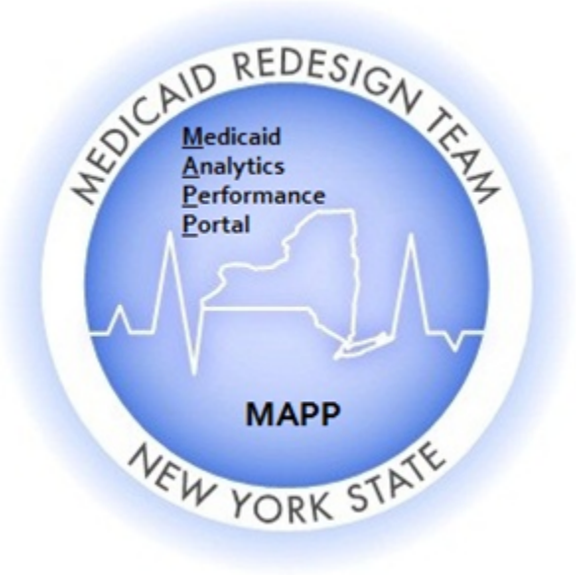
# New York State Department Of Health
# Delivery System Reform Incentive Payment Project

# DSRIP PPS Organizational Application




# Albany Medical Center Hospital

# Albany Medical Center Hospital (PPS ID:1)

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## DSRIP PPS Organizational Application

## Albany Medical Center Hospital (PPS ID:1)

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: **1_SEC000_Albany Medical Center Hospital dsrip_pps_lead_financial_stability_test_excel_toolvIICombined.pdf**

**Description of File**

PDF of Financial Stability Test excel tool.

File Uploaded By: brookse1
File Uploaded On: 12/22/2014 04:20 PM

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

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

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

Last Updated By: brookse1
Last Updated On: 12/22/2014 04:22 PM

Certified By: cliffog
Certified On: 12/22/2014 04:31 PM
Lead Representative: George Clifford

Unlocked By:
Unlocked On:

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

## DSRIP PPS Organizational Application

## Albany Medical Center Hospital (PPS ID:1)

## 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 | Over the project period, reduce avoidable emergency room use by 25% for the target population | Data from New York State and Albany Medical Center Hospital's (AMCH) community needs assessment indicate that there are opportunities to reduce cost, improve integration of care, provide services in more appropriate alternate sites to the ER, and change both provider and patient perceptions of what the ER can and should be used for. The goal of reducing avoidable utilization is measureable and obtainable over the project period of implementation. There are interested and committed partners in AMCH's performing provider system who are capable of working together to transform the system of care. There is also expertise available from Montefiore Medical Center and the Hudson Valley Collaborative PPS they lead, who we will partner with, to provide economices of scale and efficient and effective use of available funds. |
| 2 | Over the project period, reduce avoidable inpatient admissions by 25% for the target population. | Utilization data provided by the State and by the participating hospitals in AMCH's PPS, indicate that opportunities exist to reduce avoidable inpatient admissions for Medicaid beneficiaries and the uninsured. Reducing these avoidable admissions will generate system savings, freeing up space and other health care resources, over time. The goal is measureable and obtainable. The participating hospitals in the 5 county region are both willing and able to actively participate in the project. The goal is integral to most of the projects that AMCH, in partnership with Montefiore Medical Center, propose to undertake, consistent with additional details provided for domain 2, 3 and 4 projects in remaining sections of this application. |
| 3 | Over the project period, reduce the system-wide cost of care within our 5 county service area. | Over time, health care system expenses have rarely gone down. The current system is unaffordable and unsustainable. Working with Montefiore, the NYSDOH, our participating partners and the community, we can and will reduce the cost of care over time. The success of this goal is dependent on the degree to which we succeed in the first two goals, above. This goals is also measureable and obtainable. |
| 4 | Improve system integration by co-locating services and using community based approaches to care. | The health care system is fragmented. Health and behavioral health providers do not routinely coordinate care. Care is frequently not patient centered. Regulations and licensure create barriers to efficiencies. Care integration is essential to improved efficiencies and clinical outcomes. Like the other goals, it is measureable and obtainable. Health and behaviorlal health partners in AMCH's PPS are willing and able to improve integration of care in the 5 county region. |
| 5 | Reduce health disparities | Race, ethnicity, poverty, disability, poor education and other factors are linked to poorer clinical outcomes for large segments of the target |

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| # | Goal | Reason For Goal |
|---|---|---|
| | | population. Some of these issues are based on a failure of segments of the health care sector to insure that staff are culturally competent and that providers ensure that their patients understand what they are told so that they can become better partners in managing their own care. We know that materials that are frequently provided to patients are written at a level that is beyond their ability to comprehend. There are also patients who do not speak or have adequate comprehension of English. We will educate the workforce about cultural issues. Our recruitment strategies will prioritize hiring DSRIP-funded staff who are representative of the demographics of the target population. We will insure that all materials provided to the patients are in a language and developed at a reading comprehension level they can understand. |
| 6 | Improve clinical outcomes for patients with chonic conditions | Too many patients with chronic illnesses do not consistently benefit from available treatments for numerous reasons. The resulting increases in morbidity and mortality can be reduced with a renewed focus on compliance with best practice guidlines, increased preventive care, better access to life-saving diagnostic screening, assistance with medication adherence, health navigators with a focus on reducing access barriers and realted initiatives. Standardization of clinical protocols across the network of providers is acheiveable, especially given the sucess that Montefiore Medical Center has had in implmenting this in its pioneer ACO. Clinical outcomes can and must be improved. These are measureable and improvements are obtainable. Participating providers in the PPS are committed to improving quality and outcomes. |
| 7 | Improve key population health measures in the community over time | As a nation and region, we compare poorly across many population health measures, especially when compared to other developed nations. While there are many examples, rates of obesity in the country are high, with long-term health consequences that may not be felt for decades. We can do better. Within our 5 county region, tobacco use in the target population is too high. Cancer rates are too high. An insufficient number of individuals receive appropriate screenings. like mamograms, PAP tests and colonoscopies. Rates of immunizations for pneumococus and influenza could be higher. We must work collaboratively to improve the health of the community. Along with Montefiore and the extensive expertise they bring to the table, AMCH's PPS is committed to working collaboratively to improve key population health measures and sustain gains that are made beyond the DSRIP project period. |
| 8 | Transition the health care system to pay for performance so that 90% of payments are made this way. | AMCH's PPS is largely reimbursed in a fee for service arrangement. There is a relatively low penetration of value based or pay for performance payment. Working with Montefiore, it will be important to lead the PPS to pay for performance. This is both measureable and obtainable within the project period. Substantial education will be needed, but the majority of our participating organizational partners understand why this is important and are committed to working together in compliant ways to accomplish the goal. |

***Formulation:**

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

AMCH's PPS, comprised of over 175 organizational partners and 3,900 individual providers, coalesced over a short period of time to address issues identified in the community needs assessment, including barriers to care, clinical outcome disparities, fragmentation of care, poor communication of patient level data, gaps in services and inadequate linkages between health, behavioral health and community based providers. The collaborative contracting model under which the PPS operates allows for future integration into a larger PPS structure as is contemplated through a merger with the Hudson Valley Collaborative (HVC), led by Montefiore Medical Center. Responsibility for PPS management, project development and associated services has been delegated to a Project Advisory Committee (PAC), functional and project subcommittees, and AMCH as the lead applicant. Governance of the PPS was codified with approval of a Charter and operating principles by the PAC, which in turn is governed by an elected excutive committee comprised of 21 members. The PAC is a diverse, inclusive body representative of the community at large, including management, labor, CBOs and numerous provider

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types.

***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.

AMCH, along with the leadership of Montefiore Medical Center, share a vision of the future of health care across a large geographic region that is consistent with the triple aim. Both during and after the 5 year project period, the delivery system will follow a strategic path predicated on four components: 1. increasing access and volume of primary care visits and reducing outmigration, keeping more care local and better coordinated; 2. continuing operational efficiency through economies of scale and shared use of resources; 3. value based contracts with payers and enhanced care management to ensure financial sustainability; and 4. fixed cost reduction through rightsizing, integration and potential mergers. The PPS, as represented by the PAC and the PAC's executive committee, have endorsed the vision for the future as well as a full merger of AMCH's PPS with Montefiore's HVC. The contiguous region would cover the Hudson Valley, from Westchester to Warren county, providing a sufficient number of total beneficiaries to manage risk, improve population health and sustain health care transformation into the future.

***Regulatory Relief:**

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

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

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

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

| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| 1 | (Establishment)<br>10 NYCRR 405.1 (c)<br><br>The regulation requested for waiver is 10 NYCRR 405.1 (c). | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to exempt the PPS from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements and approving protocols that impact the delivery of services.<br><br>There are no alternatives to this if DOH believes that the activities of the PPS would require establishment as an operator.<br><br>The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols which influence how care is provided. Waiver of the regulation for establishment, however, and any potential impact on patient safety, will be mitigated by the PPS by having clinical experts develop the protocols and clinical pathways based on evidence-based practice and standards of care. The partner organization facilities will need to adopt the protocols and pathways through the shared governance structure of the PPS or otherwise authorized to perform clinical |

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| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| | | services and the activities of the PPS are under the oversight of the DOH through the DSRIP program and will include quality assurance and quality improvement monitoring and reporting. Also, all of the providers of services are licensed and will remain independently authorized and required to exercise clinical judgment to ensure high quality patient care and to avoid patient risk. |
| 2 | (Establishment)<br>10 NYCRR 600.9<br><br>The regulation requested for waiver is 10 NYCRR 600.9. | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to exempt the PPS from the requirement of becoming an established operator as it carries out its role in governing the PPS, creating collaborative arrangements and approving protocols that impact the delivery of services.<br><br>There are no alternatives to this if DOH believes that the activities of the PPS would require establishment as an operator.<br><br>The impact on patient safety potentially arises in the development and implementation of clinical pathways and protocols which influence how care is provided. Waiver of the regulation for establishment, however, and any potential impact on patient safety, will be mitigated by the PPS by having clinical experts develop the protocols and clinical pathways based on evidence-based practice and standards of care. The partner organization facilities will need to adopt the protocols and pathways through the shared governance structure of the PPS or otherwise authorized to perform clinical services and the activities of the PPS are under the oversight of the DOH through the DSRIP program and will include quality assurance and quality improvement monitoring and reporting. Also, all of the providers of services are licensed and will remain independently authorized and required to exercise clinical judgment to ensure high quality patient care and to avoid patient risk. |
| 3 | (Revenue Sharing)<br>10 NYCRR 600.9 (c)<br><br>The regulation requested for waiver is 10 NYCRR 600.9 (c). | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to ensure that the aspects of DSRIP activities which involve distribution of revenue and collaborative arrangement among providers does not violate this regulation which prohibits regulated entities from fee-splitting or sharing in gross revenues of non-established entities.<br><br>This has been identified as a potential impediment to the flow of funds through the PPS as part of the DSRIP project and a waiver is requested with respect to the financial components of any agreements or other processes providing for the flow of funds with non-established operators since the PPS and Partner Organizations, may share in distribution of DSRIP funding as part of sharing a patient population and participating in the DSRIP projects. It is important to distinguish this in a manner that it does not constitute illegal fee-splitting with non-established providers.<br><br>There are no alternatives to waiver if this would be considered to implicate the prohibition on fee-splitting.<br><br>Patient safety is not impacted because the governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers regardless of funds flow within the PPS. |
| 4 | (Corporate Practice of Medicine)<br>Request determination | The prohibition on the corporate practice of medicine may raise a concern since corporations may not employ licensed professionals to practice medicine, and accordingly, while not a regulatory waiver request, we request DOH to acknowledge, in consultation with Department of Education, that PPS activities do not constitute the corporate practice of medicine under Educ. Law 6522 which provides that only a person licensed |

