap to a Rational, Sustainable and Replicable System of LTC Services in the Eastern Adirondacks."

The Commission for Healthcare in the 21st Century and the NCHSRC Report identify that in the AHI North Country PPS region there is a reliance on institutional care and preventive as well as home and community based community based services need to be strengthened. A key strategy in transforming the current system will be developing a stronger, more coordinated system of primary care integrated with behavioral health services. The PPS service area has 337 PCMH certified primary care practices so the building blocks for coordinated care already exist. The plan is to expand the number of PCMH certified providers and integrate behavioral health providers into this system.

The North Country Health Systems Redesign Commission also identified that there is a wide range of home and community based services but that providers and community members need a better more systematic referral system to ensure access for patients.

There will be a need to regionally coordinate training and retraining programs. As the system transforms from institutional based care to home and community based services health care providers will need to be trained or retrained with new skill sets. There will also be a need to create incentive programs for recruitment and retention specifically for identified shortage 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.

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***Community 1:**

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

The AHI North Country PPS used a variety of existing community input sources to guide the selection of DSRIP projects and the initial project planning phase. Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, and Warren, and Washington counties actively work together on community health planning through the Adirondack Rural Health Network (ARHN).

As part of the community health planning process ARHN contracted with the Center for Human Research (CHSR) to conduct a survey between December 5, 2012 and January 21, 2013. The purpose of the study was to provide feedback from community service providers in order to understand what health issues are most prevalent in the populations the organization serves as well as guide planning, and identify areas for training. The survey was sent to a broad spectrum of community based organizations, agencies, and providers that serve vulnerable populations in the region such as county agencies, Community Action Programs, schools, YMCAs, health care providers, and many others. The recipients of the survey were asked to answer the questions as a representative of the people that they serve.

The survey was administered electronically using a web-based survey program and distributed to an email contact list of 624. Ultimately, 285 surveys were completed during the six-week survey period, a response rate of 45.7 percent.

Additionally findings from two other surveys have been used to inform the DSRIP process. Saratoga Hospital conducted a survey of residents of Saratoga County. A survey was conducted in St. Lawrence County as part of a three county effort with Lewis and Jefferson Counties.

***Community 2:**

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

The surveys described in the previous section were supplemented with focus groups and community meetings. St. Lawrence County conducted three focus groups: one with key informants of the Community Health Improvement Collaborative, another with low-income residents, and third, with firefighters. Washington County hosted three community engagement meetings, Essex County held six community stakeholder meetings and Warren County formed the Community Health Assessment Team.

The PPS plans to issue a short consumer survey early in January 2015. The PPS will ensure that Medicaid beneficiaries are well represented in the responses. The PPS will work with community based organizations such as Community Action Programs, Centers for Independent Living, churches as well as providers to distribute the survey. The survey focuses on a number of items including ease of access/barriers to accessing services, perception of health issues in the community, recommendations for expanding or initiating services and programs to address community need. The survey results will be used to inform the more targeted planning process that will take place for the March 1 submission.

***Community 3:**

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

Although the AHINCPPS spans 9 counties, the surveys, focus groups and community meetings had many similar findings. Community members perceive that behavioral health, substance abuse, obesity and chronic disease are predominant health concerns for the PPS region. The population groups identified most in need of targeted interventions are: the poor, children, individuals with mental health issues, the elderly, and substance abusers.

One important finding from the ARHN survey indicated that a third of health care and service professionals did not know the effectiveness of existing programs to address the identified health issues and more than half indicated that these programs were only slightly to moderately effective.

Other issues raised were housing and transportation. There is need for both affordable housing and supportive housing for those with disabilities. Lack of transportation was raised as a concern by many stakeholders. Public transportation in this mostly rural area is a challenge. Although Medicaid-insured individuals can receive taxi rides, accessibility is an issue. The reservation system, timely return rides and urgent appointments were cited as problematic.

In the chart below, please complete the following stakeholder & community engagement exhibit. Please list the organizations

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engaged in the development of the PPS strategy, a brief description of each organization, and why each organization is important to the PPS strategy.

[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
1	Adirondack Health Institute (AHI)	The Adirondack Health Institute (AHI) expands regional collaboration among health care and social service providers serving the Adirondack Region of New York State. AHI addresses rapid changes and challenges to the health care industry by working with local providers and organizations through the coordination of planning, recruiting, clinical activities, outreach and managing of grant-supported programs. AHI is a joint venture of Adirondack Health, Community Providers, Inc. (CVPH), Glens Falls Hospital and Hudson Headwaters Health Network. Its service area includes Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, Warren and Washington counties.	AHI is the Lead Agency within the PPS
2	Hudson Headwaters Health Network (HHHN)	Comprehensive primary care including adult, pediatrics, OB/GYN, behavioral health, dentistry, care management, hospital/nursing home/home visits, urgent care and certain specialty services including infectious disease, neurology, podiatry and rheumatology.	As a FQHC providing services in Clinton, Essex, Hamilton, Warren and Washington counties, HHHN is an important partner in planning and implementing all DSRIP projects.
3	Champlain Valley Physicians Hospital (CVPH)	CVPH facilities include a 341-bed acute care hospital with wide array of medical and surgical specialties, along with a 54-bed skilled nursing facility.	As the predominant provider of inpatient and outpatient services in Clinton and northern Essex counties this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.
4	Adirondack Health	The continuum of healthcare at Adirondack Health incorporates a complete range of in-patient, residential and out-patient services at Adirondack Medical Center in Saranac Lake and AMC-Lake Placid; health centers in Keene, Lake Placid, Saranac Lake and Tupper Lake; Living Centers in Lake Placid and Tupper Lake; and a Dental Clinic in Lake Placid.	As the predominant provider of inpatient and outpatient services in northern Essex, southern Franklin, and northern Hamilton counties this provider serves a substantial portion of the northern PPS region and will be important in implementing all DSRIP projects.
5	Glens Falls Hospital (GFH)	Glens Falls Hospital provides a comprehensive safety net of health care services to a rural, economically-challenged region in upstate New York. GFH serves as the hub of a regional system of health care providers and offers a vast array of health care services including general medical/surgical and acute care, emergency care, intensive care, coronary care, obstetrics, gynecology, a comprehensive cancer center, renal center, occupational health, inpatient and outpatient rehabilitation, behavioral health care, primary care, and chronic disease management, including a chronic wound healing center. In addition to the hospital's main campus, these services are provided through 11 neighborhood primary care health centers and physician practices, several outpatient rehabilitation sites, seven specialty	As an important provider of inpatient and outpatient services in southern Essex, northern Saratoga, Warren and Washington counties, this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		practices, three occupational health clinics, and two rural school-based health centers.	
6	Behavioral Health Services North (BHSN)	Behavioral Health support (mental health & substance abuse services), along with a vast array of other social supports.	One of two important providers of behavioral health services to the residents of Clinton and northern Essex counties. This provider is a key in implementing multiple AHI PPS projects.
7	820 River Street	Alcoholism Supportive Living Facility and treatment center.	Inpatient and outpatient substance abuse services are important elements in multiple AHI PPS projects. 820 River Street serves the southern half of the PPS region and will be important in implementing multiple AHI PPS projects.
8	Adirondack Samaritan Counseling Center	Providing mental health services to children, adolescents and adults in Warren, Washington, Essex and Saratoga Counties.	A behavioral health provider serving residents of numerous counties in the PPS service area, this provider this partner will be an important part of implementing the behavioral health and substance abuse DSRIP projects.
9	Adirondack Tri-County Nursing and Rehabilitation Center	Skilled nursing and rehabilitation facility.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this is an important provider as the only nursing home in northern Warren County.
10	Alice Hyde Medical Center	General medical and surgical hospital.	As the predominant provider of inpatient and outpatient services in northern Franklin, eastern St. Lawrence, and western Clinton counties this provider serves a substantial portion of the northern PPS region
11	Blue Line Group	An affiliation of long-term care facilities.	Four long-tern care facilities that serve Essex, Franklin, Hamilton, and northern Warren counties. Together the facilities serve a substantial portion of the PPS region. Skilled nursing and rehabilitation are an important part of the continuum of services to help prevent preventable inpatient and ER visits.
12	Can Am Youth Services dba Rose Hill	Residential treatment for substance abusing youth.	Inpatient and outpatient substance abuse services are important elements in multiple AHI PPS projects. Rose Hill serves the northern half of the PPS region.
13	Capital District Psychiatric Center	Provides inpatient psychiatric treatment and rehabilitation to patients who have been diagnosed with serious and persistent mental illnesses and for whom brief or short-term treatment in a community hospital mental health unit has been unable to provide symptom stability.	Residents of the AHI PPS will need access to all levels of the continuum of care. CDPC serves the southern half of the PPS region with inpatient psychiatric care.
14	Centers for Specialty Care	Offering rehabilitation and skilled nursing services.	Skilled nursing and rehabilitation are

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			an important part of the continuum of services to reduce inpatient and ER visits, this provider owns multiple facilities in the PPS region serving a substantial number of residents
15	Central NY Health Home Network	Providing comprehensive care coordination and management services for people with complex combinations of chronic conditions.	Health Home providers are already serving complex Medicaid patients, CNYHN is an important partner in helping serve the high utilizing beneficiaries in the AHI PPS
16	CGSR Inc. D/B/A Meadowbrook Healthcare	A skilled nursing facility providing medical, continuous nursing, and other health and social services to patients.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Clinton and northern Essex counties.
17	Champlain Valley Family Center for Drug Treatment and Youth Services, Inc.	OASAS certified prevention program, OASAS certified medically supervised outpatient clinic, Adolescent case management services, Shelter plus care housing, MRT/PSH housing program, Vocational educational services, DOH grant for "Advancing Tobacco Free Communities."	Outpatient substance abuse and prevention services are important elements in multiple AHI PPS projects. CVFCDTYS serves Clinton and northern Essex counties.
18	Clinton County Community Services Board Mental Health & Addiction Services	Outpatient mental health and addiction clinic services.	One of two important providers of behavioral health services to the residents of Clinton and northern Essex counties. This provider is a key in implementing multiple AHI PPS projects.
19	Champlain Valley Senior Community	A 63 room assisted living and memory care residence.	Assisted Living is an important partner as stable housing that facilitates socialization helps seniors thrive and lead a better quality of life.
20	Citizen Advocates, Inc.	Behavioral Health Treatment and Case Management, Substance Use Disorder Treatment and Prevention, Developmental Disabilities Rehabilitation and Residential Services.	Citizens Advocates is the predominant provider of outpatient behavioral health services in Franklin County. This provider is a key in implementing multiple AHI PPS projects.
21	Clinton County Chapter NYSARC, Inc. dba Advocacy and Resource Center	A private non-profit human service agency which has provided services to the developmentally disabled citizens of Clinton County since 1954.	This organization is important in representing the needs of the developmentally disabled. This chapter of NYSARC serves residents of Clinton County.
22	Clinton County Nursing Home	80 bed Medicare and Medicaid certified skilled nursing facility operated by Clinton County.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Clinton and northern Essex counties.
23	Clinton County Office for the Aging	Programs in health and wellness, housing, nutrition, transportation and a number of other services for seniors.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
24	Community Health Center of St Mary's Healthcare & Nathan Littauer Hospital	Offering a full range of in-home health care services.	Home Health will be a key service moving forward with the DSRIP projects. This provider serves people