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| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| | | or otherwise authorized under Education Law shall practice medicine and 6527 which provides that a non-profit medical or dental expense indemnity corporation or a hospital service corporation may employ licensed physicians. DOH and Department of Education should determine that PPS activities do not constitute the corporate practice of medicine.<br><br>All projects are requested for waiver since the PPS and partner organizations will need to enter into collaborative arrangements with physicians to implement PPS-approved care protocols and referral practices.<br><br>There are no alternatives and patient safety is not impacted because physician fees for professional services will not be shared with non-physicians who are affiliated with the provider and the governance structure will ensure that services are provided in conformance with scope of practice and standards of the professions by qualified and licensed providers regardless of funds flow within the PPS.<br><br>Patient safety is not impacted. |
| 5 | (HIT)<br>10 NYCRR 401.3 (a)<br><br>The regulation requested for waiver is 10 NYCRR 401.3 (a). | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to facilitate rapid implementation in preparation for commencing DSRIP Y1, as all partner organizations must be in a position to make rapid changes in HIT.<br><br>All of these projects require the expanded use of HIT technologies and interoperability, which will require investment in new EHR technologies, outlay of capital and the provision of vendor services. The reasons for the waiver request are to relieve the PPS and all partners from seeking further review or approval from the DOH regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP projects.<br><br>No alternatives were identified due to the fundamental requirements of DSRIP for data collection, sharing and reporting and also the priority to implement collaborative objectives to integrate care and ensure technologic infrastructure for providers to be interoperable and working in uniformity to promote the objectives of DSRIP.<br><br>This provision does not negatively impact patient safety and would not risk patient safety since HIT systems that will be utilized will meet all prevailing EHR standards and be certified to promote meaningful use objectives of providers. Also it is important to note that integrating patient records and increasing electronic access improves patient safety and assist in quality data extraction which is fundamental to the quality assurance and quality improvement activities of the PPS. |
| 6 | (HIT)<br>10 NYCRR 710.1 (c) (2), (3)(i)(j and q), (5) (iv)(g)<br><br>The regulation requested is as above | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii. to facilitate rapid implementation in preparation for commencing DSRIP Y1, as all partner organizations must be in a position to make rapid changes in HIT.<br><br>All of these projects require the expanded use of HIT technologies and interoperability, which will require investment in new EHR technologies, outlay of capital and the provision of vendor services. The reasons for the waiver request are to relieve the PPS and all partners from seeking further review or approval from the DOH regarding HIT acquisition, installation, modification or outlay of capital to implement necessary technology advances to participate in DSRIP projects. |

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| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| | | No alternatives were identified due to the fundamental requirements of DSRIP for data collection, sharing and reporting and also the priority to implement collaborative objectives to integrate care and ensure technologic infrastructure for providers to be interoperable and working in uniformity to promote the objectives of DSRIP.<br><br>This provision does not negatively impact patient safety and would not risk patient safety since HIT systems that will be utilized will meet all prevailing EHR standards and be certified to promote meaningful use objectives of providers. Also it is important to note that integrating patient records and increasing electronic access improves patient safety and assist in quality data extraction which is fundamental to the quality assurance and quality improvement activities of the PPS. |
| 7 | (Add capacity/relocate)<br>10 NYCRR 401.3 (a and e)<br><br>The regulation requested for waiver is as above | The projects requested for are: 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to facilitate the addition or expansion of services and capacity to meet DSRIP goals.<br><br>The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services, including also relocating services, in some respect by partners implementing the projects. Projects 3.a.ii. for example is aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. The request for waiver is to relieve the requirements of the need for new CONs and application of assessing need methodology for determination of public need and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation.<br><br>The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief.<br><br>This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services and will monitor quality and outcomes to ensure the quality of services. |
| 8 | (Add capacity/service)<br>10 NYCRR 670.1 (a-c)<br>The regulation requested for waiver 10 NYCRR 670.1 | The projects requested for are: 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to facilitate the addition or expansion of services and capacity to meet DSRIP |

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| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| | (a-c) | goals.<br><br>The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services in some respect by partners implementing the projects. Projects 3.a.ii. for e.g. is aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. The request for waiver is to relieve the requirements of the need for new CONs and application of assessing need methodology for determination of public need and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation.<br><br>The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief.<br>This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services and will monitor quality and outcomes to ensure the quality of services. |
| 9 | (Add capacity/service)<br>10 NYCRR 710.1 (c) (1-5,7)<br><br>The regulation requested for waiver is as above. | The projects requested for are: 2.a.v.; 2.b.iii.; 3.a.i., and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to facilitate the addition or expansion of services and capacity to meet DSRIP goals.<br><br>The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted, to transform the delivery of services to be integrated and collaborative and expand the ability to meet patient needs in alternative locations such in primary care sites and elsewhere in the community to reduce the reliance on ED and inpatient hospital care. All of these projects require the expansion of capacity or adding or changing existing services in some respect by partners implementing the projects. Project 3.a.ii. for e.g. is aimed to expand the ability to meet the needs of patients in a more comprehensive and collaborative manner so that medical and behavioral care needs are assessed and treated with streamlined access and by implementing collaborative methods including but not limited to IMPACT. The addition of services and capacity may be by primary care and/or behavioral health providers, as determined by whether they pursue implementation through a single provider approach or by co-locating and integrating with other licensed providers in shared space. Project 3.a.i. will |

## Albany Medical Center Hospital (PPS ID:1)

| # | Regulatory Relief(RR) | RR Response |
|---|---|---|
| | | require increasing or adding crisis mobilization and stabilization services and locating the provision of such services in alternate locations in the community. The request for waiver is to relieve the requirements of the need for new CONs and prior review and approval and in the alternative, for DOH to determine that these elements of the required determinations, review and approval have been satisfied upon approval of the DSRIP Project application and upon PPS notice to DOH of such changes in capacity and service prior to implementation.<br><br>The alternative considered by the PPS is that if prior review is going to be required to request that DOH only require limited review. We ask this as alternative relief if review will be required.<br><br>This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services and will monitor quality and outcomes to ensure the quality of services. |
| 10 | Relocation/Integration of Services and Home Visits by Article 28 staff)<br>10 NYCRR 401.2 (b)<br>As above | The projects requested for are: 2.a.i.; 2.a.v.; 2.b.iii.; 3.a.i., and 3.a.ii. and may be supplemented as project teams work on implementation design plans, to permit: (1) behavioral and/or substance use providers to operate primary care under the oversight of their regulatory agency in place of DOH and waive adherence to DOH facility standards; (2) Article 28 providers to operate primary care at additional locations within space of a different provider who is separately licensed by a state agency and (3) Article 28 staff to conduct home visits with a site of service in the patient's home.<br><br>It is a priority to restructure in a way which integrates primary care, behavioral health and/or substance use services and one option is through a single provider with a single licensing agency and another is through integration and co-location of non-Article 28 medical providers or OMH-licensed behavioral and/or substance use providers with Article 28 providers. All of these projects may require changes in the location of existing services to reduce the reliance on hospital-based Emergency Departments and inpatient hospital care in some respect which may be accomplished through the relocation or addition of more locations of services by Article 28-licensed providers to off campus locations. The request for waiver is to permit approval by DOH in the form of approval of the DSRIP project application for relocation or additional locations to sites other than the currently designated site with no further CON required. Waiver will enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted. The reason to authorize patients' homes as a site of service eligible for the provision of care and reimbursement is that in order to promote mental health services and reduce the reliance on ED and inpatient use, innovative methods of ensuring that patients receive necessary treatment will be implemented. The PPS will work with service providers and community based organizations to reduce barriers to access and this may necessitate patients being evaluated and treated in their residence.<br><br>As an alternative, the PPS will consider compliance with integrated care regulations if promulgated. Alternatives for this waiver do not exist to permit home visits.<br><br>Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS |

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| | | monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency. Patient safety will be addressed in PPS-approved clinical protocols and policies to ensure patient and staff safety in determining the appropriateness and necessity of home visits to ensure that the location of services does not compromise the quality of care or safety. |
| 11 | (Changes to facility (capacity/relocation))<br>10 NYCRR 710.1(c)(iv)(4)<br>The waiver requested as above | The projects requested for are: 2.a.i.; 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to facilitate the relocation of services by waiving prior approval.<br><br>All of these projects may require changes in the location of existing services to reduce the reliance on hospital-based Emergency Departments and inpatient hospital care in some respect which may be accomplished through the addition, reconfiguration, or relocation of services by Article 28-licensed providers. The request for waiver is to waive any prior review approval and permit letter notification only to DOH only with DOH approval within 15 days. The reason for the waiver requested is to enable the PPS to promote rapid system reconfiguration for implementation of these projects as envisioned in the DSRIP projects submitted.<br><br>Alternatives considered by the PPS are to comply but this will result in a delay in implementation.<br><br>This waiver will not adversely impact patient safety and is not a patient safety risk because the providers involved are regulated for the provision of care and DOH will receive ample notice of the changes that will be implemented with specificity as to which providers will be collaborating and how the services will be reconfigured. The PPS will oversee the design and implementation of these services and will monitor quality and outcomes to ensure the quality of services. |
| 12 | Single license integrated care to provide medical/primary care services)<br>10 NYCRR 600.2<br>Waiver above | The projects requested for are: 2.a.i.; 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit behavioral and/or substance use providers to operate primary care under the oversight of the agency regulating them (OMH, OASAS or OPWDD) without the requirement of DOH approval.<br><br>One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to expand their scope of services.<br><br>As an alternative, the PPS will consider compliance with integrated care regulations if promulgated.<br><br>Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency. |
| 13 | (Colocation/Shared Space Integrated Sites- provide medical/primary care services)<br>10 NYCRR 401.3(d) | The projects requested for are: 2.a.i.; 2.a.v.; 2.b.iii.; 3.a.i., and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit integration of non-Article 28 medical providers (such as physicians in private practice) or OMH-licensed behavioral and/or substance use providers within the space of an Article 28 and to authorize the Article 28 provider to lease Article 28-approved space to a provider |

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| # | Regulatory Relief(RR) | RR Response |
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| | | licensed by another State agency without meeting requirements of 10 NYCRR 401.1 et seq.<br><br>The reason for the request is that the focus of DSRIP is on developing integrated delivery systems, particularly addressing integration of behavioral health, substance use and medical care, must remove or limit impediments to the co-location of services to support implementation of DSRIP integrated care project and redirect some patients away from the ED and reduce hospital admissions through availability of primary and secondary care. One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through locating providers in shared space within certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to locate their services within Article 28 space under appropriate leasing arrangements.<br><br>As an alternative, the PPS will consider compliance with integrated care regulations if promulgated.<br><br>Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency. |
| 14 | (Single license integrated care to provide mental health services)<br>14 NYCRR 599.4 (ab)<br>Waiver above | The projects requested for are: 2.a.i., 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit Article 28 licensed providers to operate mental health services either within the general hospital or in an outpatient hospital department in amounts which exceed the current limits of visits annually.<br><br>The 14 NYCRR 599.4 (ab) limits for volume of annual visits which may prevent a provider from qualifying for exemption, for purposes of DSRIP integrated service projects, should be increased from the current limits (10,000 and 2,000) for annual visits to eliminate an annual cap, to exempt the requirement for OMH certification in order to promote the integration of care as part of DSRIP projects. This exemption from requiring OMH licensure, regardless of the number of patients served, will help transform the method of delivering services and increase access to behavioral health and primary care.<br><br>Alternatives considered include other regulatory relief such as single agency licensure.<br><br>Patient safety will be ensured because Article 28 providers will comply with DOH regulations and standards. |
| 15 | (Single license integrated care-to provide mental health services)<br>14 NYCRR 85.4<br>Waiver of above | The projects requested for are: 2.a.i; 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit DOH-regulated providers to operate mental health services under the oversight of the agency regulating them (DOH) and to forgo the requirements of an operating certification from OMH .<br><br>One of main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health and/or substance use services and this may be most efficiently accomplished through a single provider with single licensing agency at certain sites of service. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to |

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| # | Regulatory Relief(RR) | RR Response |
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| | | expand their scope of services to promote an integrated care model.<br><br>As an alternative, the PPS will consider compliance with integrated care regulations if promulgated.<br><br>Patient safety will be ensured by meeting similar standards of care when providing services as is required by the licensing agency and through PPS monitoring of quality and outcomes. Additionally, PPS-approved protocols and clinical pathways will serve as guide to ensure evidence-based and standardized care regardless of the oversight agency. |
| 16 | (Colocation in OASAS space)<br>14 NYCRR § 814.7<br><br>The regulation requested for waiver is 14 NYCRR 814.7. | The projects requested for are: 2.a.i; 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit partner organizations who locate services in shared space with OASAS providers flexibility in the physical requirements of the space provided that the requirements of the federal regulations are adhered to.<br><br>One of the main priorities of accomplishing DSRIP objectives is to transform the care to patients by restructuring in a way which integrates primary care, behavioral health with substance use. In order to collaborate and integrate, the OASAS providers need to have flexibility to collaborate with other provides in their space and treatment activities. We seek to remove or limit impediments to the provision of integrated services by licensed providers who seek to promote an integrated care model.<br><br>As an alternative, the PPS will consider compliance with integrated care regulations if promulgated.<br><br>Patient safety and confidentiality will be ensured by adherence to standards adopted by the integrated provides and approved by the PPS. |
| 17 | Share Health Facility)<br>10 NYCRR 83.2(a)<br><br>The regulation requested for waiver is 10 NYCRR 83.2 (a). | The projects requested for are: 2.a.i.; 2.a.v.; 2.b.iii.; 3.a.i. and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to request waiver of being considered a "Shared Health Facility" under 10 NYCRR 83.2(a) and to eliminate need for registration under 10 NYCRR 83.4 and 83.5 and compliance with any requirements of Part 83.<br><br>Waiver of this regulatory definitional standard will permit integration of medical providers, behavioral and substance use providers in same settings to promote access to patient. Focus of DSRIP on developing integrated delivery systems, particularly addressing integration of behavioral health, substance use, medical care, and palliative care, so key to remove or limit impediments to the co-location of services to support implementation of DSRIP integrated care projects.<br><br>The alternative is to comply with the regulations applicable to Shared Health Facilities which will cause delays in DSRIP project implementation and may increase costs.<br><br>Patient safety is not negatively impacted by the requested waiver as the space that services will be located will comply with standards that the PPS sets in accordance with its DOH-approved project application. |
| 18 | Hospital Observation beds<br>10 NYCRR 405.19 (g) (2,5(b))<br>The regulation requested for waiver above | The projects requested for are: 2.a.i and 2.b.iii., and may be supplemented as project teams work on implementation design plans, to increase the number of hospital observations beds for the addition of observation unit beds without prior review under section 10 NYCRR 710.1(c)(2) or (3), regardless of project cost and to waive the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of 10 NYCRR for construction projects approved or completed after January 1, 2011 and to waive the physical space and location requirements applicable to placement of observation beds. |