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			in their homes in Fulton County.
25	Conifer Park	Alcohol and Substance abuse Medically Supervised Detox, Adult and Adolescent Inpatient Rehabilitation, and Outpatient services in 6 locations.	Inpatient and outpatient substance abuse services are important elements in multiple AHI PPS projects. Conifer Park serves the southern half of the PPS region and will be important in implementing multiple AHI PPS projects.
26	CWI	Providing support for people with developmental disabilities in their communities.	This organization is important in representing the needs of the developmentally disabled. CWI serves the residents of Saratoga, Warren and Washington counties.
27	Elizabethtown Community Hospital	A critical access hospital.	As one of the predominant providers of inpatient and outpatient services in Essex County this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.
28	Essex County Chapter NYSARC, Inc. dba Mountain Lake Services	Providing support for people with developmental disabilities in their communities.	This organization is important in representing the needs of the developmentally disabled. This chapter of NYSARC serves residents of Essex County.
29	Essex County Mental Health	Outpatient MH Tx : Psychiatry, psychotherapy, crisis services & HH care coordination services.	An important partner in planning behavioral health and substance abuse projects serving residents of Essex County.
30	Essex County Office for the Aging	Offering programs in health and wellness, housing, nutrition, transportation and a number of other services for seniors.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
31	Essex County Public Health	Works preventing disease and injury by promoting healthy lifestyles, offering educational programs, developing policies, and administering services.	Essex County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Essex County.
32	Fort Hudson Certified Home Health Agency, Inc.	Providing I/A, Case Management, Advocacy, Nutrition, Transportation, HIICAP, non-Medicaid home care and social model adult day care services.	CHHA and Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Saratoga, Warren, and Washington counties.
33	Fort Hudson Home Care, Inc.	Community based services Services available through Fort Hudson Homecare include Companion Care, Licensed Home Healthcare, Certified Home Health Agency, and Service Coordination.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Saratoga, Warren, and Washington counties.
34	Families First in Essex County, Inc.	HCBS Waiver, ICM, Family Support, 1915i services.	Families First is an important partner for planning and implementing behavioral health projects in Essex County.
35	Fort Hudson Nursing Center, Inc.	Fort Hudson Health System, a Not-for-Profit senior provider, offers a comprehensive and individualized approach to senior services conveniently located on	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		one integrated campus; as well as throughout the community.	visits, this provider serves the residents of Warren and Washington counties.
36	Franklin County Community Services	Manages a system of agencies that provide mental health programs throughout Franklin County.	Franklin County Community Services is important in planning and implementing projects in Franklin County to serve residents with behavioral health and substance abuse needs.
37	Franklin County Public Health	Provides home and public services utilizing personal and community resources to prevent and manage problems that contribute to poor health and to promote wellness.	Franklin County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Franklin County.
38	Franklin-Hamilton Counties Chapter, NYSARC, Inc. dba The Adirondack ARC	Offering skilled nursing, sub acute rehab, and wound care services.	This organization is important in representing the needs of the developmentally disabled. This chapter of NYSARC serves residents of Franklin and Hamilton counties.
39	Fulton County Office for the Aging	Provides service and advocacy for Fulton County seniors.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
40	Fulton County Public Health Department	Offers a variety of health services and programs to county residents, geared toward improving both individual health and well being and that of the community.	Fulton County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Fulton County.
41	Glens Falls Crossings, LLC d/b/a The Pines at Glens Falls Center for Nursing and Rehabilitation	Offering skilled nursing and rehabilitation services along with, pulmonary rehabilitation, heart failure services for CHF, cardiac recovery, amputee rehabilitation, stroke rehabilitation and wound care management.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Warren and Washington counties.
42	Greater Adirondack Home Aides	Provides I/A, Case Management, Advocacy, Nutrition, Transportation, HIICAP, non-Medicaid home care and social model adult day care services.	Home Health will be a key service moving forward with the DSRIP projects. This provider serves people in their homes in Warren County.
43	Hamilton County Community Services	Offering Mental Health/ Substance Abuse Treatment, and Prevention services.	Hamilton County Community Services is important in planning and implementing projects in Hamilton County to serve residents with behavioral health and substance abuse needs.
44	Hamilton County Public Health Nursing Service	Programs include WIC, Immunizations, EI, and Preschool.	Hamilton County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Hamilton County.
45	HCR Home Care (L. Woerner, Inc.)	Providing nursing, home health aide service, physical therapy, occupational therapy, and palliative care services.	CHHA and Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			in Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties.
46	Health Services of Northern New York	Nursing, Therapies, Aide Services, and Telehealth services.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in St. Lawrence County.
47	Heritage Commons Residential Healthcare dba Moses Ludington Nursing Home	84-bed skilled nursing facility.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Essex and Washington counties.
48	Highland Nursing Home	Nursing and Rehab Facility specializing in physical therapy and occupational therapy.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of St. Lawrence county.
49	Home Health Care of Hamilton County, Inc. dba Helping Hands Caregivers	Offering in home care services.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in St. Lawrence County.
50	Hospice and Palliative Care of St. Lawrence Valley	Interdisciplinary care to relieve pain and suffering.	Hospice is an important provider in the continuum of care. This provider serves St. Lawrence County.
51	Hospice of the North Country, Inc.	Interdisciplinary care to relieve pain and suffering.	Hospice is an important provider in the continuum of care. This provider serves Clinton and northern Franklin counties.
52	Lakeside House, Inc.	A network of behavioral health providers in Northern New York committed to working together to strengthen behavioral health services in the region.	An important partner in planning behavioral health and substance abuse projects serving residents of northern Essex and Franklin counties.
53	Liberty House Foundation, Inc.	Offering services in psychiatric rehabilitation, pre-vocational training, supported employment and on-going integrated employment supports.	An important partner in planning behavioral health and substance abuse projects serving residents of Warren County.
54	Living Resources CHHA, Living Resources Home Care Agency, and Living Resources Corporation	Offers a variety of services for disabled adults.	CHHA and Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in the southern portion of the PPS.
55	Massena Memorial Hospital	A full-service community hospital.	As an important provider of inpatient and outpatient services in northern St. Lawrence County this provider will be important in implementing all DSRIP projects.
56	Mental Health Association in Essex County, Inc.	Care Coordination, Mobil Crisis, Peer to Peer, Supported Employment, Supported Education, Housing, Community Centers, Respite and Transportation	ECMH is the predominant provider of outpatient behavioral health services in Essex County. This provider is a key in implementing multiple AHI PPS projects.
57	Mental Health Association in Fulton and Montgomery Counties	Providing peer services; advocacy services; family support services for mental health issues.	An important partner in planning behavioral health and substance

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			abuse projects serving residents of Fulton County.
58	Montcalm Manor HFA	An assisted living community, located in Ticonderoga, NY. The facility provides care to elderly people who need help with daily tasks such as meal preparation, mobility, bathing or dressing.	Adult Homes are an important partner as stable housing that facilitates socialization helps seniors thrive and lead a better quality of life.
59	Moses Ludington Hospital	Provides general medical and surgical care for inpatient, outpatient, and emergency room patients, and participates in the Medicare and Medicaid programs.	As an important provider of inpatient and outpatient services in Essex County this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.
60	Nathan Littauer Hospital & Nursing Home	General hospital care plus primary and specialty MD care, and skilled nursing care.	As an important provider of inpatient and outpatient services in Fulton County this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.
61	North Country Home Services, Inc.	Provides a variety of home health care services to assist individuals in their homes enabling them to remain as independent as possible when undergoing stress and/or hardships due to illness, disability, injury or limitations due to age. Home Health Aides, Personal Care Aides and Chore Companions are available via contract from North Country Home Services.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Clinton, Essex, and Franklin counties.
62	North Country Physicians Organization	A physician organization composed of 160 physicians in St. Lawrence County, New York and the upper half of Franklin County, New York. NCPO also includes the physicians and hospital associated with Fletcher Allen Healthcare in Burlington, Vermont.	An important partner bringing private practice physicians to the table for planning and implementing DSRIP projects.
63	Northern Area Health Education Center, Inc.	Working to improve health and health care through education. Activities Include: Outreach to youth to promote an interest in healthcare careers; Support of training programs to ensure access for interested participants; and Promotion of continuing education and professional development opportunities for health.	NAHEC is an important partner in planning and implementing workforce strategy and projects. Workforce is a key component to transforming the way that care is delivered.
64	Office of Community Services for Warren and Washington Counties	The Office of Community Services is responsible for administering the local Single Point of Access (SPOA) for all referrals for mental health residential and case management services. We also coordinate the Assisted Outpatient Treatment (AOT) Program for Warren and Washington Counties. This program provides for an enhanced array of outpatient services, either through voluntary agreement or court order, for eligible individuals over 18 years of age with a history of non-compliance with recommended treatment.	The Office of Community Services is important in planning and implementing projects in Warren and Washington counties to serve residents with behavioral health and substance abuse needs.
65	Planned Parenthood Mohawk Hudson, Inc.	Offering family planning/primary care, HIV/STI screening, cancer screening, colposcopy, and abortion services.	Planned Parenthood is an important partner as it provides prevention and clinical services in the southern half

Adirondack Health Institute (PPS ID:23)