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| | | In order to reduce the rate of hospital admission and facilitate the proper assessment and treatment of patients who may be able to be cared for in the community, or in accordance with a care transitions program, returned to a community setting following a short stay in the hospital as an outpatient, providers will ned to expand capacity of observation beds and to have flexibility in the location of the beds.<br><br>Alternatives to this would be to comply with the applicable regulations but this will cause delays in implementation of DSRIP project plans and will likely increase cost and may be unable to be carried out due to constraints of physical space.<br><br>Patient safety will not be impacted because the care will be provided in appropriate alternative space. The PPS will monitor patient care quality to ensure that patients are cared for in accordance with appropriate standards. |
| 19 | HOME VISITS OASAS<br>14 NYCRR Parts 822 and 841 | This request is for DOH to work with CMS through a plan amendment to move OASAS services to the rehabilitation option of the State Medicaid Plan to permit Medicaid reimbursement off site providers to provide home visits. Once OASAS is authorized, we will request waiver relevant sections in 14 NYCRR Parts 822 and 841 to request OASAS to authorize home visits for substance use treatment. |
| 20 | Source of Payment—admission and discharge<br>10 NYCRR 405.9 (b)(2) and (f)(7)<br>Waiver requested of above | The projects requested for are: 2.a.i.; and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit providers when making admission decisions and when conducting discharge planning and placement of Medicaid and Uninsured 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. |
| 21 | Shared Credentialing<br>10 NYCRR Part 405; specifically 405.2(e)(3) and §405.4(c)(5)<br>Waiver of above | The projects requested for are: 2.a.i.; 2.a.iii.; 2.a.v.; 2.b.iii.; 2.d.i.; 3.a.i.; 3.a.ii.; 3.b.i.; 3.d.iii.; 4.b.i.; and 4.b.ii.to streamline the credentialing process within the PPS to create a system-wide process which will facilitate the rapid integration of services required to provide coordinated care by providers participating in PPS. In particular, the waiver would allow PPS to establish a shared credentialing process and standards to: (i) conduct primary source verification; (ii) screen for Medicare and Medicaid exclusion; (iii) and assure consistent standards to promote quality and patient safety, relying on data available to partner organizations and to the PPS through its own monitoring and data collection.<br><br>The waiver would reduce the cost and administrative burden of credentialing by each partner organization, and would allow health care professionals to practice in different settings as needed for care coordination without duplicative credentialing by numerous providers throughout the PPS. The waiver is also requested to permit certain practices that may be necessary to implement coordinated care models, such as allowing a physician in private practice to supervise more than two physicians' assistants (10 NYCRR 94.2).<br><br>The only alternative would be to continue the existing process for credentialing which as noted above will be highly demanding and labor and cost intensive, and will not provide the same degree of oversight or operational coordination based on a single set of credentialing standards and criteria. |

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| | | PPS will use development of a single set of credentialing standards, criteria, and centralized review process to improve patient safety by assuring that consistent, sound standards are adopted and uniformly applied for health care professionals across partner organizations. Centralized credentialing would still entail collecting and relying upon information from each partner organization about health care professionals practicing under their license and supervision, but would also allow for a more objective evaluation by professionals who are not peers of individual practitioners. Moreover, PPS will be able to use its own quality data and observations based on project participation to inform the review process. |
| 22 | Home Visits-OMH<br>14 NYCRR 679.5<br><br>This request is to waive 14 NYCRR 679.5. | The projects requested for are: 2.a.i.; 3.a.i.; and 3.a.ii., and may be supplemented as project teams work on implementation design plans, to permit to permit clinic treatment staff to conduct home visits and be eligible for reimbursement with a site of service in the patient's home.<br><br>The reason for this request is that in order to promote mental health services and reduce the reliance on ED and inpatient use, innovative methods of ensuring that patients receive necessary treatment will be implemented. The PPS will work with service providers and community based organizations to reduce barriers to access and this may necessitate patients being evaluated and treated in their residence.<br><br>Alternatives for this waiver do not exist to permit home visits.<br><br>Patient safety will be addressed in PPS-approved clinical protocols and policies to ensure patient and staff safety in determining the appropriateness and necessity of home visits to ensure that the location of services does not compromise the quality of care or 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.

Albany Medical Center Hospital's (AMCH) Performing Provider System (PPS), created under the NYSDOH's DSRIP program, chose a collaborative contracting model for its governance structure. Beginning in May, 2014, AMCH sought input from our PPS, as it was being formed, as well as legal advice from our outside counsel. AMCH investigated how other PPSs were being structured and determined that the collaborative contracting model would best meet the region's needs. This concept was presented to the PPS at our first project advisory committee (PAC) meeting on August 29th and then formally adopted on September 29th. The PAC approved our charter and operating principles and guidelines. Because of our desire to be collaborative we reached out to Montefiore Medical Center, lead applicant for HVDC, due to the two county overlap of our initially proposed service areas. In order to leverage Montefiore's expertise in population health and payment reform, we proposed merging our PPSs into a larger region. Due to time constraints, this was not done. AMCH's structure does not create impediments to merging our PPS with Montefiore's given they also use a collaborative contracting model.

Factors considered in our organizational structure included capital funding contributions, regulatory and licensure waivers, PPS member's

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willingness to accept financial risk, other large providers willingness to contract with AMCH, AMCH's internal capacity and expertise to manage large, complex contracts and whether the structure would integrate the PPS into a highly functioning network. Our PPS has evolved quickly into a functioning network, under the leadership of the project management office. The PMO directed the efforts of the subcommittees, and the executive committee of the PAC, both of which were created when the PPS adopted a formal charter and operating principles, clearly defining governing roles and responsibilities.

AMCH's PPS includes thousands of providers and over 175 organizational participants. It is simply too large a group to govern itself efficiently and effectively. To address this, AMCH's PAC is comprised of PPS organizational members, vendors, union members, workers and managers drawn from the participating organizations. The PPS has delegated governance functions to the PAC, lead applicant and PMO responsibilities to AMCH, and project development activities to its various committees, which continue to meet and approve items of importance. While the PPS contains thousands of members, the PAC is limited to having two representatives from each organizational member, consistent with guidelines for membership and representation established by the DOH.

The PPS is the largest organizational body and approves major decisions impacting the entire PPS. The PPS is supported by smaller sub committees which are organized around functional areas and project areas of the PAC. These smaller committees perform the large majority of the work that the PAC undertakes and are made up of organizational representatives and subject matter experts. Most sub-committees are represented on the executive committee which is the governing body of the PAC. The executive committee structure is described in detail in section 2.2. At its October meeting, the PAC elected a slate of representatives to the executive committee, although not all of the 21 positions were filled at that time. There are three categories of membership on the executive committee: the 12 largest Medicaid provider organizational members; selected sub-committee chairs; and at large members. The Project Management Office (PMO) of AMC is staffed by AMC employees and report regularly to the Executive Committee of the PAC as well as AMC's executive leadership.

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: **1_SEC021_DSRIP_Org Chart 121814.pdf**

**Description of File**

Organization chart of the AMC PPS.

File Uploaded By: brookse1

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***Structure 2:**

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

Governance is largely about two things: the willingness of participants to be governed and the leadership abilities of those who are governing. The governance goals of AMCH's DSRIP project include transparency, management efficiency, accountability and effectiveness. The collaborative contracting model aligns with these governance goals. By consent, AMCH's PPS has agreed to participate and be represented by the PAC and be governed by the Executive Committee and AMCH as lead applicant. As the region's largest hospital and the only academic health science center, AMCH has the proven leadership needed to be fair and effective governors. The leadership is both positional and earned. AMCH possesses the necessary management structure to efficiently and effectively utilize DSRIP funds to meet the triple aim goals of DSRIP. We elaborate on this in other sections but we have in place the necessary compliance structures, fiscal controls, information management capabilities, contracts management, payroll, accounts payable and receivable, and grants management expertise to utilize funds provided by DSRIP to meet NYS DOH goals and transform the regional healthcare system.

We provide an organization chart that provides the reporting, structural design and function of key units within AMCH's DSRIP operations. The PPS includes nearly 4000 individual providers working for over 175 organizations. While it is the provider network ultimately responsible for project implementation, under the direction of the PMO it is too large to govern. The PAC is a large, inclusive, transparent and representative body made up of two representatives from each participating organization. We provide significant additional information about the PAC in subsequent sub-sections of this section of the organizational application. It became clear within the first two weeks of

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the planning grant award that additional structure was necessary to allow for efficient decision making and coordinate expertise regarding specific tasks. As already noted, the PPS created the PAC. The PAC formed an executive committee, which is a policy-making group comprised of no more than 21 PAC members elected by the PAC. The executive committee, as the governing body of the PAC and PPS is representative of the PPS. As an elected body, it is able to evolve to reflect the changing composition of the PPS. It is authorized to act on behalf of the PAC and the PPS. It includes the largest Medicaid providers, chairs of sub-committees and other key stakeholders consistent with the organizational chart attached, with attempts to balance the diverse region's interests including representation of rural areas and CBOs. To complete the structure six functional sub-committees address issues that cross project boundaries: finance, membership, data management, workforce development, consumer affairs and clinical affairs. Based on CNA data, six project related and clinical sub-committees include: long term care, behavioral health, asthma, cardiovascular, tobacco & cancer, and medication management. We provide additional information about membership and the various committees in subsequent sections of this application as well as in the attached organization chart.

The governance structure as established by the charter and operating principles supports the management and integration of the PPS as a fully functioning healthcare delivery system by creating clearly defined roles responsibilities and lines of accountability. It is a structure that is transparent, representative and inclusive of the underlying PPS membership.

***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.

Clinical governance is vitally important and is being addressed during the planning phase of project development by the DSRIP clinical affairs subcommittee. This sub-committee draws upon the expertise of the AMC Faculty Group Practice's Clinical Quality Committee and the medical directors of the two largest primary care groups in the region, Capital Care and Community Care Physicians. With cross-departmental expertise and a dedicated focus to clinical quality improvement, AMCH's Clinical Quality Committee has positioned itself within the PPS to assist with establishing quality standards and measures, clinical care management processes and accountability for clinical outcomes. It has assumed the role of the DSRIP Clinical affairs subcommittee during the planning phase. During implementation, AMCH in collaboration with Montefiore Medical Center, will create a medical director's office, which will lead the clinical affairs subcommittee and be housed within the DSRIP project management office. This physician lead office will have broader responsibility for clinical processes, management and performance. AMCH will have a close collaborative relationship with Montefiore Medical Center and the HVDC PPS that they lead, in terms of the development and management of clinical quality and management issues. Drawing on Montefiore's expertise and working within a larger regional area in the Hudson Valley, AMCH's DSRIP medical director and Quality Committee will provide the management, leadership and follow-through to insure collaborative, integrated and accountable clinical outcomes. Accountability is a significant concern and is addressed in several other sections of this application. Clinical accountability, however, drives performance, access and expense reduction and continues to be a high profile focus area for the PPS and AMCH. It is our intent to align our clinical processes with Montefiore as we move forward with implementation.