[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
			of the PPS.
66	Planned Parenthood of the North Country New York, Inc.	Offering GYN services, pregnancy testing with options counseling, and STD testing.	Planned Parenthood is an important partner as it provides prevention and clinical services in the northern half of the PPS.
67	Saratoga Hospital	Inpatient and Outpatient Care/Diagnostic Services	As an important provider of inpatient and outpatient services in Saratoga and Warren counties, this provider serves a substantial portion of the PPS region and will be important in implementing all DSRIP projects.
68	Seaway Valley Council for Alcohol/Substance Abuse Prevention, Inc.	Providing a high-quality prevention services to school districts, communities, businesses and colleges.	An important partner in planning behavioral health and substance abuse projects serving residents of St. Lawrence County.
69	St. Joseph's Rehabilitation Center, Inc. d/b/a St. Joseph's Addiction, Treatment and Recovery Center	Offering treatment for all stages of addiction. Also include assessments, family intervention, community outreach, education, inpatient services, outpatient services, residential family program and veterans residence.	Inpatient and outpatient substance abuse services are important elements in multiple AHI PPS projects. St. Joes serves the northern half of the PPS region and will be important in implementing multiple AHI PPS projects.
70	St. Lawrence County Office for the Aging	Provides service and advocacy for county residents 60 years and older.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
71	St. Lawrence County Public Health	A variety of health services and programs to county residents, geared toward improving both individual health and well being and that of the community.	St. Lawrence County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Franklin County.
72	St. Lawrence Health System (Canton-Potsdam Hospital and Gouverneur Hospital)	Canton-Potsdam Hospital is establishing a new health care system, though the creation of the Gouverneur Hospital and the St. Lawrence Health System. At the same time, Canton-Potsdam Hospital has moved ahead aggressively with major construction and renovation projects, physician recruitment, and partnerships with our area colleges. The Hospital-wide focus is on quality, safety, and service.	As an important provider of inpatient and outpatient services in eastern St. Lawrence County this provider will be important in implementing all DSRIP projects.
73	St. Lawrence NYSARC	Offering services in the community for persons with intellectual and other developmental disabilities.	This organization is important in representing the needs of the developmentally disabled. This chapter of NYSARC serves residents of St. Lawrence County.
74	St. Lawrence Psychiatric Center	Offering individual and group counseling, diagnostic evaluation, psychological testing, crisis intervention, psychopharmacology, medical evaluation, vocational assessment, education, socialization, task and skill training, physical therapy, structured learning therapy, occupational therapy, and recreational therapy.	Residents of the AHI PPS will need access to all levels of the continuum of care. SLPC serves the northern half of the PPS region with inpatient psychiatric care.
75	St. Regis Nursing Home	Provides skilled nursing services, dietary services, social services, activities services, maintenance services, housekeeping services, laundry services,	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
		respite and hospice, along with OT and PT services.	visits, this provider serves the residents of St. Lawrence County.
76	The Cambridge Valley Rescue Squad, Inc.	Offering emergency medical services.	EMS is an important part of the health care system. This provider serves a portion of Washington County.
77	The Family Counseling Center of Fulton County Inc	Providing a broad range of high-quality mental health and social services, with particular attention to the needs of children and families.	The Family Counseling Center is an important partner for planning and implementing behavioral health projects in Fulton County.
78	The Orchard Nursing and Rehabilitation Centre (Capital Living & Rehabilitation Centers)	Services. Short-Term Care; Long-Term Care; Rehabilitation; Nursing; Medical; Education; Nutritional; Activities	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Washington County.
79	The Stanton Nursing and Rehabilitation Centre (Capital Living & Rehabilitation Centers)	Providing long-term care along with short-term rehabilitation care.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Warren County.
80	The Substance Abuse Prevention Team of Essex County, Inc.	A nonprofit community-based agency with more than 35 specialized programs for all ages, including counseling, skills-building, training, and prevention services to improve quality of life by reducing child abuse, drug abuse, gang involvement and crime; by increasing social & coping skills, school success and employability; by healing emotional pain and helping individuals and families become strong and independent.	An important partner in planning behavioral health and substance abuse projects serving residents of Essex County.
81	United Cerebral Palsy Association of the North Country, Inc./ Community Health Center of the N. Cou	Serving people with any type of developmental disability in the community.	As a FQHC providing services in St Lawrence and Franklin counties, HHHN is an important partner in planning and implementing all DSRIP projects.
82	United Helpers and Northern Lights Home Health Care	Offers home health care services in the North Country.	United Helpers is an important post-acute provider in St. Lawrence County providing skilled nursing, assisted living, and home care. They are vital to planning and implementing DSRIP projects.
83	Upstate Cerebral Palsy, Inc.	Direct-care services and programs for individuals who are physically, developmentally, or mentally challenged and their families.	This organization is important in representing the needs of the physically and developmentally disabled. This chapter of NYSARC serves residents of St. Lawrence County.
84	Visiting Nurse Service of Northeastern New York	Offers in home nursing services.	CHHA and Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in the southern portion of the PPS.
85	Visiting Nurses Home Care	Offers in home nursing services.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in the southern portion of the PPS.

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[Adirondack Health Institute] Stakeholder and Community Engagement

#	Organization	Brief Description	Rationale
86	VNA Home Health	Providing Nursing, Physical Therapy, OT, Speech therapy, Social Work, Home Health Aides, Nutrition counseling, Telehealth, Community Mental Health Nurse, and Transition coaches.	Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties.
87	Warren County Health Services Certified Home Heath Agency	A certified Home Health Agency with numerous programs.	CHHA and Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Warren County.
88	Warren County Health Services Long Term Home Health Care Program	A Long Term Home Health Care Program that is New York State Department of Health certified and provides Medicaid eligible clients who qualify for skilled nursing facility care.	Long Term Home Health services are important in the planning and implementation of multiple DSRIP projects. This provider serves people in Warren County.
89	Warren County Health Services Public Health	Protecting and promoting the health of Warren County citizens through prevention, science, and the assurance of quality health care delivery.	Warren County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Warren County.
90	Warren Washington Association for Mental Health	A not-for-profit provider of community mental and behavioral health services.	An important partner in planning behavioral health and substance abuse projects serving residents of Warren and Washington counties.
91	Warren-Hamilton Counties Office for the Aging	Advocates for seniors and their families, providing support services, education and assistance in accessing available services.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
92	Washington County Office for Aging and Disabilities Resource Center	Providing education and advocacy to meet the needs of Washington County Seniors.	Office for the Aging provides vital services for elders in the community. They offer important programing that can complement DSRIP projects and are a trusted community resource.
93	Washington County Public Health Nursing Service	Providing nursing services to the residents of Washington County, NY.	Washington County Public Health is an important partner for planning and implementing multiple DSRIP Projects. This provider operates a CHHA and key prevention services in Washington County.
94	Wells Nursing Home	Multi-disciplined skilled nursing facility, which includes a 100 bed, skilled nursing home, Adult Day Health Program and Outpatient Rehab services.	Skilled nursing and rehabilitation are an important part of the continuum of services to reduce inpatient and ER visits, this provider serves the residents of Fulton County.
95	Wesley Health Care Center	Offering housing and services for independent seniors and those requiring all levels of care.	Senior housing is an important partner as stable housing that facilitates socialization helps seniors thrive and lead a better quality of life.

Section 3.8 - Summary of CNA Findings:

Description:

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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.

[Adirondack Health Institute] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
1	Need for integrated delivery system focused on evidence-based medicine/population health management	Service delivery within the PPS is siloed within the various institutional settings, including hospitals, behavioral health and substance abuse, post-acute care, and long-term care. Patients are served within the walls of these institutions, but there is little knowledge, little communication, and little coordination of care beyond the walls to ensure smooth transitions and to ensure that patients are served in the most appropriate settings. As such, there is an institution-focused approach to care rather than a patient-centered, holistic, and population based approach to care.	1)NCHSRC. Toward an Integrated Rural Health System: Building Capacity & Promoting Value in the North Country. Apr 2014. 2)Adult & pediatric PQIs & PDIs, Health Data NY. 3)Potentially preventable ER visits (PPV) data, Health Data NY. 4) Refer to CNA page 63-66 for a complete listing
2	Need for primary care practitioners with PCMH certification and/or Advanced Primary Care Models	The region needs to build on the Adirondack Regional Medical Home Pilot to improve and strengthen the primary care infrastructure, improve access to primary care, and access to a regular provider. Having a primary care medical home with strong care coordination is critical to ensuring good preventive care, coordination of needed services, and health transitions from one setting to another.	1)Adult & pediatric PQIs, PDIs, Health Data NY 2)Potentially preventable ER visits (PPV), Health Data NY. 3)Access to Health Care-Expanded BRFSS July 2008–June 2009 4)Population Health Indicators-CHIRS reporting Community Health Assessment Indicators (CHAI) 5) Refer to CNA p.63 for a complete lis
3	Need for a medical village using existing hospital infrastructure	There is an excess hospital bed capacity and a lack of outpatient services and urgent care settings.	1)Adult & pediatric PQIs, PDIs, Health Data NY 2)Potentially preventable ER visits (PPV), Health Data NY 3) Health Facility Cert Info file, Health Data NY 4)NCHSRC. Toward an Integrated Rural Health System: Building Capacity and Promoting Value in the North Country. Apr

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[Adirondack Health Institute] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
			2014 5)Refer to CNA p.64
4	Need for hospital-home care collaboration solutions	More and more patients are being discharged to home. Ensuring adequate support in the home is essential to reducing readmissions.	1)Quality Improvement Organization (QIO) Clinical Warehouse as Reported by the NYS DOH – 2012; 2)Adult and pediatric PQIs and PDIs, Health Data NY. 3)Potentially preventable emergency room visits (PPV) data, Health Data NY. 4)Certified Health Homes Agencies and Hospice Data: DOH website
5	Need to implement patient activation activities to engage, educate & integrate Medicaid population	The need to implement patient activation activities to engage, educate, and integrate uninsured & low/non-utilizing Medicaid populations into community-based care The uninsured depend on the ER for their needs and only present for health care services when there is a crisis or emergency. Low-utilizers are not engaged in care and miss opportunities for preventive care; thus, leading them also to use of the ER. Both of these contribute to high cost of services that better patient activation in community-based services may have prevented.	1)Adult & pediatric PQIs, PDIs, Health Data NY. 2)Potentially preventable ER visits (PPV), Health Data NY. 3)U.S. Census Bureau's American Community Survey, 5-Year Estimates for 2008-2012 4)Population Health Indicators—NYS CHIRS reporting Community Health Assessment Indicators (CHAI)
6	Need for integration of primary and behavioral health services	Primary care and behavioral health operate in two separate silos of care, with little communication and coordination between the two service delivery organizations. Patients must attend two separate venues to care for medical conditions and behavioral health conditions, even though there is a high degree of co-morbidity and that the two are inter-related. There is often stigma related to going to behavioral health service settings; thus, decreasing the probability that patients will seek needed care. On the other hand, often patients with serious and persistent mental illness and/or chemical dependency feel more comfortable receiving their care in behavioral health settings; thus, the need for caring for their medical conditions in these settings.	1)Leading Causes of Hospitalization - 2010-2012 SPARCS data, located on spreadsheets accessible through the New York State Community Health Indicator Reports (CHIRS) webpage. 2)Salient New York State Medicaid DSRIP Dashboards and DSRIP Performance Chartbooks for hospital and ER drivers.
7	Need for behavioral health community crisis stabilization services	When a behavioral health crisis occurs, patients present to the emergency room and are admitted for inpatient care. Crisis stabilization services are efficient and effective alternatives to addressing the mental health and substance abuse issues that are driving high rates of emergency department and	1)Leading Causes of Hospitalization - 2010-2012 SPARCS data, located on NYS Community Health Indicator Reports (CHIRS)