***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.

AMCH and our PPS is partnering with Montefiore Medical Center and the HVDC PPS which they lead. This bold step, formally approved by our PAC, helps us all evolve under the administrative leadership of Montefiore, who has a proven record of success with transforming systems of care to pay for performance and creating and managing the State's only successful pioneer accountable care organization (ACO). Many things can and will change over the five year project period. It is impossible to predict what new diseases, changes in treatment modalities, legislative interventions, environmental health factors, technologic improvements, behavioral changes, economic factors and societal changes will occur and what impacts they will have on various components of an evolving health care sector. While several of these things can be modeled to determine potential outcomes, multi-factorial analysis of more than two variables leads to uncertainty and increasing unpredictability. AMCH both recognizes and is committed to a flexible operating structure that allows us to be nimble and responsive to change. The selected collaborative model gives us this flexibility without tying us to a potentially burdensome legal structure. Transformation is an evolutionary process, to succeed, leadership must be provided to individual PPS partners, the integrated network, and to beneficiaries so they understand and can be engaged in the process of changing the healthcare system. AMCH and Montefiore share a vision regarding this transformation including integration of the delivery system with improved access,

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accountability and quality in a value based purchasing payment methodology.

### Section 2.2 - Governing Processes:

**Description:**
Describe the governing process of the PPS. In the response, please address the following:

***Process 1:**
Please outline the members (or the type of members if position is vacant) of the governing body, as well as the roles and responsibilities of each member.

The Executive Committee of the PAC is the governing body of the PPS whose members are responsible for policy making, executive decision making, approving the reports and activities of each subcommittee, reviewing financial statements, approving the annual budget and audit and disciplining members pursuant to the code of conduct and compliance requirements. Each member has equal status, membership is in three categories – 1) Medicaid covered lives. AMCH, Dr. S. Frisch; AMC's Faculty Physicians, Dr. F. Venditti,; Columbia-Memorial Hospital, Wm. VanSlyke,; Planned Parenthoods of NENY, K. Atkins; Saratoga Hospital, D. Jones; Capital Care Physicians, Joan Hayner; Community Care Physicians, Dr. N. Mitnick; Northern Rivers, Audrey LaFranie; VNA of Albany, S. Larman; Whitney M. Young CHC (FQHC) D. Shippee; Capital District Psychiatric Center, Wm. Dickson; H.Oberlander, Trinity Institute, Vacant. 2) Subcommittee chairs: Behavioral health, K. Stack, Addictions Care Center of Albany; Asthma, Dr. K. Manjunath, Whitney Young CHC; Cardiovascular, Vacant; Consumer Affairs, E. Brooksby; Finance, Wm. Hasselbarth, AMC; Clinical Affairs Dr. J. Desemone, FGP.

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

Selection of members was straight-forward, since it was dictated by the operating guidelines and principles and the organizational charter formally adopted by the PAC in September. Our governance documents clarified how members would be chosen, the role of the PAC in electing them and the roles and responsibilities of the executive committee. Each member of the executive committee represents their organization's interests in the PPS and PAC. The largest Medicaid providers are expected to participate in all aspects of the development and transformation of the regional system of care and to provide de-identified patient information regarding patterns of utilization, costs, reimbursement and other proprietary data unique to their own organization's operations and management. They constitute the PPS's core leadership and represent both geographic and scope of practice variations across the regional service area. The chairs of the sub-committees have specific roles and responsibilities, as well. As the leaders of each group, they direct the committee's efforts to develop well-thought out plans to address timelines, resources, key partners and strategies regarding the specific focus of each committee. There are two different types of sub-committees: (1) those with cross cutting responsibility for broad activities, like clinical and consumer affairs that apply to all aspects of the PPS and (2) those with focused responsibility on a particular domain project, like asthma and cardiovascular health. In both instances, the chair of the sub-committee represents the committee's interests on the executive committee and serves as an expert internal consultant able to clarify the committee's intent and decision making. The chairs of each sub-committee are elected by voice vote by the members of the sub-committee. The third and final category of executive committee membership is reserved for at large representatives. These members have the responsibility of providing community based input into the deliberations of the executive committee. The PAC invited a representative from the Albany County Department of Health, but the individual was unable to serve due to organizational constraints. Active discussion is occurring to identify the remaining members of the executive committee, bringing it to its full complement of 21 voting members. We believe that the diversity of participants, the different geographic locations they serve, their demographic makeup that attempts to balance gender and other factors and the content expertise they collectively bring provides the PPS and the PAC with a dedicated cadre of stakeholders committed to successful project development, implementation and management.

In terms of community based partners, the PAC includes at least 20 CBOs. They are actively engaged in the activities of the various sub-committees, have been well represented at community forums and stakeholder meetings conducted across the region and have been vocal advocates for their consumers. Like all participating organizations, they are represented on the PAC by two voting delegates – one managerial and one either union or worker representative. They continue to offer innovative suggestions in terms of project development. They understand that there are caps placed upon how much of the funding can be provided to them, based on a 5% funding limit to organizations that are not qualified safety net providers. AMCH will contract with CBOs when and where necessary and will remain within the NYSDOH and CMS guidelines in terms of funding limits. Contractual relationships will include funding strategic partners in the

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community essential to successful project implementation.

***Process 3:**

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

The executive committee is a decision making group. It is designed to be representative of the broader membership of the PAC and PPS. It includes 7 participating hospitals, FQHCs and group practices. It includes OMH, OASAS and OPWDD licensed providers and consumer representation. By capping its size at 21 members, it cannot include every type or sub-category of provider in the PPS, but it is representative of the geographic region served, the diversity of the membership and the different licensed providers who are members of the PPS. Many CBOs, school districts, county health and mental health departments, long term care facilities, retail pharmacies and other organizations are actively engaged as partners serving the regional area covered by AMCH's DSRIP project. At large positions on the committee allow the leadership team to appoint members to fill gaps in representation. We anticipate that the members of the committees will change over time and as needs evolve.

***Process 4:**

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

AMCH reached out to CBOs who could contribute in significant ways and invited them to join the PPS. Through word of mouth additional organizations reached out to us and became members. We have never refused an organization's request to join the PPS. We are clear in our mission that we need to be inclusive, representative, and diverse, reflecting the unique differences and services offered by the wide array of hundreds of CBOs that serve the poor in the 5-county region. In terms of the structure, all CBOs are members of the PPS and have voting representation on the PAC. We have designated 3 at large seats on the executive committee of the PAC to ensure CBO participation on the governing body. In terms of contracting, we will contract with CBOs for various components of project implementation as necessary to accomplish the goals of DSRIP.

***Process 5:**

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

We adhere to Roberts Rules of Order to facilitate an orderly process of discussion and decision making. We also recognize that as a group we may make mistakes. The executive committee will strive to reach a consensus and work to resolve legitimate concerns as they arise. AMCH has conducted votes electronically, using real-time web-based applications that allow members to vote on items up for consideration. The project management office is developing guidelines for conflict resolution and mitigation that will be presented to the PAC for adoption at its January meeting. Our charter requires that we have a quorum present to conduct official business of the PAC and the executive committee. Items requiring adoption require a motion, a second, and an affirmative vote by the majority of the voters present. Records of votes are recorded as are the official sessions of formal meetings of the PAC and its governing executive committee. This complete record is made available to all members of the PPS in order for all transactions to be completely transparent to the membership. Consistent with the roles and responsibilities of the executive committee of the PAC formal items requiring review and approval include subcommittee reports, annual budget, audit review, membership disciplinary action, and proposed policies for consideration by the full PAC. Project implementation plans will be developed by the committees and forwarded to the executive committee for formal review and approval.

***Process 6:**

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

A group of 21 individuals representing diverse interests and geography will not always agree. Conflict can ensure. To mitigate this, as previously noted, we adhere to Roberts Rules of Order to facilitate an orderly process of discussion and decision making. We also recognize that as a group we may make mistakes. The project management office is developing guidelines for conflict resolution and mitigation that will be presented to the PAC for adoption at its January meeting. The executive committee will strive to reach a consensus and work to resolve legitimate concerns as they arise. Open and honest discussion will be encouraged. The PMO will support the executive committee in conflict resolution by offering to mediate between organizations, and provide data reporting as needed to justify decisions. The projects and our efforts to transform the system will rely heavily on data and its analysis.

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***Process 7:**

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

AMCH's PPS, follows Robert's Rules of Order. A quorum must be present to conduct a vote, items to be voted on require motions and they must be seconded. There is always opportunity for discussion as well as options to amend motions, table them, etc. AMCH has conducted votes electronically, using real-time web-based applications that allowing members to vote on items up for consideration. Minutes of all executive committee meetings are maintained and web-based presentations and meetings are recorded. Minutes and the meeting recordings are made available on the internet and can be easily accessed by members. Minutes are also distributed via weekly e-mails to keep all members informed, building a sense of belonging and facilitating participation and decision making across the network. Meeting agendas are provided in advance of the meetings. All of these things are designed to create a transparent governing structure that can be held accountable by its members for its actions.

***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.

AMCH's PPS and PAC are proud that they have created a consumer affairs sub-committee. We want stakeholders to be engaged and to hear from our patients and consumers. This initiative is designed to improve their lives. There may be unintended consequences from some things pursued. Having real time feedback from consumers and other community stakeholders is imperative. Going forward, we will have community forums to present progress, received feedback, suggestions, complaints and advice on a quarterly basis. Additionally other key stakeholders will be engaged through various means including surveys, CHAPS surveys, stakeholder meetings, and an open door policy at the PMO. Under the direction of the executive committee of the PAC the PMO will coordinate the efforts of conducting ongoing performance measures across the entire continuum of care throughout the PPS.

### Section 2.3 - Project Advisory Committee:

**Description:**

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

***Committee 1:**

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

The PPS created in June recognized that it was too large and complex to function efficiently. Prior to the planning grant award announcement, AMCH entered into discussions with outside legal counsel, seeking advice regarding how to create an efficient structure in order to accomplish the business of the PPS and fulfill the State's DSRIP requirements. After both internal and external discussion and in recognition of the State's guidance in terms of PAC membership, we prepared a draft organizational charter and operating principles and guidelines. We communicated the draft documents to all members of our PPS and presented what the structure, roles and responsibilities would look like to the first full meeting of the PPS in late August. Based on feedback from that discussion, we made some modifications to the documents and presented them to the PPS at the monthly organizational meeting in September. After substantial discussion and modification of the documents, they were approved in modified form by vote of the PPS on September 29, 2014. As a result, the PAC was created and empowered by the PPS to serve as the advisory body representing all participating provider interests. We describe this and the PAC's membership in additional detail in the previous section. The PPS is now governed by the Executive Committee of the PAC comprised of 21 members elected by the PAC. While the PPS exists on paper and is important to attribution and systems transformation, the PAC, it's subcommittees, and executive committee are the bodies that meet on a routine basis. As project implementation proceeds the PAC will assume an increasing advisory role through the executive committee of the PAC. Consistent with state guidelines the PACs membership is limited to two voting members from each organization, with representation from both management and labor. Membership grew consistently from the inception of the PPS until membership was closed on December 1. The PPS hopes to be able to add new membership when potential members are identified that can play an important role in health systems transformation.

***Committee 2:**

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

AMCH believes that the collaborative contracting model supports the role of the PAC as a governing and advisory entity, representing the interests of participating network providers. By empowering the PAC, the PPS has reduced redundancy, improved efficiency and

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accountability, improved opportunities for participation, especially on sub-committees where everyone is a volunteer with competing demands on their time, and facilitated additional provider participation because potential partners recognized that the structure and operations were efficient and well-managed. As an institution, we continue to analyze how to do things to facilitate engagement, seek stakeholders whose voice we have not always heard, reduce real or perceived barriers to meaningful participation and create a highly functioning, integrated network of providers pulling in the same direction. The PAC role is to advise the executive committee by providing this input to AMCH.

***Committee 3:**

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

The PAC has been instrumental in the development of our structure. In terms of the community needs assessment, the PAC, on behalf of the PPS, has been engaged in reviewing data, making requests for additional information, and providing feedback and analysis of both qualitative and quantitative data. Since the formation of the PAC occurred at the same time the CNA was developed there were synergistic benefits to the creation of the CNA and the PAC. For example, as it became clear that asthma would be a high needs issue in the region, it was logical to seek out the Asthma Coalition to become a member of the PPS, which they did under the auspices of the FQHC Whitney Young, their parent organization. This also worked in the opposite direction where strong leadership from several of our behavioral health PPS partners encouraged selection of project 3.a.i integrating primary and behavioral health. As the CNA evolved it was shaped by the interest and expertise of our key stakeholders.

***Committee 4:**

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

The PAC is representative of the region, the variety of licensed and unlicensed providers serving the region and numerous stakeholders serving the poor. We have also ensured that both rural and urban settings are represented by providers and organizations. We have a variety of community based organizations, school districts, pharmacies, long term care facilities and other provider types from the five-county service area we propose to cover. In addition we have advocacy organizations, local government agencies and large primary care groups serving multiple locations across the regional area. Safety net organizations are strongly represented in our PPS. While the scope of health systems transformation limits participation from every organization that might like to be involved our community forums and stakeholder engagement sessions afforded opportunities to a wide variety of organizations to provide input.

### 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.

The PAC will implement an effective compliance program comporting with Social Services Law §363-d to prevent, detect, and address compliance matters relating to PPS operations and Projects. The PAC will designate a Compliance Official with strong expertise in health care compliance to work with the AMCH, as Lead Entity, and Participants' compliance officers. The Compliance Official will report to the PAC Executive Committee which will oversee all aspects of the compliance program, approve the PPS Code of Conduct, compliance polices, annual compliance plans and review audit findings, problems or any other matter brought to the Committee's attention, and ensure resolution, including, reporting and refunding of overpayments to Medicaid and Medicare, as necessary.

***Compliance 2:**

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

Mechanisms for identifying and addressing compliance problems related to the PPS's operations and performance include specific required procedures for reporting as well as monitoring individual performance on an ongoing basis. The PAC and its executive committee will develop these procedures which will be reviewed and approved at a formal meeting of the PAC. The PAC will establish and publicize a

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hotline for anonymous, confidential reporting of compliance concerns. PAC Members and Participants will be required to report potential violations arising from PPS operations and DSRIP Projects to the Compliance Official and assist in resolution of issues. As part of the compliance program, the PAC will conduct audits and analyze data on quality and cost to identify issues and ensure compliance with all applicable laws and standards. The PAC will sanction participants for failure to report and for compliance violations deemed to be an element of "poor performance."

***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 PAC will develop compliance training for PAC Members and Participants that covers: (i) PPS Code of Conduct and policies; (ii) relevant fraud and abuse laws; (iii) PPS hotline; and (iv) PPS non-retaliation and non-intimidation policies. PAC members will be required to certify that staff training has occurred for all appropriate staff. To the extent that additional training is required, either because violations are reported or otherwise founded, it will occur in a frequency and manner to be determined by the compliance official and the PAC. All safety net providers are required, in accordance with their agreement to accept Medicaid reimbursement, to attest that they are in compliance with applicable rules and regulations. The PAC will leverage training programs that exist within these organizations and from the state and other associations to support training needed across the provider network. New training will be developed as needed to address circumstances that arise particularly with organizations that have limited existing programs.

***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 PAC will establish and publicize a hotline for anonymous, confidential reporting of complaints by Medicaid beneficiaries. With input from the consumer affairs subcommittee and focus groups comprised of Medicaid beneficiaries, procedures will be developed that will be culturally and linguistically appropriate, easy to use, and confidential. Materials will be developed and disseminated advising individuals seeking to file compliance complaints how to follow this simple process. The compliance official and the PAC will provide assistance in terms of the development of these processes as well as clarity regarding expectations so that consumers understand potential outcomes and are confident in the integrity of the system.

### 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.

With assistance from the finance subcommittee, the executive committee of the PAC will establish and implement processes to ensure that financial controls are established and maintained. These controls will be designed to support the financial success of the PPS. They will be voted on by the PAC in order to be operationalized. Advice will be sought by an independent audit firm in terms of the suitability and feasibility of these processes as they relate to financial controls. Generally accepted accounting principles will be utilized as well as transparency and accountability to ensure that all participating providers are clear about the expectations, eligible uses and consequences associated with inappropriate use of DSRIP funds. Processes will be reviewed at least annually and modified as circumstances dictate. The Finance sub-committee will create transparent, easy-to-understand, reproducible criteria for funds distribution. They will make recommendations to the executive committee for bonus payments based on the achievement of established milestones. The executive committee will approve recommendations and share the results of their decisions with the entire PPS and PAC.

***Organization 2:**

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

Given our collaborative model, AMCH assumes fiduciary responsibility of the management of the PPS. As lead applicant, funds will be received by AMCH and distributed to organizational partners, vendors and others based on a combination of detailed line item budgets, performance based metrics and incentives, identified resource needs to implement projects and manage the entire undertaking and funds

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required for mandated purposes, like annual independent audits. AMCH will develop a formal mechanism to delegate selected financial functions to the finance committee of the PPS, which is in turn answerable to the executive committee of the PAC. These functions will include but not be limited to expense management, financial reporting and analysis, desk audit review for eligibility, funds flow forecasting, individualized cost center budget development detail, initiation of payroll and other expense processes requiring executive approval and budget justification. AMCH will retain cash flow, audit, accounts payable, payroll, accounts receivable, financial controls and compliance responsibilities.

***Organization 3:**

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

Once DSRIP awards are made the PMO will hire internal auditors to assist with funds management control and financial compliance and reporting. The PMO working with the compliance officer will ensure that internal audit functions are consistent with internal and external reporting requirements and best practices. Staff involved in all aspects of project implementation will receive training and technical assistance from the internal audit team regarding safeguards and appropriate tools and techniques to ensure that funds are spent for intended eligible purposes. In addition to these internal controls an external audit agency will be hired to conduct an annual comprehensive financial and management audit of the program. External auditors will also be engaged if internal controls discover irregularities that may indicate compliance issues. Results of annual independent audits will be provided to the executive committee of the PAC as required by the PPS operating principles and guidelines.

***Organization 4:**

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

We discuss compliance with NYS Social Service law 363-d in section 2.4 above. Consistent with the detailed compliance program that will be developed issues related to financial structure and controls will be consistent with all applicable state and federal laws rules and regulations. With advice from the compliance officer and outside counsel, as necessary and appropriate, we will rigorously review and ensure consistent compliance with these matters.

### 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 PPS will monitor performance in numerous ways. For providers and organizations receiving funding, contractual obligations will define roles responsibilities and requirements as well as ramifications when milestones are not met or services delivered consistent with contractual expectations. This monitoring process will be transparent and predicated on domain one metrics and additional reporting expectations established by the PAC, executive committee of the PAC, or AMCH as the lead applicant. Performing providers not meeting expectations with regard to performance metrics associated with project plans will be counseled, coached, and given opportunities to remedy their performance. Processes regarding how performance will be measured will be provided as they are developed consistent with the project plans. These processes will also be available on AMCH's website so that expectations are clear to all participants. IT infrastructure will facilitate reporting clinical and other metrics consistent with the approved implementation plans.

***Oversight 2:**

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

Performing members who fail to meet performance expectations will go through a series of gradually escalating corrective actions. Low performers will receive technical assistance, training and counseling to identify and address deficiencies for correction. This process will be based on agreed upon performance metrics and will follow a documented process of corrective action. This process will commence as advisory and proceed for repeated violations to removal of the member for cause, consistent with procedures and policies to be developed. While we anticipate that this action will be rare consequences for non-performance will be well known to all participants. We recognize at the outset that some organizations will face greater challenges due to limitations of their infrastructure, staff expertise, and capacity. We address this concern through the speed of implementation of each project by assimilating those providers into implementation consistent their organizational needs.

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***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.

AMCH and the PAC will develop mechanisms to insure compliance with numerous requirements, including compliance with all applicable federal and state rules, regulations, laws and policies and milestone reporting requirements. Funded partners will be contractually obligated to meeting performance standards. Payment will be linked to performance. Failure to perform will result in a financial penalty. Depending on specific circumstances of the failure, penalties will range from 10% reduction for a low level first offence to 100% for repeat high level failures. Monitoring and assistance will be provided to prevent all funded entities, including vendors, licensed health and behavioral health providers and community based social service agencies, from missing any milestone. Extensive training will be provided in terms of data collection, reporting and analysis.

It is not enough that data be submitted on time. It must also be accurate, precise, complete and verifiable. Required metrics must also be met. Remediation plans to assist all PPS members will be developed when necessary. However, for contractors who are unable and/or unwilling to comply, they will be found to be in default of their contract and will be defunded. All defunded contractors will be denied membership in the PPS and will be removed from PAC lists. We expect this action will be rare and will require approval from the executive committee of the PAC. Detailed policies and procedures regarding oversight and member removal will be developed with assistance from legal counsel, the compliance officer and chief fiscal officer.

PPS members can be removed for other reasons besides contract compliance. A code of conduct is being developed that lays out expectations of behavior, including requirements to protect proprietary and protected health information, press relations, fraud or abuse, gross misconduct and related areas. Expectations of behavior will be clarified and violations will be prosecuted following due process guidelines that will be developed. All PPS members will be expected to sign a code of conduct pledge that acknowledges they read and understand performance expectations. Formal processes will include rights to appeal, to gather and present testimony, to seek independent counsel for representation and to receive written explanations of violations.

***Oversight 4:**

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

Medicaid beneficiaries and their advocates will be encouraged to provide information regarding membership renewal and removal with input from the consumer affairs subcommittee whose chair is a member of the executive committee of the PAC. Feedback about the development of processes and procedures regarding all aspects of membership will be expected. AMCH and the PAC understand that all members participate to serve the needs of the consumer. Their voice in all aspects of the PPS is not only valued but required. Prior to removal of any member from the PPS consumers will be encouraged to provide testimony in support or opposition to the removal.

***Oversight 5:**

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

Upon removal of any member from the PPS Medicaid beneficiaries and their advocates will be notified of the action. This notification will include identification of the provider on the AMCH DSRIP website. Sanctioned organizations will be advised of their responsibility to notify their consumers regarding their inability to participate with the DSRIP program elements. Additionally the AMCH PPS will notify the appropriate state agencies of the action.

### 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

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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.

AMCH utilized a multi-faceted approach during the 5 months invested in developing our 5 county CNA, covering Albany, Saratoga, Columbia, Greene, and Warren counties spanning the Capital Region and Hudson Valley. All sections of the "Guidance for Conducting Needs Assessment Document" provided by the NYSDOH were followed and completed, including the checklist developed by the DSRIP team of consultants, and the referenced data sets and many of the resource links were referenced and utilized. The CNA consultants hired by AMCH's PPS followed an organized process for completion, generating drafts for review and discussion, modifications to data and data tables as necessary and adherence to a timeline and schedule to keep all stakeholders informed. AMCH gathered important and thorough qualitative and quantitative data, utilizing primary and secondary data sources, providing rich information and insights into community needs. In particular, listening to the personal stories shared by Medicaid recipients was beneficial for both staff and participants involved. Primary and secondary data analysis occurred throughout the planning period, with drafts circulated in late October. Quantitative input included a wide variety of prevention indicators, performance indicators, encounters with providers, measurable drivers and outcomes and impacts. Qualitative input included expert interviews, Web on-line electronic surveys, listening sessions, focus groups, stakeholder engagement and community forums. Data available from the NYSDOH and other public sources was analyzed, including Dashboard indicators by county and Salient data by institutional provider. Additional data from the hospitals and other large stakeholders was then used to supplement this information to obtain cost, utilization patterns and related information. Gaps in services by county and in some cases zip code were completed, based on a resource inventory and surveys conducted of providers and beneficiaries.

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

The following qualitative sources were leveraged:

(A) Seven wide-reaching focus groups, involving 63 Medicaid participants, conducted throughout the service area (3 Albany, 2 Schenectady, 1 Rensselaer/Troy, 1 Hudson/ Columbia /Greene), grouped into four areas: Behavioral and Health, Substance Abuse, Dual Diagnosis and Chronic Health.

(B) Four Listening Sessions were held throughout the service area (1 Ballston Spa, 2 Albany, and 1 Amsterdam). The 102 participants were asked to identify gaps and make suggestions for system improvements. Attendees represented a wide range of stakeholders, including physicians, nurses, nursing home staff, hospital staff, recovery program staff, CBO's, departments of health and elected officials.

(C) Over 100 surveys were completed on line by a representative sample of AMC patients. Additional on line surveys were completed by patients served by other providers, for a total sample size of 220 respondents.

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

## DSRIP PPS Organizational Application

## Albany Medical Center Hospital (PPS ID:1)

In terms of quantitative data:

(A) Public data referenced in the CNA document came from a variety of additional sources including NYSDOH dashboard and SPARCS data, various county departments of health, participating providers, internal performance indicators, the NYS prevention agenda as well as attribution data analysis.

(B) Hundreds of key data sets informed our CNA process, including: lists of community assets and resources, charts of projects, 4 CBO demographic appendices, 5 provider and participant appendices, 9 Medicaid population demographic appendices, 3 SPARC analysis appendices, 11 appendices on health status of the population, and numerous notes from meetings, input groups, survey results and common threads according to health care challenges, gaps, barriers, access, capacity and attitude.