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[Adirondack Health Institute] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
		inpatient utilization.	webpage. 2)Salient New York State Medicaid DSRIP Dashboards and DSRIP Performance Chartbooks for hospital and ER drivers. 3)HRSA Mental Health HPSAs 4)HRSA ARHF 2012
8	Need to develop withdrawal management capabilities and appropriate enhanced abstinence services	Need for the development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs. Chemical dependency affects a significant portion of the population, but there is inadequate capacity to treat and care for this population. Generally, patients suffering with chemical dependency depend on the emergency department for their care. Substance abuse is a large driver of emergency department use.	1)Leading Causes Hospitalization, 2010-12 SPARCS 2)Salient NYS Medicaid DSRIP Dashboards & Perf Chartbooks Hospital & ER drivers. 3) 2006 NYS School Survey, 2006 NYS Adult Household Survey, 1998 NYS Heroin Study; applied 2011 pop. Chemical Dep Treatment Capacities: OASAS Cert capacity Mar 2013
9	Need for integration of palliative care into the PCMH model	Patients often suffer needlessly from pain, either due to a serious illness and/or during the end of their lives. This negatively impacts their quality of life as well as results in unneeded emergency room trips and/or hospitalizations.	1)NCHSRC. Toward an Integrated Rural Health System: Building Capacity and Promoting Value in the North Country. Apr 2014. 2)Weisman & Meier. Identifying patients in need of a palliative care assessment in the hospital setting. A consensus report from the CAPC. Journal of Palliative Medicine, 2011.
10	Need to strengthen mental health and substance abuse infrastructure across systems	There is fragmentation and lack of coordination between behavioral health, substance abuse, and primary care settings. As a result, mental health and substance abuse conditions drive hospital admissions and emergency department use. There is a lack of mental health services and chemical dependency treatment services.	1)Leading Causes of Hospitalization - 2010-12 SPARCS 2)Salient NYS Medicaid DSRIP Dashboards & Perf Chartbooks 3)2006 NYS School Survey, 2006 NYS Adult Household Survey, 1998 NYS Heroin Study; applied 2011 pop. Chemical Dep Treatment Capacities: OASAS Cert capacity Mar 2013 4) Refer to CNA page 66

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[Adirondack Health Institute] Summary of CNA Findings

Community Need Identification Number	Identify Community Needs	Brief Description	Primary Data Source
11	Need to increase access to high quality chronic disease preventive care & mgmt in multiple settings	Need to increase access to high quality chronic disease preventive care and management in both clinical and community settings. To address chronic disease (notably COPD) requires a population-based focus. This includes targeting communities with health education and prevention messages and opportunities as well as improved and coordinated chronic disease management in primary care settings.	1)Pop Health Indicators, NYS Community Health Indicator Reports (CHIRS) reporting Community Health Assessment Indicators (CHAI) 2)Adult & pediatric PQIs, PDIs, Health Data NY 3)Potentially preventable ER visits (PPV), Health Data NY 4)U.S. Census Bureau, American Community Survey, 5 Yr Est 2008-12

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
23_SEC038_Appendix E - Metrics.pdf	12/22/2014 03:26:21 PM	Appendix E- Metrics
23_SEC038_AHINCPPS_CNA_Appendices.pdf	12/20/2014 11:15:10 AM	COMMUNITY NEEDS ASSESSMENT FINAL REPORT: AHI NORTH COUNTRY PERFORMING PROVIDER SYSTEM December 2014
23_SEC038_AHI Needs Assessment Final Report_12.19.14_final.pdf	12/20/2014 11:11:33 AM	COMMUNITY NEEDS ASSESSMENT FINAL REPORT: AHI NORTH COUNTRY PERFORMING PROVIDER SYSTEM December 2014

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

DSRIP PPS Organizational Application

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SECTION 4 – PPS DSRIP PROJECTS:

Section 4.0 – Projects:

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

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

Please upload the Files for the selected projects.

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

Currently Uploaded File: **Adirondack_Section4_Text_AHINCPPS_DSRIP Project Plan Application_Section 4.Part I_AHINCPPS.docx**

Description of File

Section 4: DSRIP Projects for AHI North Country PPS

File Uploaded By: ahidsrip

File Uploaded On: 12/22/2014 03:14 PM

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

Currently Uploaded File: **Adirondack_Section4_ScopeAndScale_DSRIP Project Plan Application_Section 4.Part II (Scale & Speed)_AHINCPPS.xlsx**

Description of File

Scale and Speed document, awaiting new provider counts from DOH for completion by 1/12/2015.

File Uploaded By: ahidsrip

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

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SECTION 5 – PPS WORKFORCE STRATEGY:

Section 5.0 – PPS Workforce Strategy:

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

The following subsections are included in this section:

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

Scoring Process:

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

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

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

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

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

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

According to the North Country Health Systems Redesign Commission report published in April 2014, transformation of a system across nine counties, requires an integrated approach to care that emphasizes prevention, increases primary care, builds more community-based options, strengthens coordination and communication, supports critical safety net providers and builds affiliations and partnerships. The partner organizations in the AHINCPPS committed to various DSRIP projects represent a current workforce nearing 16,500. Health care is a major employer across the region and a critical element of the economy. Mitigating potential reductions in the workforce is of upmost importance.

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Most of the region has shortage designations for primary care, mental health and dental health professionals. As DSRIP projects are implemented, reliance on community based care will impact the current workforce as home and community based services need to be strengthened and increased to support transformation. Improving access to these services as well as continuing to improve primary care capacity are key to the transformation of the AHINCPPS health care system. Due to an aging workforce with shortages in key sectors and distribution in more populated areas, the potential reductions in the workforce are projected to be minimal, based on project plans received from five Regional Health Innovation Teams, findings from the Community Health Needs Assessment and key stakeholder input, including union and workforce associations.

Recruiting new staff, retraining, redeployment and attrition through retirement, will be the key strategies for the health care workforce to be appropriately sized and prepared to serve the target populations in the PPS. In addition, workforce strategies will include support services and change management trainings for staff to highlight career opportunities and to mitigate any negative impacts as care shifts from the acute care to ambulatory settings.

Initial projections report that more than 850 new hires are needed and an additional 900 workers will need to be retrained or redeployed. The categories of workforce in the PPS region that will be impacted the greatest include mental health providers, as the root of most inpatient admissions for Medicaid recipients were mental diseases and disorders, and primary care providers, and support staff, as the focus on preventative and primary care services are needed to achieve the 25% reduction in avoidable hospital use (emergency department and admissions). Another category with substantial growth potential is home care. A comprehensive set of strategies to attract, train and retain these categories will build capacity and preparedness to meet the patient population needs through an integrated care system. Significant support will be mobilized to recruit and train the necessary clinicians, support staff and educators to overcome existing shortages. Overall, health services need better care coordination and interdisciplinary team approaches within, and between, settings.

Workforce strategies will positively impact access issues, while the cultural competency and health literacy efforts [Section 7] will assist in having staff with the right training, in the right place, providing high-quality care, thereby improving patient engagement and health outcomes.

The AHINCPPS' five year vision is to ensure residents in the region achieve high quality care, better health outcomes and lower costs. The future state will provide patients with a fully integrated approach that centers on preventive and primary care services, offers ample home and community based options and relies on high quality acute and long-term care facilities, when needed most.

***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.

The PPS used a local approach to identify training, redeployment and recruiting needs by soliciting input from the five Regional Health Innovation Teams [RHIT] who completed project plans and included workforce needs in each. The AHINCPPS will convene a Workforce Committee in January 2015, using the two AHECs that serve the nine county region, to develop the detailed workforce implementation plan and strategies needed to minimize the impact to the incumbent workforce. It is anticipated that positions within acute care settings will decrease minimally over time, but this decrease will be accomplished primarily due to attrition and unfilled positions. The innovative and transformative nature of DSRIP will require ongoing clear and consistent communication with employees. The project overall will provide new, exciting opportunities in community based settings. Communicating the positive aspects through multiple outlets like the Healthy ADK web based clearinghouse, as well as sharing available training and job opportunities will also minimize the impact to the workforce.

The region has difficulty recruiting all types of providers, particularly physicians. There are 40% fewer active primary care physicians (86 per 10,000 population) than statewide (120 per 100,000) and 73% fewer active physician specialists. There are also fewer dentists (45 per 100,000) than the rest of the state or upstate (78 and 62, respectively). The North Country has a disproportionate number of primary care shortage areas, with 3% of the state's population but 17% of the state's designations as underserved by primary care professionals. Additional workforce shortages identified include home care, long term care staff, emergency medical services (EMS), and behavioral health and substance abuse clinicians.
With increased coordination, resources and staffing, a significant decrease in the number of avoidable hospitalizations and ED visits can

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be attained. To assist with recruitment and retention efforts related to primary care providers and behavioral health providers, the PPS will utilize programs currently available such as Doctors Across NY and Primary Care Service Corps along with promotion and support of other programs such as the Northern New York Medical Foundation Scholarship to support 3rd and 4th year medical students attending one of NY's public medical schools who make a commitment to practice in Essex, Clinton, Franklin and St. Lawrence counties.

Training is available within the region for home health aides and incentives such as sign on bonuses will be offered and other methods to enhance recruitment efforts will be implemented. Through established collaborations with SUNY, the PPS will work with educational institutions/training organizations and employers/providers within the region to review the needs related to behavioral health, substance abuse and palliative care and develop capacity initiatives to enhance current training opportunities.

Integrated care management and care coordination will be necessary to achieve DSRIP goals, and in this region the need is particularly strong related to chronic disease management and behavioral health issues. The AHINCPPS will work with HM AHEC, which has existing curriculum and training experience through its HWRI funded project in Care Management Skills to provide additional programming within the region.

Attainment of DSRIP project goals relies on an adequately sized, located and trained workforce. The AHINCPPS will utilize the Workforce Committee, its workforce vendors, the Communications Manager, the communications engagement plan, and the Workforce Manager to design, develop and implement a multi-pronged workforce approach including recruitment, educational capacity, training, monitoring and evaluation to transform the region's health care system.

***Strategy 3:**

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

Workforce Implication	Percent of Employees Impacted
Redeployment	1%
Retrain	5%
New Hire	5%

Section 5.2 – WORKPLACE RESTRUCTURING - RETRAINING EXISTING STAFF :

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

Description:

Please outline the expected retraining to the workforce.

***Retraining 1:**

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

Retraining will be offered to current staff having base skills and experience, with those within the department offered the opportunity first. Communication with staff will highlight that health care transformation impacts all and that opportunities to be part of the future redesigned system with a team approach to care are available. Workflows and processes within departments may change, requiring staff to be retrained. All retraining opportunities will be voluntary. Those declining retraining will be referred to Human Resources within their organization for referral to Rapid Response services. Staff may also need to be retrained if another position with similar skills is vacant. The AHINCPPS strives to retain the existing workforce as it is the most efficient method to meet the needs of the health care system, avoiding recruiting costs, on-boarding and orientation costs in a system that already has difficulty hiring and retaining appropriate levels of staff.
Our workforce vendors and Workforce Manager will coordinate meetings of the Workforce Committee to ensure an exhaustive list of existing training programs, available in different modalities is current to expedite any needed education for staff. Training capacity issues

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will be identified and a strategic plan will be created. Training modules will be presented when available via webinar sessions to expand the reach throughout the 11,000+ mile region.
The Workforce Committee will beginning meeting in January 2015, and then at least quarterly thereafter, to review and update the workforce projections for retraining across the 11 projects. With assistance from the Workforce Manager, workforce vendors and union representatives, the Committee will develop a comprehensive, transparent strategy to address workforce retraining throughout the project period. Certain projects will be impacted to a greater degree by retraining. The Regional Health Innovation Teams [RHIT] provided initial recommendations that identified more than 880 staff in various areas including:

- Nursing staff will need additional behavioral health training to provide home care services to manage the patient population
- Team members, including care managers and home care staff, will receive training in how to support evidence-based medicine and chronic care management, specific to dementia patients and how to identify and respond to patient risks for readmission
- Certifications for nursing staff as Certified Hospice and Palliative Care Nurses and LPNs
- Cross training ambulatory detox staff, mobile crisis teams and first responders
- Primary care staff trained on PCMH models, including evidence-based preventive and chronic disease management
- Community navigators training
- Patient engagement training including escalation techniques and motivational coaching
- Ambulatory detox training development and certification
- Education and training for first responders, physician offices and hospital staff for referrals to the outpatient detox programs
- Advanced certification for home health aides
- Dual certifications of HHA/CNAs
- Develop centralized COPD training support
- Training to implement collaborative, team based care models
- Cultural and linguistic training on MEB health promotion, prevention and treatment
- Training social workers as community services experts on the care team
- Telemedicine training
- Medical Villages provide an opportunity to retrain staff to work in the new service lines.

The PPS will allow for retraining on a regional level instead of each provider implementing programs individually for small numbers of staff. As the project plans are implemented, there will be overlaps in programing and the needs can be coordinated on a regional level and implemented on a local level, with resources and best practices shared with neighboring PPSs via a learning collaborative model.

***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.

Changes in a transformed health care system can be expected as care moves from the acute to ambulatory setting. Acute care pay rates have been traditionally higher and some impact will be expected. Continued sustainability of the health care system will rely on a value based approach, easing the negative impact of decreased salaries, as teams of health care providers manage the population's health. The Workforce Committee will work with Human Resource staff and the workforce vendors to compare salary ranges currently and future expectations as volume increases in ambulatory settings, with staff retrained, credentialed or certified through the AHINCPPS investment in workforce strategies. There is the potential that a small percentage of the staff that are redeployed will have a decrease in compensation between 75% and 95%. The Workforce Manager and workforce vendors will develop a template for Human Resource departments to utilize that will clearly summarize key factors of current and new positions to assist employees in making informed decisions. When compensation decreases by 5% or less, those employees will be categorized as having their compensation unchanged.

***Retraining 3:**

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

The goal of the PPS is to retain all staff who want to work in a transformed health care system with many opportunities and needs. The workforce vendors engaged for the AHINCPPS all have experience with NYS DOL displaced worker case management projects and will work closely with union representatives and partner organization Human Resource staff to rapidly respond to staff who are not interested in offered retraining or redeployment. Similar positions at another organization, through the Health Jobs ADK website, additional

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assessment of the employees' interests, and other positions with different job titles but requiring similar skills will be offered. Resume writing assistance, mock interviews and referral to local DOL services will be provided.

***Retraining 4:**

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

The AHINCPPS will include labor representatives as members of the Workforce Committee. Labor will also assist in engaging and informing frontline staff of changes and employment opportunities through communication channels including the Health Jobs ADK section of the Healthy ADK website. Union leaders will work directly with the Workforce Manager to design changes that meet the needs of the PPS and unions, review future staffing models, project staffing needs and assist with support services for staff, including additional resources and case management of any displaced workers.

***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	75%
Partial Placement	25%

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.

In order to transform the regional health care system and attain the ambitious goals of the DSRIP projects over a five year period, the AHINCPPS is committed to a comprehensive, multi-pronged approach to the health care workforce. We will need to increase the supply of health care workers in many occupations to meet the demand of the patient population. Redeployments are opportunities for existing staff to work in a new department or organization with the same job title, or to consider a new position that has similar job skills at the current employer or another partner organization in the PPS, that may require additional training or education. This is the most efficient way fill vacancies. Staff that remain in their current department and are only changing their role or job class are not considered to be redeployed. These staff will work with the partner organization's existing resources to implement the required change. The goal of redeployment is to have adequate staffing at appropriate locations with sufficient training and education to be productive, satisfied members of the care team in a patient centered model.

The Workforce Committee will beginning meeting in January 2015, and then at least quarterly thereafter, to review and update the workforce projections for redeployments across the 11 projects. With assistance from the Workforce Manager, workforce vendors and union representatives, the Committee will develop a comprehensive, transparent strategy to address workforce redeployments throughout the project period. Certain projects will be impacted to a greater degree by redeployments. The Regional Health Innovation Teams [RHIT] provided initial recommendations for those areas including:

• Ambulatory detox will require a reduction of inpatient beds; nursing staff will be retrained and redeployed with the detox program. An existing Medical Director will be redeployed; other staffing requires a Psychiatric Nurse Practitioner, two care managers, and eight peer support staff; with social workers shared with the Crisis Stabilization program.

• Inpatient palliative care services and teams will need to be redeployed to Community Palliative Care teams

• Mobile COPD unit and teams using outreach telehealth to connect patients

• Inpatient staff redeployed to work in home care settings to reduce re-hospitalizations within 30 days

The Workforce Committee will review project projections related to anticipated staff reductions or additions. The initial employee deployment numbers provided by the RHITs anticipated there would be 50 redeployments. If a partner organization does not have an

existing redeployment strategy, the AHINCPPS will recommend that staff, with acceptable performance ratings, facing a potential layoff, would have up to two weeks to make a determination if they wanted to accept the redeployment. Staff that refuse redeployment or do not meet minimum performance measures, will remain employed for three months and would be referred to the Rapid Response team for services. Human Resource managers at impacted organizations will request detailed information from department managers with expected vacancies. Staff details will be reviewed to determine if they belong to a protected class. The Committee will also combine and share PPS partner organization's new position requirements to create a detailed matrix of the vacancy needs of the 11 DSRIP projects.

***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.

The Workforce Committee will develop a redeployment/communication plan to keep employees abreast of changes and opportunities available. The Rapid Response team approach will provide additional detailed information about redeployment openings, offering on-site job shadowing opportunities and training assistance, if necessary. Staff will be provided key factors of new positions to assist them in making informed decisions. A comparison of staff's current positions with vacancies will be provided, particularly noting longer commute times, different schedules and care settings/locations. In some instances, these barriers may prove to be substantial enough that the staff will decline redeployment. This is a risk the PPS intends to mitigate as much as possible. There is the potential that a small percentage of the staff that are redeployed will have a decrease in compensation between 75% and 95%. When compensation decreases by 5% or less, employees are categorized as having their compensation unchanged. If staff chose redeployment, the PPS will strive to keep them within the regional health care system, making referrals to neighboring PPSs if needed.

***Redeployment 3:**

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

The goal of the PPS is to retain all staff who want to work in a transformed health care system. If staff are offered redeployment in their same position but in a different organization, department or location, but choose not to accept the opportunity, they will be referred to the Rapid Response team. The workforce vendors engaged for the AHINCPPS all have experience with NYS DOL displaced worker case management projects and will work closely with union representatives and partner organization Human Resource staff to rapidly respond to staff who are not interested in redeployment. Additional assessment of the employee's interests and career counseling assistance will be offered. Resume writing assistance, mock interviews and referral to local DOL services will be provided.

***Redeployment 4:**

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

The AHINCPPS will include labor representatives as members of the Workforce Committee. Labor will also assist in engaging and informing frontline staff of changes and employment opportunities through communication channels including the Health Jobs ADK section of the Healthy ADK website. Union leaders will work directly with the Workforce Manager to ensure that contractual agreements of partner organizations in the AHINCPPS are shared and followed and to support filling vacancies with their members before recruiting on the open market. The Workforce Committee will develop a communication plan to keep staff abreast of changes and opportunities in the midst of transforming the region's health care system. Communication templates will be provided to various workforce stakeholders, including Human Resource staff, union representatives and PPS staff to ensure transparent, comprehensive, timely information sharing. As workforce needs will changing throughout the project period, this plan will be reviewed at least quarterly.

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.

Recruitment in rural, underserved areas pose particular challenges to the health care system in the AHINCPPS region. A comprehensive, coordinated strategy utilizing existing resources and expertise while supplementing with new opportunities and technology to engage the

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future generation of health care workers will be needed. The pipeline approach to "growing our own" has the best results in retaining recent graduates whether from high school, community college, graduate school or medical training programs. There were 850 new positions initially identified by the Regional Health Innovation Teams across the 10 county region to address the 11 projects. The number will fluctuate as the project period advances and workforce needs emerge. The region faces significant retirements in the near future in public health, EMS, physicians and nurses, with many in their 50s and older. Coupled with a "brain drain" of youth leaving the region, recruitment of qualified candidates, to fill vacancies and expand the workforce as needed in primary and preventive care settings, will be a challenge, requiring significant resources.

Using the recommendations and strategic plan of the Workforce Committee, the PPS will promote Health Jobs ADK across the region as a web based platform to post vacancies, provide a "one stop" for resources such as signing bonuses, available training and tuition support/scholarships. This platform will also allow for virtual job fairs to be conducted, allowing for position announcements to be done outside the area if the needed staff cannot be located from within the region in a timely manner. Using the workforce vendors, educational institutions and current health care employers will be contacted to promote employment opportunities like community navigators, health coaches and other primary care/preventative care support staff. Additional recruitment strategies will include funding support to preceptors and students for clinical rotations utilizing a web based platform, CT Connect, to coordinate placements; supporting the use of LMSWs with supervision/mentorship until they achieve LCSWs; a Healthy ADK loan forgiveness program [requiring minimum service periods]; and assistance to advance the region's rural residency program for family medicine.

New hires initially identified include:

- Home health and personal care aides to provide community based care in home settings, and to reduce unnecessary admissions and re-admissions [n=375]
- Physicians to expand primary care services and ambulatory detox [n=18]
- Nurse Practitioners to assist with transformation needs across all projects [n=53]
- Pharmacists to assist with palliative care needs of patients [n=4]
- Transition and health coaches, social workers, and case managers to assist with hospital to home care and preventative services [n=196]
- Mental health providers including psychologists, psychiatrists, psychiatric nurse practitioners and social workers to provide expanded mental health services to targeted populations identified in DSRIP projects [n=37]
- Hospice and/or Hospice-like service providers for palliative care
- Administrative positions such as team leaders and care coordinators
- IT staff to assist with technology and EHRs across all projects
- Union/non-union mix not expected to change significantly

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	39
Physician	19
Mental Health Providers Case Managers	109
Social Workers	73
IT Staff	18
Nurse Practitioners	53
Other	559

Section 5.5 - Workforce Strategy Budget:

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

Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Retraining	750,000	1,000,000	250,000	225,000	100,000	2,325,000

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Funding Type	DY1 Spend($)	DY2 Spend($)	DY3 Spend($)	DY4 Spend($)	DY5 Spend($)	Total Spend($)
Redeployment	200,000	100,000	50,000	50,000	5,000	405,000
Recruiting	300,000	1,000,000	475,000	225,000	45,000	2,045,000
Other	250,000	400,000	225,000	200,000	100,000	1,175,000

Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

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

As health care workforce has been an ongoing concern, AHI has already dedicated resources to this issue. Staff participate on the HANYS Workforce Advisory Group to advocate for resources with statewide partners for various workforce initiatives, most notably Doctors Across NY [DANY]. The Primary Care Service Corp application upcoming deadline was promoted recently via blog post. Staff participate in regional residency planning meetings in both Glens Falls and Plattsburgh and will support those projects with PHIP funding. AHI will also be developing a regional web-based
clearinghouse, Healthy ADK, through its PHIP funding, to provide information, education and resources to engage patients, providers, payers and purchasers in region's transformed health care system. One component of this site will be Health Jobs ADK that will have updated resource directories from a NYS DOL health workforce planning project and the SUNY Right Professionals in the Right Place initiative, along with current information from educational institutions, trainers, the two AHECs serving the region and various associations including HANYS, CHCANYS and Iroquois Healthcare Alliance. Through the Health Jobs ADK site, the Workforce Committee members and the AHINCPPS partner organizations will be notified about additional state programs such as DANY, Primary Care Service Corp, and Health Workforce Retraining Initiative [HWRI], including deadlines for submission and award notifications. One AHEC is co-located with AHI and has two current HWRI projects that AHI is participating in, care coordination and business skills for new managers. Federal and other resources directed toward training, education and retraining for health care workers will be monitored and disseminated by the Workforce Manager. Requests for assistance with submissions will be coordinated by AHI's program, the Adirondack Rural Health Network that has a current initiative to coordinate/develop regional grant applications.