### 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 | 12 | 3 |
| 2 | Ambulatory surgical centers | 8 | 14 |
| 3 | Urgent care centers | 8 | 0 |
| 4 | Health Homes | 14 | 14 |
| 5 | Federally qualified health centers | 12 | 1 |
| 6 | Primary care providers including private, clinics, hospital based including residency programs | 497 | 494 |
| 7 | Specialty medical providers including private, clinics, hospital based including residency programs | 1786 | 1655 |
| 8 | Dental providers including public and private | 105 | 1 |
| 9 | Rehabilitative services including physical therapy, occupational therapy, and speech therapy, inpatient and community based | 34 | 16 |
| 10 | Behavioral health resources (including future 1915i providers) | 219 | 156 |
| 11 | Specialty medical programs such as eating disorders program, autism spectrum early | 0 | 0 |
| 12 | diagnosis/early intervention | 0 | 4 |
| 13 | Skilled nursing homes, assisted living facilities | 25 | 41 |
| 14 | Home care services | 126 | 14 |
| 15 | Laboratory and radiology services including home care and community access | 0 | 1 |
| 16 | Specialty developmental disability services | 0 | 4 |
| 17 | Specialty services providers such as vision care and DME | 135 | 0 |
| 18 | Pharmacies | 161 | 76 |
| 19 | Local Health Departments | 5 | 5 |
| 20 | Managed care organizations | 0 | 0 |
| 21 | Foster Children Agencies | 15 | 1 |
| 22 | Area Health Education Centers (AHECs) | 3 | 2 |

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| # | Provider Type | Number of Providers (Community) | Number of Providers (PPS Network) |
|---|---|---|---|
| 23 | Certified Home Health Agencies | 13 | 2 |

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

***Infrastructure 2:**

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

Overall, our PPS service area has a rate of 8,649.0 health care providers per 100,000 for the entire 5 county region. The county breakdown per 100,000 is: Albany 2240.8, Saratoga 2007.3, Columbia 1235.5, Greene 188.7 and Warren 1966.7. CBO's provide crucial connections that impact community health and serve as safety net providers in the community. Most of the CBOs serve a diverse clientele (over 79% of patients were non-white). The uninsured population looms around 58, 971. Each of the 5 counties has a local Health Department. Services vary, and several offer STD and Lead screening, immunizations, HIV testing, pre-natal care and linkages to care and benefits. Many of the acute, primary, specialty, behavioral and substance abuse needs of the region's Medicaid beneficiaries are being addressed, although not uniformly. Operating hours and access outside of the region's urban centers are challenges. Occupancy rates at several hospitals, skilled nursing facilities and other long term care institutions suggest that there are too many beds. This may be particularly true in Albany, where there are 3 hospitals in the county, two hovering below 90% average daily capacity. There are also excess nursing home beds in Albany, Columbia and Greene counties. As a result, health resources are tied to services that may not be needed, creating waste and inefficiency. One modification that will help "right-size" the system would be to convert excess, unneeded nursing home space to more useful purposes, as proposed in project 2.a.v. The community forums and focus groups identified several other things that can also be modified. Many patients, especially the working poor, may lack knowledge, familiarity and access to primary care and, as a result, make the emergency room their "default" place to receive services. Expanding hours of operation to accommodate the working poor will help. Providing navigators at the point of entry to the emergency rooms to triage patient needs with a corresponding link to both urgent care and primary care that is convenient and accessible is a necessary additional step. Patient education will also be helpful. CBOs have a role in helping with this, for numerous reasons, not the least of which is that they may already have frequent interactions and contact with those we need to reach. More urgent care would be helpful as would expanded hours of operation at several primary care sites. It is clear that care is not integrated. Patients with multiple co-morbidities, especially those dually diagnosed with mental or emotional health issues and chronic illness, must navigate a system that is neither user friendly or readily accessible. Service locations include either primary care or behavioral health; rarely do they coexist. An additional change in the regional composition of providers that will help address this will be the co-location and integration of primary and behavioral health services. There may also be technologic solutions to some issues, modifying the provider mix by bringing the specialist to the PCP electronically.

### Section 3.3 - Community Resources Supporting PPS Approach:

**Description:**

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

***Resources 1:**

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

| # | Resource Type | Number of Resources (Community) | Number of Resources (PPS Network) |
|---|---|---|---|
| 1 | Housing services for the homeless population including advocacy groups as well as housing providers | 168 | 1 |
| 2 | Food banks, community gardens, farmer's markets | 73 | 0 |
| 3 | Clothing, furniture banks | 17 | 0 |
| 4 | Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges) | 55 | 0 |

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| # | Resource Type | Number of Resources (Community) | Number of Resources (PPS Network) |
|---|---|---|---|
| 5 | Community outreach agencies | 3 | 0 |
| 6 | Transportation services | 1 | 0 |
| 7 | Religious service organizations | 3 | 0 |
| 8 | Not for profit health and welfare agencies | 6 | 0 |
| 9 | Specialty community-based and clinical services for individuals with intellectual or developmental disabilities | 2 | 1 |
| 10 | Peer and Family Mental Health Advocacy Organizations | 8 | 3 |
| 11 | Self-advocacy and family support organizations and programs for individuals with disabilities | 2 | 1 |
| 12 | Youth development programs | 60 | 3 |
| 13 | Libraries with open access computers | 37 | 0 |
| 14 | Community service organizations | 455 | 0 |
| 15 | Education | 87 | 5 |
| 16 | Local public health programs | 30 | 2 |
| 17 | Local governmental social service programs | 5 | 5 |
| 18 | Community based health education programs including for health professions/students | 5 | 0 |
| 19 | Family Support and training | 19 | 1 |
| 20 | NAMI | 0 | 0 |
| 21 | Individual Employment Support Services | 8 | 0 |
| 22 | Peer Supports (Recovery Coaches) | 7 | 0 |
| 23 | Alternatives to Incarceration | 3 | 0 |
| 24 | Ryan White Programs | 7 | 3 |
| 25 | HIV Prevention/Outreach and Social Service Programs | 33 | 3 |
| 26 | Adult Day Care/ Senior Support | 8 | 3 |
| 27 | Business/ Case Management | 5 | 0 |
| 28 | Ethnic/ Cultural Support | 1 | 0 |

***Resources 2:**

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

While there may always be shortages of one type of service or another, especially in the more rural areas of Albany, Columbia, Greene and Warren counties, the list of community resources identified above is impressive. In discussion with the PAC's executive committee, AMCH has focused on established CBOs with a more direct impact on health, mental health or supportive services needed to maintain health, like food and nutrition programs as well as behavioral health like counseling and supportive family services, and large organizations serving more than one county. When the list is sorted this way, several CBOs stand out as being important to health systems transformation.

There are things that need to be modified to meet the needs of the community. Just because CBOs offer a service does not guarantee that it is easily accessed. Hours of operation need to be evaluated and expanded so that the working poor and others will be able to obtain services when needed. Too many CBOs work in silos and unknowingly create knowledge gaps and confusion when they are not aware of how other services can be obtained and coordinated. Some CBOs place "rules of engagement" barriers that negatively impact those most in need. For example, only one shelter in the region will allow an individual to spend the night if they are not clean and sober. More flexibility may be needed to accommodate people in helping them "where they are at" as opposed to where we might want them to be.

A common theme voiced by provider and patient communities via focus groups, surveys and listening sessions focused on

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communication. This goes back to the concept of silos. Real time communication across health and social service providers is rare. Much needs to be done to fix this. We believe that this will need to be a priority if meaningful transformation can be achieved. Work needs to be done to improve telecommunications, IT infrastructure, data capture, reporting and analysis for the majority of CBOs. Other resources to be modified include: capacity to make and receive referrals, additional funding to reduce high caseloads, more trained outreach and in-reach activities, and more community health navigators. Co-location of health and behavioral health in selected CBOs could greatly improve care coordination and reduce unnecessary utilization. AMCH and our PPS believe we generally have an adequate number of CBOs. To reach DSRIP goals, they must modify how they work to create an integrated delivery system.

### 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:

Compared to New York State (NYS), the 10 county service area had smaller childhood and larger elderly populations (for <15 years of age: NYS-17.8%; 10 county-15.4%; for 65+ years of age: NYS-14.5%; 10 county-17.5%). Of the 10 counties, Montgomery (18.8%) and Schenectady (18.1%) counties had the largest < 15 year old populations, while Greene (14.1%), Columbia (15.1%), and Ulster (15.2%) had the smallest childhood populations. For the senior population, 75 years of age and older, the rural counties of Columbia (8.6%), Montgomery (8.5%), and Fulton (7.9%) had the largest percentages. Saratoga (6.3%) and Rensselaer (6.4%) counties had the lowest percent of the population over 75 years of age.

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

Fulton, Warren and Montgomery counties had predominantly White non-Hispanic populations, while Dutchess, Albany, and Schenectady counties had the largest minority populations. Albany, Schenectady and Dutchess counties had Black non-Hispanic populations greater than 10%; Montgomery and Dutchess counties had Hispanic populations of greater than 10% (CNA Appendix C 6). Over 151,000 service area residents (10.4%) spoke a language other than English at home, with 50,000 residents (3.4%) speaking English "less than very well". Dutchess and Montgomery counties had the largest number of non-English speaking residents as well as those who didn't speak English well. Montgomery County had the largest Spanish-speaking population (CNA Appendix C 7). Of the 10 service area counties, almost 115,000 residents were foreign-born (7.4%). Dutchess and Albany counties had the largest foreign-born populations. About 54% of the foreign-born population were naturalized citizens (CNA Appendix C 8).

***Demographics 3:**
Income levels:

Median household income ranged from $42,830 for Montgomery, and $45,333 for Fulton counties, to $67,712 for Saratoga and $71,508 for Dutchess counties (CNA Appendix C 10). There were over 117,000 households with incomes under $25,000 per year in the 10 County service area (19.7%). Fulton and Montgomery counties had the largest percentages, while Saratoga and Dutchess the smallest percentage of such households (CNA Appendix C 10). White non-Hispanic and Asian non-Hispanics had higher median household incomes in the 10 county service area compared to Black non-Hispanic and Hispanic households (CNA Appendix C 6).

***Demographics 4:**
Poverty levels:

Over 75,000 service area residents (5.1%) were living at <50% of the FPL; 167,000 (11.3%) at < 100% FPL; and 213,000 (14.5%) at < 125% FPL (CNA Appendix C 11). Across the three FPL's, Montgomery and Fulton counties had the highest percentages, while Dutchess and Saratoga counties the smallest percentage living below the FPLs. The geographic distribution of those living below the poverty line is shown in Figure B 17. The greatest concentrations are in the Tri City urban area as well as in Amsterdam, Johnstown, Kingston, Hudson and, Poughkeepsie. There are also pockets of poverty in Ballston Spa and Saratoga Springs. (CNA Appendix C 11). For the 10 County service area: females had higher % living below the FPLs compared to males.

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***Demographics 5:**

Disability levels:

Approximately 185,000 residents of the 10 county service area, or 12.3%, indicated that they lived with a disability. This percentage is higher than the NYS average of 10.9%. All but Saratoga County (10.1%) had percentages higher than the State average. Fulton County at 16.4% (n=8,871) and Montgomery County at 16.1% (n=7,921) had the highest disability percentages of the 10 counties (Figure B 18) (CNA Appendix C 13). As one would expect, the percentage of disabled increases with age in the 10 county service area: 5.1% (n=16,687) in the < 18 year age group; 10.0% (n=96,086) in the 18-64 year age group; and 33.8% (n= 77,228) in the 65+ age group. Fulton and Montgomery counties had the highest disability rates across the age groups.

***Demographics 6:**

Education levels:

When reviewing educational attainment in the 10 county service area, about 107,000 residents, aged 25 years and older, had less than a high school education, or 10.2% of the population. While this rate was better than the NYS average of 15.1%, two counties were above the NYS average: Montgomery (16.5%) and Fulton (15.2%), with Greene County close at 14.7%. (CNA Appendix C 9). For residents with a four year college degree or greater, the 10 county service area had a rate of 31.2%, slightly lower than the NYS rate of 32.7%. Fulton (14.5%), Montgomery (16.1%), and Greene (19.1%) counties had the lowest rates for residents with a bachelor's degree or greater.

***Demographics 7:**

Employment levels:

While the 10 county service area's unemployment rate of 8.0% as of July 2013 is better than the NYS rate of 8.5%, there were still approximately 61,000 individuals who were looking for work but unemployed (CNA Appendix C 12). As with other socioeconomic indicators, Fulton (10.6%), Montgomery (10.4%) and Greene (9.4%) counties had the largest rates of unemployment.

***Demographics 8:**

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

Most census-based demographic information represents the resident population. Group quarters information from the Bureau of Census (2010 Census) offers information on specific types of the institutionalized and non-institutionalized populations. There were almost 71,000 individuals living in group quarters in the 10 County service area. Of this group, approximately 15,900 (22.4%) were in adult or juvenile correctional facilities; 10,200 (14.5%) in nursing or skilled nursing facilities; 29,900 (42.3%) in college or university housing; and 14,000 (19.9%) in other non-institutionalized facilities such as emergency and transitional shelters, adult group homes, or adult residential treatment centers. There were large correctional facility populations in Greene, Dutchess and Ulster counties. Dutchess (n=2,300), Albany (n=1,831), Ulster (n=1,273), Rensselaer (n=1,133) and Schenectady (n=988) counties had large nursing home populations.