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.

Health care workforce needs across the nine county region have been a long standing issue. Stakeholders have been engaged through the North Country Health Systems Redesign Commission from 12/13 – 4/14, SUNY's Right Professionals in the Right Place project from 10/13 – 5/14 and from ongoing efforts of the two Area Health Education Centers that serve the region. Workforce stakeholders participated DSRIP meetings from April to December. There are more than 100 representatives that will be invited to participate in the Workforce Committee, with two subcommittees convened in person and information synthesized and shared to the entire Committee via webinar meetings, scheduled to begin in January. A chairperson will be nominated and approved by the Committee, which will be comprised of various representatives from across the care continuum and various sectors including providers of all types, community based organization and education, government, associations and labor representatives.

***Engagement 2:**

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

AHI convened regional meetings, open to the public, beginning in April 2014, inviting over 400 interested parties. Since then, the Project Advisory Committee and five Regional Health Innovation Teams have convened across the nine county service area, connecting with stakeholders at the local level to ensure involvement and participation. Planning and development of the PPS workforce approach will be detailed in the implementation planning period beginning 1/15. The PPS will contract with the two AHECs to assist with this part of the

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project. Each partner organization in the AHINCPPS has identified a worker representative [over 100] and an initial list of 21 union representatives including SEIU 1199, CSEA and the NYS Nurses Association. Workforce stakeholders, (including more than 50 participants at each of the three SUNY RP2 meetings held over a six month period), will be invited to participate on the Workforce Committee, one of the Standing Committees in the PPS organizational structure that will be serving in an advisory capacity to the Leadership Board of the AHINCPPS.

***Engagement 3:**

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

Front line workers will be engaged throughout the DSRIP project period through a targeted communications plan with messages, timeframes, media outlets, responsible parties and metrics. Focus groups with frontline workers will be conducted during the implementation planning period. Concerns and risks shared will be a focal area of the Workforce Committee to identify solutions. The Communications and Workforce Managers will develop a template for an electronic newsletter that Human Resource staff at the 100+ partner organizations, unions and associations could use to keep staff informed of changes. Webinars, web site postings, town-hall type meetings and on-site visits scheduled in five RHIT areas, will include workforce plans, encouraging feedback and input. Throughout the project period, the Workforce Committee proceedings/outcomes will be publicly available via website posting. Staff will be provided various resource contact information to allow for direct communication of concerns, questions and guidance.

***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.

During implementation planning, the Workforce Committee will hold meetings that include more than 30 workforce representatives, to review summarized project templates submitted by five Regional Health Innovation Teams [RHIT] in early December; the 11 project applications and the anticipated workforce impacts. The Committee will identify and catalog workforce needs by sector/type of facility, opportunities, challenges and strategies. This catalog will be added to the recently completed SUNY RP2 regional resource directory. The Committee will also develop a review process to address any structural barriers that arise during the project period. A communications plan with messages, timeframes, media outlets, and metrics will be developed. Town-hall type meetings scheduled in five RHIT areas, will include workforce plans, encouraging feedback and input. Throughout the project period, the Workforce Committee proceedings/outcomes will be publicly available via website posting.

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.

The transformation being undertaken by the AHI North Country PPS requires effective use and sharing of data. It is important to balance patient's rights to data protection/confidentiality with the need for collaboration and coordination within the PPS. Our data sharing & confidentiality plan will be based on policies and procedures set forth by NY State, HIPAA and Federal Policy for the Protection of Human Subjects. The PPS' Information Technology and Data Sharing Committee will be responsible for developing policies and procedures that ensure compliance with regulations that promote the responsible use of data and ensure strict confidentiality. AHINCPPS will leverage the local RHIO, a Qualified Entity (QE) that must abide by NY State standards, policies and procedures for data privacy and security.

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

The PPS' Information Technology and Data Sharing Committee will be responsible for ensuring uniform application and compliance with PPS data sharing and confidentiality protocols. Each partner in the AHINCPPS will be required to sign a Participation Agreement (PA) outlining participant responsibilities, Business Associate Agreement (BAA) containing the elements specified at 45 CFR 164.504(e) (use, disclosure and data protection) and Data Use Agreements (DUA) describing in further detail what the shared data will be used for, including additional safeguarding regulations. Additionally, all PPS participants that will be participating in the RHIO will sign a Hixny Participation Agreement (Hixny PA) adhering to NYS standards for QEs including breach and privacy protocols and HIPAA provisions.

***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.

Most of the PPS' hospitals and PCPs have already implemented meaningful use compliant eHRs. A large proportion of these were connected to Hixny as part of a HEAL 10 grant administered by AHI making them part of a network that includes 28 hospitals and 2,200 physicians. Hixny will become part of the SHIN-NY, making AHI NC PPS' Hixny participants part of a secure, consent-based, state-wide data sharing network. The PPS will leverage this infrastructure, including Hixny's robust patient data privacy and confidentiality protocols,

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to support appropriate real time data sharing among all of the PPS' authorized users. Hixny provides a variety of options for data sharing, including full bidirectional exchange of CCD-As, patient and provider portals, data extracts, alerts and messaging based on surveillance tools that monitor changes in the patient's health status, that can be deployed based on the participant's role in the PPS.
AHINCPPS has conducted a survey of our participants HIT capabilities and will use that information and our HEAL 10 experience to expand sharing of core data elements across the PPS. In addition to implementing a robust population health platform, our data sharing strategy includes providing participants with tools to effectively communicate with their patients to obtain informed consent. We will deploy education and training resources to assist the practice in developing and managing consistent data sharing, communication, analytic and performance tracking capabilities. These training needs have been accounted for in our workforce strategy.

Section 6.2 – Rapid-Cycle Evaluation:

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

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

***RCE 1:**
Identify the department within the PPS organizational structure that will be accountable for reporting results and making recommendations on actions requiring further investigation into PPS performance. Describe the organizational relationship of this department to the PPS' governing team.

Rapid-cycle evaluation (RCE) is the basis for realizing performance improvements that will drive outcomes-based payments that will account for a growing share of our DSRIP payments and key to sustainability as participants enter into value-based arrangements with payors. This will require a culture devoted to optimizing outcomes for patients, clear responsibilities and accountability of staff for outcomes, optimizing and standardizing processes vital to realize outcomes and continuous measurement outcomes and process metrics that drive outcomes.

The experience AHI and its partners have gained building regional quality and all payor claims databases and metrics, creating a Triple Aim-based P4P program and entering into performance-driven shared savings programs will provide a solid foundation for AHI NC PPS' performance management programs. Deployment of our RCE performance program will be guided by the PPS' Clinical Governance & Quality and Audit, Compliance & Finance committees and coordinated by our Regional Health Improvement Teams (RHIT) which will have responsibility for the clinical and financial outcomes of individual programs and will be represented on those committees.

***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 PPS will use the MAPP PPS-specific Performance Measurement Portal for the monitoring of its performance on the claims-based, non-Hospital CAHPS DSRIP metrics, as well as the DSRIP population health metrics. This portal will show our performance vis-à-vis baseline information, benchmarks, and gap-to-goals targets per metric. We will also develop our own PPS Population Health and Performance Measurement platform using data from medical records. The PPS will seek to obtain claims-based data from the MCOs and the State to merge with clinical data to provide a powerful, integrated, multi-tiered system that will support population-based quality improvement activities and deliver risk adjusted composite data allowing our analysts and care management teams to direct resources to the greatest clinical and financial risks.

***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).

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The Population Health and Performance Measurement platform will provide a single source for role-based access to dashboards and reports documenting the performance of the AHI NC PPS. The clinical and finance committees will have dedicated dashboards that will allow them to drill down from an overall PPS level to investigate performance issues and successes. Dashboards will also provide the RHITs, analysts and providers role-based capability to drill down by program and participant. The platform, an evolution of the regional quality metrics and all payor utilization dashboards developed for the Adirondack Medical Home Initiative (AMHI) by AHI and its partners through the Heal 10 grant, will provide consistent data to support program management and accountability.

***RCE 4:**

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

The RCE will be the core of the AHI NC PPS performance management program. Using real-time practice and inpatient eHR, ADT, care plan and screening data and surveillance-based alerts and messages in combination with timely claims data, the RCE program will provide current information on the health status of PPS clients to the members of the care team best positioned to take appropriate action. It will link outcomes to interventions allowing timely monitoring, evaluation and adjustments by governance committee, RHITs and participants. The RCE will connect and invest the entire care team in a common goal, creating a true integrated delivery system.

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SECTION 7 – PPS CULTURAL COMPETENCY/HEALTH LITERACY:

Section 7.0 – PPS Cultural Competency/Health Literacy:

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

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

Scoring Process:

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

Section 7.1 – Approach to Achieving Cultural Competence:

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

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

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

The AHI North Country PPS [AHINCPPS] focuses on building healthy communities across an expansive geographic area, that is largely rural, presenting unique cultural diversity issues related mainly to age, education and income. These key determinants of health need to be addressed to deliver care that is respectful of patients, whether poor, aged, disabled or illiterate, to reduce disparities. The population skews older than the Upstate NY distributions for those 65 and over, with three counties ranging from 17.3% to 23.3%, compared to Upstate at 14.6%. An aging population living in a rural area is hindered by transportation, weather, isolation, information technology limits, inability to manage a complex health care system, incidence of health issues, and memory loss.

Other challenges with a rural population include access issues. Rural residents need to travel farther for employment, may have more hourly/minimum wage positions or be self-employed, and work in seasonal occupations like food service and logging that may not allow time off for routine medical care. The income levels in this region are lower than Upstate NY, impacting housing choices, leisure activities and healthy food purchases. Coupled with lower education attainment, barriers in accessing primary care and preventative services, inability to comply with a course of treatment or preventative activities can evidence itself more often as unwillingness to seek care or non-compliance. Cultural and generational norms contribute to unhealthy behaviors and lifestyle choices including higher rates of smoking, alcohol and substance abuse, mental health issues and chronic diseases. Though the region is predominately white, there are sections with racial and ethnic diversity due to migrant farm workers, seasonal tourism industry workers and the St. Regis Indian Reservation population, each of these have distinct cultures that will also need to be understood and considered to deliver high-quality care.