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

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

| File Name | Upload Date | Description |
|---|---|---|
| 1_SEC034_Project 3.b.i, Question 4C, Albany Medical Center Hospital.docx | 12/22/2014 04:07:02 PM | Answer to Question 4C for Project 3.b.i |
| 1_SEC034_CNA DEMOGRAPHICS FINAL.xlsx | 12/22/2014 09:23:16 AM | Demographics Excel Document Containing Tables for each section, please note there are multiple tabs. |

## 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:

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The Leading Causes of Death for the 10 counties mimicked Upstate: 1-Heart Disease; 2-Cancer; 3-Chronic Lower Respiratory Disease (CLRD); 4-Stroke; 5- Unintentional Injury (CNA Appendix D 4).
The Leading Causes of Premature Death for the 10 counties mimicked Upstate for the 2 leading causes: 1-Cancer; 2-Heart Disease. The 3rd and 4th leading causes of premature death fluctuate between Unintentional Injury (5 counties) and CLRD (5 counties). The 5th leading cause of death varies between stroke, diabetes, and suicide (CNA Appendix D 5).

***Challenges 2:**

Leading causes of hospitalization and preventable hospitalizations by demographic groupings:

The 10 County service area averaged over 15,500 adult preventable hospitalizations per year. Fulton County's rate of 163.7/10,000 fell into the 4th quartile and Montgomery (138.5) and Warren (134.6) counties into the 3rd quartile of NYS counties (CNA Appendix D 6).
The service area averaged about 175,000 hospitalizations per year. Fulton (1,290/10,000) and Montgomery (1,266) counties had age-adjusted hospitalization rates in the 4th quartile , while Warren County (1,182) fell into the 3rd quartile (CNA Appendix D 6).
The service area averaged 560,000 ED visits per year. Montgomery (6,462/10,000), Fulton (4,834) and Schenectady (4,710) had adjusted ED visit rates that fell into the 4th quartile (CNA Appendix D 6).

***Challenges 3:**

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

Ambulatory care sensitive conditions are potentially preventable admissions or ED visits. When reviewing the Potentially Preventable Emergency Department Visits (PPV) for the 10 county service area, all counties had much higher Medicaid rates compared to the all payer rates (Figure B 42) While the NYS difference between the PPV all payer versus Medicaid population is 12.5 per 100 (Medicaid-36.0; all payer-23.5), 6 of the 10 counties had differences over 20 per 100: Rensselaer-50.6; Fulton-40.2; Albany-36.0; Ulster-22.9; Schenectady-22.5; and Dutchess-22.5. Four counties had higher all payer PPV rates than NYS (23.5 per 100): Montgomery- 42.9; Columbia-37.3; Schenectady-36.5; and Warren (27.4) (CNA Appendix D 31). There was an average of 154,000 Medicaid PPVs in the 10 County service area (Figure B 48). Of these 22% were from Albany, 15% from Schenectady, and 15% from Rensselaer. All 10 counties had equal to or greater Medicaid PPV rates than NYS (35 per 100 Medicaid recipients). Rensselaer (68), Schenectady (59), Albany (58) and Columbia (55) counties were in the 4th or 5th Quintile of all NYS counties for Medicaid PPVs. (CNA Appendix E 5).

***Challenges 4:**

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

The service area averaged 2,184 hospitalizations per year where diabetes was the primary diagnosis, but 34,217 where diabetes was listed in any diagnosis. For the age-adjusted diabetes (primary diagnosis) hospitalization rate, only Fulton County's rate of 19.2/10,000 fell into the 4th quartile. Five of the 10 service area counties have seen their smoking prevalence rates similar or increasing from 2008-09 to 2013-14. Eight of the 10 counties had higher smoking prevalence rates than Upstate, with Fulton (29.0%), Greene (24.5%), and Rensselaer (23.8%) having rates in the 4th quartile, and Montgomery (23.4%), and Columbia (21.0%) falling into the 3rd quartile of NYS counties.The 10 County service area averaged 1,600 asthma related hospitalizations. For the age-adjusted asthma hospitalizations rates, Fulton (15.6/10,000), Warren (12.5) and Albany (12.3) fell into the 4th quartile, while Rensselaer, Dutchess, Montgomery, Ulster, and Schenectady counties fell into the 3rd quartile of NYS counties (Figure B 33) (CNA Appendix D 15). There was an average of 90 new HIV cases per year in the service area, for a rate of 5.9/100,000. Albany (10.1) and Schenectady (7.5) counties had rates in the 4th quartile, with Dutchess (6.2), Rensselaer (5.6), Fulton (4.8) and Ulster (4.6) in the 3rd quartile of NYS counties (CNA Appendix D 25). There were almost 400 cases of gonorrhea in the service area for women 15-44 years of age; a service area rate of 133.0/100,000. Schenectady (197.6), Albany (173.4) and Dutchess (173.7) counties had rates in the 4th quartile, while Fulton, Ulster, Greene and Rensselaer counties fell into the 3rd quartile of NYS counties (CNA Appendix D 26). The 10 County service area had almost 3,400 women, 15-44 years of age, diagnosed with a chlamydia infection in 2012 for a rate of 1,151.4/100,000. Schenectady (1688.3), and Albany (1,444.8) were in the 4th quartile, while Fulton, Montgomery, Rensselaer, and Greene counties fell into the 3rd quartile for chlamydia infections (CNA Appendix D 26).There was an average of 2,725 heart attack hospitalizations and 550 heart attack deaths per year in the 10 County service area. Fulton (24.6/10,000) and Montgomery (22.4) counties had age-adjusted heart attack hospitalization rates falling into the 4th quartile, while Schenectady (18.9) and Warren (17.6) fell into the 3rd quartile. Only Montgomery County's age-adjusted heart attack mortality rate of 37.0/100,000 fell into the 3rd quartile of NYS counties (CNA Appendix D 11). The 10 County service area averaged 5,177 hospitalizations and 2,465 deaths per year due to coronary heart disease. Only Fulton (38.6/10,000) and Montgomery (38.5) age adjusted hospitalization rates fell into the 3rd quartile. For age-adjusted coronary heart disease mortality rates, Montgomery (165.8/100,000) and Columbia (162.7) counties were in the 4th quartile of NYS counties (Figure B 30) (CNA Appendix D 11).

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When reviewing the % of Adults who are obese in the service area, 8 of the 10 counties showed rates increasing from 2008-09 to 2013-14. Nine of the 10 counties had obesity rates higher than NYS (CNA Appendix D 9).

***Challenges 5:**

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

There was an average of over 1,500 premature (< 37 weeks gest.) births per year in the 10 County service area for a rate of 10.6% of all births. Greene County (13.3%) fell into the 4th quartile, and Albany (11.3%), Schenectady (11.2%), Montgomery (10.9%) and Warren (10.5%) counties fell into the 3rd quartile of NYS counties (CNA Appendix D 17).
For the premature birth rate in the Medicaid population, Greene (16.9%), Columbia (13.0%), and Schenectady (11.8%) were higher than NYS (11.7%). Five of the 10 counties had lower prematurity rates for the Medicaid births than non-Medicaid births. The lowest ratios were in Montgomery (0.79) and Saratoga (0.80) counties. Greene (1.31) and Columbia (1.25) counties had Medicaid/non-Medicaid prematurity ratios in the 4th quartile (CNA Appendix D 17).
Approximately 4,500 births in the 10 County service area were without adequate prenatal care (as defined by the Kotelchuck index). Warren (54.9%), Montgomery (61.2%), Greene (61.9%), and Columbia (62.9%) counties fell into the 4th quartile. Albany, Ulster, and Dutchess counties were in the 3rd quartile for adequate prenatal care (Figure B 34)(CNA Appendix D 18).

***Challenges 6:**

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

Tobacco use is the leading cause of preventable death in the United States . It affects not only those who use tobacco, but also people who live and work around smokers. In the recent Prevention Agenda planning efforts of counties and hospitals in the 10 County service area, three counties identified reduction of smoking-related illness as a focus area. Binge drinking is an alcohol-related indicator collected by the EBRFSS. Binge drinking is defined as males having 5 + drinks, or females having 4+ drinks at a time at least once in the past month. Six of the 10 service area counties had 2013-14 rates of binge drinking higher than the Upstate average of 17.4%. Good nutrition and regular physical activity are important to health. However, excessive calorie consumption and insufficient physical activity can lead to overweight and obesity and thus to increased risk for conditions such as coronary heart disease, diabetes, and some cancers. When reviewing the recent 10 county Prevention Agenda planning efforts, every county identified obesity/diabetes as a priority focus area. Seven of the 10 counties had school student obesity rates higher than the upstate average of 17.7%

***Challenges 7:**

Any other challenges:

Clean air and water are core components of a healthy community. Air pollutants such as fine particulate matter are harmful to the population's health and environment. Contaminants in drinking water can lead to poisoning, illness, and increased cancer risk. The 10 County service area have fine particulate matter (PM2.5) measures lower than the NYS (11.7). Safe roads and automobile travel is another component of a health built environment. There were about 120 motor vehicle-related deaths per year in the Service Area. While 8 of the 10 service area counties had motor vehicle mortality rates higher than NYS rate of 6.1/100,000 . Community Safety is another important component of a healthy community. Unsafe neighborhoods can cause anxiety, depression, and stress. Fear can also keep people indoors and away from exercise and healthy foods. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery and aggravated assault. The NYS violent crime rate was 392/100,000. Two of the Service Area counties, Schenectady (451) and Albany (401) had rates higher than NYS.

### 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 number of beds has been declining since the 1998 Berger Commission's recommendation of reducing hospital bed count by 4,200 and reduce the number of nursing beds by 3,000. In 2006 there were 3.3 hospital beds per 1,000 New Yorkers as compared to 2.8 beds

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per 1,000 nationally. Today there are 3.0 beds per 1,000 in New York and 2.6 beds per thousand in the USA. However, current levels of hospital beds are high in our PPS, although bed utilization varies greatly across the hospitals. Presently in the PPS service area, there are 3,910 certified hospital beds in 22 hospitals, and 9,473 nursing home beds in 57 facilities in the broader 10 county region. Hospitals bed numbers by county and facility range from 0 in Greene County, to 1,381 in Albany. There are more beds in urban areas and less in rural areas. Albany County has the highest number of hospital beds (N=1381), above the state average and an excess of 455 beds). There are a total 3,864 beds in skilled Nursing homes and assisted living facilities, 1,743 in Albany, 789 in Saratoga, 688 in Columbia and 256 in Greene counties and 388 in Warren. Based on reported nursing home occupancy rates, we believe there are excess beds in Albany, Columbia and Greene counties, with as many as 200 excess beds in Albany alone (see project 2.a.v). Albany has the most pediatric beds (at 61), Saratoga has 12 and there are 4 in Columbia County. Rehabilitation Services (including PT, occupational therapy, speech therapy, inpatient and CBO) seem adequate, but only Albany and Schenectady have chemical dependency beds. Albany also hosts 15 AIDS certified beds and 6 bone marrow transplant beds. There are also 61 pediatric beds in Albany and 14 neonatal beds. No other county has certified neonatal beds. Saratoga has12 and Columbia has 4 pediatric beds. Of all Behavioral Health/chemical dependency rehabilitation beds, Albany has 40 as well as additional beds in article 31 and 33 facilitates. Albany also has 18 behavioral health/chemical dependency detoxification beds. For other important health services utilizing the hospital setting, Albany also has the most ICU beds (at 84) while Columbia has 9, and there are 7 in Saratoga.

***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.

Most people lack a full grasp of the current complex and fragmented health delivery system – and their own role in relation to the total. Lack of understanding can lead to frustration and feelings that there is nothing they can do to improve their situation. Medicaid coverage often does not cover needed services leaving beneficiaries to try and pay on their own. Our projects will identify services that are needed and fill those gaps as we create a value based payment system.

Preventive health services need to be expanded. Necessary follow-up orders and filling of prescriptions needs to be more convenient. Focus group participants wanted to have healthy lifestyles and mentioned wanting to lose weight or quit smoking.

The working poor use the ED because they have no time available to make an appointment with a physician during business hours and may not have a PCP. Members will not take an hour or more off of work to go to an appointment. Limited facilities exist within our PPS that offer extended hours. Our DSRIP strategy is aimed at developing additional extended hours treatment opportunities outside of the ED.

Members not only need to be engaged, but empowered to have a voice in their own care. Some Members noted the difficulty of understanding all the complex processes needed to manage their own health. Community and hospital based navigation services will close this gap as these services don't currently exist in a robust form.

Many members rely on public transportation, family, friends, and available community transportation services. The ED is usually on a bus line, while the PCP may not be. The logistics of transportation to and from appointments can be extremely difficult and time consuming to manage. The PPS will work to close the transportation gap.