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***Competency 2:**

Describe the strategic plan and ongoing processes the PPS will implement to develop a culturally competent organization and a culturally responsive system of care. Particularly address how the PPS will engage and train frontline healthcare workers in order to improve patient outcomes by overcoming cultural competency challenges.

AHI will use its experience convening and engaging stakeholders with the Patient Centered Medical Home, Adirondack Rural Health Network and Health Home projects to collaboratively develop a regional strategic plan that will be approved by March 1, 2015 and will include ongoing processes for DY2-DY5 to ensure the vision for a culturally competent and responsive system of care is attained. AHINCPPS is committed to patient centered care, delivered respectfully and appropriately, regardless of race, age, gender, ethnicity, religious beliefs or sexual orientation, to improve patient outcomes and to reduce health disparities, providing optimal care to all patients. The following strategies will be implemented to achieve this vision:

• Measuring disparities in outcomes for different groups and assessing current cultural practices; through analysis and results being disseminated/published by AHINCPPS staff with annual progress monitoring reports to the AHINCPPS Leadership Board

• Ensuring adequate translation services; through assessment of the more than 100 partner organizations in the PPS

• Providing evidenced-based best practices, tools, resources and policy recommendations to providers and community based organizations including adoption of the National CLAS Standards; tracking implementations and reporting progress at least quarterly

• Sharing lessons learned between systems, agencies and groups via the Healthy ADK website clearinghouse

• Developing customized cultural competency training content that focuses on understanding the patient's culture, preventing personal bias, social determinants of health, social and cultural barriers/solutions; and linguistics appropriateness; the PPS plans to archive this content in the education library of the Healthy ADK website;

• Offering quarterly staff training to front line workers as well as executive management, via webinars, which will be recommended for inclusion in new staff orientations and annual in-service sessions.

***Competency 3:**

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

The PPS will solicit applications from its existing partners interested in contracting for cultural competence advancement including:
1. Adirondack Rural Health Network, with an 18 member Steering Committee including EMS, United Way, and the Office of Community Services
2. Community Health Planning Committee with 30 participants including public health departments and hospitals
3. AHI's Enrollment Assistance Services and Education (EASE) Department with Education & Outreach staff who have conducted professional training to 1,431 staff at 456 different organizations on the NY State of Health Marketplace and other insurance options including Child Health Plus and Medicaid
4. North Country Population Health Improvement Collaborative's Health Advisory Council to be convened in January 2015 with more than 30 organizations representing 14 stakeholder groups including education, employers, prevention agencies and behavioral health organizations and
5. The lead training content provider, with expertise in community engagement and cultural competency, along with the PPS's workforce vendors and other experts.

Interested community based organizations (CBOs) will serve as contractors and agree to:

- conduct community based focus groups for a cultural diversity assessment,
- provide content to the cultural competency training and/or
- attend a Train the Trainer program to transfer knowledge to staff, other groups and systems to ensure engagement in a culturally competent and responsive system of care.

The PPS staff will review applications and determine contracts based on cost, experience, geographic reach and preparedness for rapid deployment. Contracted CBOs will commit to participate through year 5 of the project, provide quarterly progress reports and disseminate information regarding cultural competency issues at least quarterly. Staff will monitor completion of deliverables, if found to be inadequate, will terminate the contract and seek other CBO contracts.

Section 7.2 – Approach to Improving Health Literacy:

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

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

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

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

The PPS will improve and reinforce health literacy of patients and clients served by educating and sharing resources with providers, patients and community based organizations across the nine county region. According to the 2013 QARR-Medicaid-Satisfaction-with-Experience-of-Care, only 48% of respondents in this region were satisfied with the shared decision making aspect of their care, down nearly 10% from 2011. The most recent National Assessment of Adult Literacy reported an indirect estimate of 8% to 15% of this region's population lacking basic prose literacy skills. The lower educational attainment of the region, combined with gaps in literacy skills and resistance to seek care, assistance and/or clarification make obtaining, processing and understanding basic health information and services problematic. Other challenges include technological gaps in lower income households with limited availability to computers, broadband internet and cell service. Patient information dissemination methods will include a health literacy focus whether verbally, in documents or electronically, in order for patients to make informed health decisions.
The PPS is committed to a comprehensive understanding and approach to ensure health literacy is integral to its mission, structure and operations, evidenced by inclusion in governing documents, reporting mechanisms and key activities to achieve milestones. A multi-pronged approach is needed to ensure materials, environments and challenges associated with prevention and health promotion are provided in a "health literate" way, to improve the region's health literacy, which is difficult to quantify, since the last regional assessment completed by the U.S. Department of Education is more than 10 years old. Education. The following strategies will be implemented to promote health literacy:
• measuring literacy levels for the population to be served and assessing current provider practices; through analysis and results being disseminated/published by the PPS staff with annual progress monitoring reports to the AHINCPSS Leadership Board
• providing evidenced-based best practices, tools, resources and policy recommendations to providers and community based organizations; tracking implementations and reporting progress, at least quarterly
• sharing lessons learned between systems, agencies and groups via the Healthy ADK website clearinghouse
• developing customized staff training content that focuses on a patient's literacy level; providing appropriate health promotion information; verbal, non-verbal and written patient-provider communication, motivational interviewing; and roadblocks to effective communication; the PPS plans to archive this content in the education library of the Healthy ADK website;
• offering quarterly staff training to front line workers as well as executive management, via webinars, which will be recommended for inclusion in new staff orientations and annual in-service sessions.
• reporting progress and evaluation measures quarterly to the AHINCPPS Leadership Board, Network and Quality Committees and stakeholders

The PPS will solicit applications from its partners and other organizations interested in contracting for health literacy advancement, using the same review, award and monitoring process noted in the cultural competency section above. Interested Community Based Organizations (CBOs) will serve as contractors and agree to:
1. conduct assessments of client's/patient's literacy levels
2. provide content for the health literacy training focused on rural health care issues
3. conduct a review of currently disseminated information and/or

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4. attend a Train the Trainer program to transfer knowledge to staff, other groups and systems to ensure an individual possesses the skills to comprehend information and services and uses those skills to make appropriate health decisions.

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 AHINC PPS DSRIP fund distribution plan provides for PPS infrastructure, regional project implementation and network sustainability. The PPS Finance workgroup evaluated and assigned 16 funding pools to ensure a sustainable financing/investment model. The 6 budget categories are: project implementation, revenue loss, internal PPS provider bonus payments, non-Medicaid covered services, contingency and innovation. Some pools are formula driven and others are performance driven to ensure achievement of DSRIP goals. Potential Pools include the Capital Fund and any State funded PPS–wide Bonus Pool or Shared Savings Pool. Excess funds that become available will go to the bonus pool.
The distribution plan allocates funds for central services and project-specific implementation, staffing, and related costs to meet milestones, metrics and DSRIP administrative needs. The plan also provides incentive based, delivery system support and transitional funding to offset costs, provide technical assistance with stabilization plans/restructuring and shift to a VBP model to achieve DSRIP goals. The finance workgroup endorsed non-qualifying DSRIP provider and transformation pools to ensure special funding to assist non-safety net providers, fund innovative and pilot projects to engage providers and community while ensuring that the SNPs receive 95% or more of the distributed DSRIP funds.
Based on the uniqueness of provider types in our region and varying contributions and roles in achieving DSRIP objectives, Regional Health Innovation Teams (RHIT) include representatives across the health care continuum including primary care, clinical specialist, SNFs, Home Care, community based organizations and other SNPs. The leaders serve as intermediaries between the PPS Network and regional partners. RHITs identified project funding needs to execute on selected projects and propose how the funding will be allocated or change over time.
To achieve DSRIP goals, project budgets will be allocated through a hierarchical process: region, specific projects, pools, then to providers/provider types and community based organizations. The distribution method assesses value of the projects, # of attributed Medicaid members impacted by the project, population health readiness and expertise, ability to provide human/financial resources committed to PPS goals. Once allocation percentages are derived for each Fund and Pool category, distribution protocols will be developed based on the hierarchical process including distribution at the provider level.

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DSRIP budget, flow of funds and capital restructuring proposals will be made to the AHI PPS Finance Workgroup who is charged with recommendations to the PPS Steering Committee. Certain financial issues will require escalation to the AHINCPPS Leadership Board as the tasks of the governance structure are finalized. This structure will include provisions for monitoring and modifying the budget and funds flow based on any changes needed to achieve DSRIP goals. As the AHINCPPS is formed, Adirondack Health Institute will exercise its reserve powers.
The distribution plan allocates funds, consistent with governance, to ensure our PPS partners and providers are positioned to respond to changes in the system as they face a unique set of circumstances due to a large geographic area, low population density, aging population with relatively poor health outcomes and poor health behaviors that create challenges further strained by the region's lower socioeconomic status. The projects have been designed to ensure a viable system and stabilize the health care delivery system. The funds flow model will reward high performers of DSRIP goals, reward progress towards value-based payments, incentivize collaboration, secure integration, inject residency slots and reserve for unexpected events as providers adapt to an evolving payment system.

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	30%
2	Revenue Loss	25%
3	Internal PPS Provider Bonus Payments	25%
4	Non-Medicaid Covered Services	5%
5	Sustainability	10%
6	Innovation	5%
	Total Percentage:	100%

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

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

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

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☑ Please click here to acknowledge the milestones information above.

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SECTION 9 – FINANCIAL SUSTAINABILITY PLAN:

Section 9.0 – Financial Sustainability Plan:

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

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

Scoring Process:

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

Section 9.1 – Assessment of PPS Financial Landscape:

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

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

To assess the financial health of AHINCPPS the PMO:
• reviewed publicly available data, including a published 2014 North Country Health System Redesign Commission report of health facilities in our region
• identified providers receiving IAAF or VAP funds
• utilized a survey method to gather financial information on PPS partners
Survey indicators included organizational stability, financial performance over a 3 year period, payer mix data and anticipated impact proposed projects would have on the financial stability of the provider during and after the DSRIP program. Respondents were asked to contemplate the foreseeable impact this MRT Initiative, which includes community-level collaborations, continued system transformation, clinical and population health improvement, would have on their sustainability.

The program management office compiled the preliminary survey results, grouped partners by provider type and then ranked the organizations by financial strength and those most sensitive to changes in reimbursement. The survey confirmed that most hospitals and nursing homes in our PPS are operating with very low or negative operating margins. Overall, the assessment corroborated existing knowledge of the financial health the PPS possessed based on past and current regional health initiatives.

AHINCPPS continues to focus on identified hospital, skilled nursing facilities, home health, and behavioral health partners that are

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currently financially challenged and are at risk for financial failure. The Finance Workgroup and PMO will contact providers who identified use of, or dependencies on, sources of funding that might or will be impacted by DSRIP. Additional financial information has been requested to evaluate operating and financial trends, including sensitivity analysis of cash flow, workforce and financial impact of reduced utilization.

***Assessment 2:**

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

The AHINCPPS funds distribution plan includes six budget categories; project implementation, revenue loss, internal PPS provider bonus payments, non-Medicaid covered services, contingency and innovation to address the expected financial impact to achieve DSRIP goals.

Specific responses from AHINCPPS partners on the anticipated financial impact of the DSRIP program include:

• As certain services are eliminated or reduced and new services are introduced during project implementation necessary transitions in workforce, space use and other costs will be incurred.

• Many facilities require renovation to existing infrastructure in order to create an integrated delivery system.

• As new provider's transition to or advance PCMH certification, revenue will be impacted by limited human resources and lost productivity due to distraction of electronic medical records implementation and/or remediation and changes to workflow process.

• Projects that increase outpatient and community-based service capacity will likely further reduce hospital inpatient volume, placing additional stress on hospital financial stability.

• Providers transition from FFS to value-based payment model

• Regulatory reforms need to be in place to enable both partners and projects to function as intended and be financially viable

• There will be competition for profitable vs an unprofitable patient population.

• There was a strong belief the financial consequences of the successful achievement of DSRIP goals (reduced admissions, reduced ED visits, etc.) may outweigh reimbursement of the Expectation of community and non-safety net providers to contribute to the transformation of the health care delivery system.

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.

During Nov. 2014, the AHINCPPS Finance Workgroup identified actions needed to develop a Financial Sustainability Plan (FSP) in Jan. 2015. Initial finance and program office tasks will be to develop policies and procedures for accountability of funds flow, budgeting, and continuous reporting of financial and non-financial metrics. Specific reporting/monitoring protocols will be established for those financially fragile providers identified during the initial PPS assessment period or those that require oversight with a restructuring or sustainability plan. The Finance workgroup will approve the policies and procedures as the foundation for the FSP that will monitor the PPS's sustainability throughout the DSRIP project period with specific criteria to engage the Leadership Board.

Selected application projects will serve as a guide for the Finance Workgroup's identification of: project interdependencies, providers critical to DSRIP goals, risks for disruption of access to services. The overarching FSP will address partners by region and the impact to the PPS as a whole. The budget and flow of funds model targets fragile SNPs and other entities providing services in geographically isolated communities and allows for reductions due to statewide missed DSRIP goals.

The finance workgroup approved DSRIP funds to temporarily stabilize partners negatively impacted by project implementation, provide technical assistance to financially fragile partners identified as sustainable, and fund transition-related lost revenue early in DSRIP as partners navigate transition to VBP systems. The AHINCPPS has identified 3 organizations requiring or currently under restructuring efforts. Two hospitals are recipients of IAAF funding and one SNF is part of the Blue Line Group VAP funded application. Each

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organization has implemented cost saving measures including layoffs over the past 2 years. While IAAF and VAP help bridge the gap, these organizations are rightsizing as quickly as possible and the PPS will work closely with leadership to ensure efforts will not have an impact on the ability of the providers to participate in the PPS. Financial restructuring and reorganization plans will be evaluated by the PPS through the funds flow process for potential funding from the Contingency Pool. Additional requests will be made in the Capital Restructuring Financial Program application.

***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 AHINCPPS Finance workgroup (FW) will utilize the KPMG DST Finance team "Partners Financial Baseline Data and Project Information Collection Templates" to further provide a comprehensive sensitivity analysis for prioritization and monitoring of partners the PPS will need to focus on during DSRIP. It will be sent to partners identified as financially fragile or vulnerable to financial distress due to participation in the PPS. The Financial Stability Plan will outline monitoring procedure for financially distressed providers based on severity of their financial condition. The FW, Clinical Quality Improvement Committee and provider will develop and monitor a Performance Improvement Plans (PIP) to ensure fragile SNPs essential to achieving the PPS DSRIP goals have a pathway to financial sustainability. The budget and funds flow plan will require quarterly assessments of all partners within the PPS, monitoring financial & operational metrics against benchmarks. This process will enable the PPS to monitor and provide needed technical support to partners as they navigate DY1. The PPS will evaluate the monitoring process to ensure overall financial stability and meet DSRIP goals.

***Path 3:**

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

The PPS goal is effective integrated health care delivery systems for preventive, medical, behavioral, and long-term care. Lead Entity AHI has key stakeholders skilled in transforming healthcare. The Adirondack Patient Centered Medical Home (Pilot) is centered on technology and sustained via enhanced payment models. This joint initiative of providers and insurers works to transform health care delivery. Working within triple aim plus, goals include: improve health care, expand access, contain costs, and enhance workforce.
The PPS sustainability plan includes:

- Engage Pilot commercial payers in VBP talks
- Provide technical assistance and best practices to reinforce provider & patient roles in quality-based population health management (PHM)
- Build on integration of Health Home program with community based social support already moving to PHM
- HIT for complete data on patients over time & across entities

The PPS will be scalable and flexible to allow all communities to participate, reinforce the health system, and lead to sustainability. Leadership experience in program and fiscal management, and leveraging partner/provider commitment positions our PPS to sustain DSRIP outcomes.

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.

AHINCPPS is well versed in payment reform. AHI facilitates and coordinates provider activities in a 5 year old Medical Home Demo that includes Medicaid, 7 commercial payers and, since 2011, CMS through the MAPCP program. With AHI's support, many partners formed an MSSP ACO that began operations in Jan. of 2014. AHI has actively led in smaller areas of payment reform; including a provider designed and funded pay for performance program that includes utilization, quality and patient experience metrics.

The PPS vision aligns the transparent regional payment reform efforts in line with the VBP approach recommended by the MRT Payment

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Reform & Quality Measurement Work Group. The PPS 5 year path towards payment transformation will evolve over the project period as additional providers and partners engage in project implementation with a model that rewards high financial performers who are actually contributing to improve health outcomes and reduced total cost of care. The PPS recognizes payment transformation must allow for flexible multi-year phase-in to recognize stakeholder administrative complexities to effectively manage shared savings programs to maximize reimbursement, improve operating costs to deliver care more efficiently and advance HIT across our region.

Three Medicaid Managed Care (MMC) plans serve our region and AHI has relationships with them via the Medical Home Initiative and as a Lead Health Home. As payors agree to move the Adirondack Patient Centered Medical Home from Pilot to Program into 2017, they are engaged in developing a shared savings program.

***Strategy 2:**

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

Regional safety net providers will be financially stressed as DSRIP projects drive down hospital occupancy rates and emergency department visits which has been a trend over the past few years. While the funds flow model addresses the financial stress caused from reductions in income, we believe payment transformation will need to redistribute funds to the providers who drive performance as well as insure a financially stable system. Moving toward a shared savings model will drive a much more efficient, effective and sustainable way forward.

Adirondack Medical Home payor discussions include three MMC's who are also engaged in value-based payment discussions with other NYS PPS's. While not all AHINCPPS partners are ready to move into a shared savings model for driving down the cost of care, the majority of the network is comprised of several primary care medical home practices who are in discussion to move toward a PCMH focused payment model coupled with shared savings arrangement with upside risk in 2015 moving towards upside 50%/50% provider/payor and downside 50%/50% provider/payor by 2017. As Medical Home discussions align with PPS implementation, DSRIP incentive payments will be needed to sustain operations until shared savings can be used to assist some of the financially fragile safety net providers with their transformation. AHINCPPS anticipates by DY 3 all network providers will be participating in this value based payment approach and will be positioned to explore other value based payment models for certain chronic conditions, episodes of care and subpopulation health management such as Health Home as the DSRIP program proceeds.

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.

For nearly 30 years, AHI has provided services, technical assistance and operated programs to provide comprehensive health care services across the Adirondack region.

The Adirondack Rural Health Network has convened and coordinated regional stakeholders, including eight public health departments, eight hospitals and the region's only federally qualified health center, to complete community health planning activities and to assess regional needs. Initiatives include developing access to primary care and oral health; integrating mental health and primary care; increasing first responder medical service capacity; growing a transportation program for the elderly and disabled; leading regional activities that advanced health literacy, obesity prevention, workforce and behavioral health priorities.

Other AHI programs that prove experience in population health include: the Adirondack Medical Home Demonstration, a multi-payor, patient-centered model for the delivery of health care services that includes over 200 primary care providers in more than 40 practice sites with approximately 100,000 attributed patients, accounting for the majority of primary care delivered in the region; the Health Home network of nine subcontractors serves Medicaid Fee for Service and Managed Care beneficiaries. This program links community and social supports with health care and provides comprehensive care management for high-risk Medicaid members with a chronic condition(s); one-on-one, in-person assistance for health insurance enrollment to individuals, sole proprietors and small business owners at 35 community-based locations; Sexual Trauma and Recovery Service program advocates for victims of sexual abuse; and Community Health Advocate program assisted patients in receiving the health care benefits they were entitled to.

Proven Workforce Strategy Vendor (PWSV):
Minimizing the negative impact to the workforce to the greatest extent possible is an important DSRIP goal. If applicable, please outline whether the PPS has or intends to contract with a proven and experienced entity to help carry out the PPS' workforce strategy of retraining, redeploying, and recruiting employees. Particular importance is placed on those entities that can demonstrate experience successfully retraining and redeploying healthcare workers due to restructuring changes.

The workforce strategy related to the 11 projects is imperative to the success and timely achievement of DSRIP milestones. Although AHI has internal workforce capacity, the PPS recognizes the need to contract with vendors with proven experience and expertise to ensure workforce activities minimize negative impacts.

In November, AHI met with three organizations [Iroquois Healthcare Association - IHA, Hudson Mohawk and Northern Area Health Education Centers – HMAHEC/NAHEC] and determined each vendor offers specific skills that will benefit all projects. Combined, these independent vendors have more than 45 years of experience, administering nearly $45 million in federal, state and other funding sources for health care workforce needs, which impacted more than 65,000 students and professionals. Each vendor is experienced in rural health care systems; prequalified to do business in NYS; managed and implemented NYS DOH and DOL programs, using a case management approach, including Health Workforce Retraining Initiatives, TANF Health Worker Retraining Initiatives, Emerging and Transitional Worker Training Initiatives and Berger Commission restructuring changes requiring retraining, redeploying and recruiting employees impacted.

The nine county region is served by these two AHECs, each is a not-for-profit, focusing on underserved areas. AHECs have worked in various settings including primary care, oral health, public health, behavioral health, and pre-hospital [EMS]. In addition, AHI will contract

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with IHA, the regional hospital membership association, which is also experienced with the long term and home care workforce. The PPS anticipates opportunities to subcontract with other vendors and partner organizations as needed.

If this PPS has chosen to pursue the 11th Project (2.d.i. Implementation of Patient Activation Activities to Engage, Educate, and Integrate the Uninsured and Low/Non Utilizing Medicaid Populations into Community Based Care) bonus points will be awarded.

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

DSRIP PPS Organizational Application

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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 Adirondack Health Institute that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: ADIRONDACK HEALTH INSTITUTE INC
Secondary Lead Provider Name:

Lead Representative:	Cathy Homkey
Submission Date:	12/22/2014 03:30 PM

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