***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.

The needs assessment identifies that care is fragmented, Medicaid beneficiaries use the ED as a default provider, services are not always accessible or affordable, and access varies by region and quality of care varies. As important, the system of care is expensive, and unsustainable. To begin to address these needs identified in the CNA our PPS selected projects that would focus on these issues. Perhaps most important we believe that the system must be integrated and made affordable and accessible. Patients must be educated about self-empowerment and management, when and how to use the ED, and how to best utilize primary care services, in ways that are culturally and linguistically appropriate. In this way a renewed focus on prevention of chronic illness will be envisioned. Along the path of transformation, many things will need to change to help address these gaps. These include integrating physical and behavioral health in ways that have never been done before. It also requires coordination and linkages with CBOs who will become equal partners in the system. They are best positioned to address may of the gaps identified including access, timeliness, communication, and knowledge. They understand the unique needs of their clientele better than healthcare providers do, and are poised to be drivers of change needed to

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succeed. Existing resources must be modified so that hours of operation are expanded to meet the patients' needs. In addition one stop shopping must become the new model at many locations to make it easy for patients to get all of the care they need. Excess capacity, particularly in nursing homes and other healthcare facilities must be repurposed. Failing to do so perpetuates waste and inefficiency the system can ill afford. Finally the role that behavioral health plays in complicating co-morbid health conditions must be recognized and addressed. This will require regulatory relief, changes in payment methodology, licensure, and scope of practice, but is essential to improving care integration over the project period. While not mentioned in the CNA, financial sustainability of the system is key to DSRIP. Integration of our proposed projects with a corresponding shift from a fee for service to a pay for performance model is essential to sustainability.

### Section 3.7 - Stakeholder & Community Engagement:

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

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

Members of CBO's, medical institutions, advocacy organizations, concerned citizens and government agencies met to provide meaningful feedback and input into the needs assessment, led by the Healthy Capital District Initiative (HCDI). The resulting CNA document created over the summer and early fall afforded input and engagement from stakeholders and community members. Numerous opportunities to discuss community needs were provided in several locations in October and November, encouraging participation. Providers also attended listening groups where they discussed Medicaid satisfaction, capacity and feedback about the Medicaid insurance program. Consumer focus Groups were held in 5 counties lead by Zone 5 Communications, and listening groups were held in 4 counties lead by Next Wave consultants. In addition to opportunities for face-to-face discussion in these forums, focus groups and listening sessions, consumers and providers were encouraged to respond to electronic surveys. We received completed paper surveys from over 100 Medicaid beneficiaries and an additional 120 were completed on line by patients. In addition, 300 post cards were distributed by CBO's to Medicaid patients. Surveys were also gathered by area medical providers. Satisfaction surveys were also collected by hospitals. Individual interviews also occurred.

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

There were 7 Focus Groups, with 67 Medicaid participants, conducted throughout the service area (3 Albany, 2 Schenectady, 1 Troy, 1 Hudson). Focus group questions addressed: demographics; general feelings about Medicaid; gaps in services; barriers to care; health concerns, and recommendations to solve needs. All participants were grateful to be heard. Consumer participants received modest incentives, pizza and drinks. In addition, there were 4 Listening Sessions for CBO's/providers conducted held by Next Wave (1 Ballston Spa, 2 Albany, 1 Amsterdam). Of the 100+ participants, topics included potential benefits and costs of DSRIP; opportunities to participate; identification of gaps; concerns about the current delivery system and suggestions for improvements. Attendees represented a wide range of stakeholders, including physicians, nurses, nursing home staff, recovery program staff, CBO's, departments of health and elected officials.

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

CBO leaders, and education and other professionals who attended the listening sessions saw their part of Medicaid as facilitators in enrollment and navigation. Licensed providers were dissatisfied with the current system, but offered important and useful insights. Some identified ways to reduce unnecessary ER visits. Most had capacity to see more Medicaid patients. They raised concerns about patient behavior, but few had workable solutions. Medicaid recipients raised several issues about a "broken system", with common themes including: lack of specialty providers, long appointment wait times/capacity, inadequate mental health services, stigma, cost of co-pays, transportation, lack of providers in certain areas, lack of coordination among various NYS departments, and lack of communication between providers. Patients also raised concerns about pharmacies which don't accepted Medicaid. Many were either added or dropped from Medicaid programs without notice. There was also a basic mistrust in the Medicaid system. Patients suggested they didn't visit the ED/ER unless necessary, but that was often their only default to solve their needs.

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

**[Albany Medical Center Hospital] Stakeholder and Community Engagement**

| # | Organization | Brief Description | Rationale |
|---|---|---|---|
| 1 | Albany Medical Center Hospital & Albany Medical Center Faculty Physician Network | Hospital, Safey Net | As the lead applicant, the hospital and faculty phyisicans group provide the most care, serve the most Medicaid beneficiaries and are critial to the success of the initiative, the PPS relies on their leadership and ability to effectively develop and manage the network of providers, including appropriate control of funds. |
| 2 | Columbia Memorial Hospital & Columbia Memorial Hospital Physician Network | Hospital, Safety Net | As a key partner and second largest safety net hospital, Columbia Memorial has lead responsibility for project coordination and management in Columbia and Greene counties. They provide care and services to a very high percentage of Medicaid beneficiaries in the two counties. |
| 3 | Saratoga Hospital & Saratoga Hospital Faculty Physician Network | Hospital, Non Safety Net | PPS's key and most important partner in Saratoga County, responsible for leadership and management of project activities within the county. Crtical role in ER care triage, reduction of avoidable usage and other imprtant elements. |
| 4 | CapitalCare Medical Group, LLC | Primary Care Provider, Non Safety Net | Several of their PCP sites are PCMH and are important to development and implementation of several projects. They also have an important role to plan in terms of referral patterns, patient education and empowerment and clinical leadership in domain 3 projects. |
| 5 | Community Care Physicians, PC | Primary Care Provider, Not Safety Net | Several of their PCP sites are PCMH and are important to development and implementation of several projects. They also have an important role to plan in terms of referral patterns, patient education and empowerment and clinical leadership in domain 3 projects. |
| 6 | Whitney M. Young Jr. Health Center | Federally Qualified Health Center, Safety Net | As one of our FQHC partners with a high volume of Medicaid beneficiaries, site is important to integration, and all of the domain 2, 3 and 4 projects. As the home of the Asthma Coalition of the Capital Region, they have added importance and relevance on that project. |
| 7 | Albany County Department of Mental Health and Hygiene | OMH Provider, Safety Net | Important to BH integration, crisis stablization, system integration, ER care triage and other projects. As a |

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**[Albany Medical Center Hospital] Stakeholder and Community Engagement**

| # | Organization | Brief Description | Rationale |
|---|---|---|---|
| | | | large BH safety net provider, they also play an important leadership role in the community. |
| 8 | Capital District Psychiatric Center | OMH Provider, Non Safety Net | As a psychiatric hospital adjacent to AMCH, they play an important role in helping to develop alternatives to ER use, integration of PCP and BH services, crisis stablization and inpatient admissions. |
| 9 | Greene County Mental Health | OMH Provider, Safety Net | Important to BH integration, crisis stablization, system integration, ER care triage and other projects. As a large BH safety net provider, they also play an important leadership role in the community. |
| 10 | Northeast Parent and Child Society | OMH Provider, Safety Net | Important to BH integration, crisis stablization, system integration, ER care triage and other projects. As a large BH safety net provider, they also play an important leadership role in the community. |
| 11 | Parsons Child and Family Center | OMH Provider, Safety Net | Added focus on pediatric and family issues provides a unique and important voice and niche in terms of BH integration, crisis stablization, ED care triage and inpatient utilization. A recognized leader important to the executive committee and further evolution of the network of providers. |
| 12 | Saratoga County Community Services/Mental Health Center | OMH Provider, Safety Net | Important to BH integration, crisis stablization, system integration, ER care triage and other projects. As a large BH safety net provider, they also play an important leadership role in the community. |
| 13 | Conifer Park | OASAS Provider, Safety Net | As one of the largest substance abuse providers, they play a critical role in terms of integration, coordination and co-location of services. They are important to the success of several projects and have a leadership role in the community and will have on the executive committee. |
| 14 | Hope House, Inc. | OASAS Provider, Safety Net | As a residentital facility and a large outpatient safety net provider, they also have an important role to integrate SA services with MH and PCP. They have recognized expertise in the community and are leaders in helping patients with addiction recovery. |
| 15 | The Addictions Care Center of Albany, Inc.. | OASAS Provider, Safety Net | As one of the largest substance abuse providers, they play a critical role in terms of integration, coordination and co-location of services. They are important to the |

# Albany Medical Center Hospital (PPS ID:1)

**[Albany Medical Center Hospital] Stakeholder and Community Engagement**

| # | Organization | Brief Description | Rationale |
|---|---|---|---|
| | | | success of several projects and have a leadership role in the community and will have on the executive committee. |
| 16 | Trinity Alliance of the Capital Region | OASAS Provider, Non Safety Net | While not a safety net provider, Trinity is a significant voice of advocacy for the poor. They provide imporant servceis needed in the community and will allow us to develop linkages and coordination as well as access to their clients for several projects. |
| 17 | AIDS Council of NENY, Inc. | OPH AIDS Institute, Safety Net | As a health home provider, they are important to the PPS for many reasons, including their practical approach and experience in care coordination and management for particularly high risk individuals with multiple co-morbidities, including HIV incection. |
| 18 | Catholic Charities of the Diocese of Albany (Columbia & Greene Counties) | OPH AIDS Institute / Health Home, Safety Net | As a health home provider, they are important to the PPS for many reasons, including their practical approach and experience in care coordination and management for particularly high risk individuals with multiple co-morbidities, including HIV incection. |
| 19 | Albany County Department of Health | Diagnostic & Treatment Center, Non Safety Net | We need county health department involvement for many reasons. Their expertise in public health management and prevention is valuable to several projects, including both domain 4 initiaitives. |
| 20 | Center for Disability Services | Diagnostic & Treatment Center, Safety Net | As the largest provider in the region serving patients with disabilities and a highly respected colleague, the Center brings unique expertise to the table to assist the PPS and the executive committee with making sure that the needs of the disabled are addressed and incorporated into project design and implmentation across all domains. |
| 21 | Planned Parenthood, Inc. (Mid Hudson Valley, Mohawk Hudson & Upper Hudson) | Diagnostic & Treatment Center, Safety Net | Very important network of providers addressing maternal child and maternal fetal health, with a clear understanding of issues of social determinants of health. Important voice on the executive committee addressing issues important to women. |
| 22 | Albany County Nursing Home | Skilled Nursing Facility, Safety Net | As a large SNF, they will play a crucial role in helping to reuse excess nursing home space to convert to medical village use, consistent with project 2.a.v |

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**[Albany Medical Center Hospital] Stakeholder and Community Engagement**

| # | Organization | Brief Description | Rationale |
|---|---|---|---|
| 23 | Catskill Crossings, LLC DBA The Pines at Catskill Center for Nursing and Rehabilitation | Skilled Nursing Facility, Safety Net | As a large SNF, they will play a crucial role in helping to reuse excess nursing home space to convert to medical village use, consistent with project 2.a.v |
| 24 | Daughters of Sarah Nursing and Rehabilitation Center | Skilled Nursing Facility, Safety Net | As a large SNF, they will play a crucial role in helping to reuse excess nursing home space to convert to medical village use, consistent with project 2.a.v |
| 25 | Kaaterskill Care Nursing and Rehabilitation Center | Skilled Nursing Facility, Safety Net | As a large SNF, they will play a crucial role in helping to reuse excess nursing home space to convert to medical village use, consistent with project 2.a.v |
| 26 | St. Margaret's Center | Skilled Nursing Facility, Safety Net | They have a unique role in providing SNF services to children and are important leaders in the community. Their input into project development and implementation will be important. |
| 27 | Van Rensselaer Manor | Skilled Nursing Facility, Safety Net | As a large SNF, they may play a role in helping to reuse excess nursing home space to convert to medical village use, consistent with project 2.a.v |
| 28 | Belvedere Health Services, LLC | Licensed Home Care Service Agency / OASAS Provider, Safety Net | Unique services to active SA users with a corresponding niche to assist PPS with alternatives to ED visits and inpatient admissions. Also has a role in integration of PCP and BH, among other important fucntions needed for PPS to succeed. |
| 29 | Visiting Nurse Association of Albany Home Care Association | Licnsed Home Care Service Agency, Safety Net | Large safety net home care agencey, with a role in CV, asthma, patient retntention, medication adherence and other projects as alternatives to existing care facilities. |
| 30 | Golub Corporation / Price Chopper Operating Co., Inc. | Pharmacy, (6 Safety Net Branches) | Pharmacies are important to several of our initiatives, since this is where patients go to pick up food and Rx, affording opportunities for nutrition counseling, medication adherence, refill reminders, etc. |
| 31 | Kinney Drugs, Inc - KPHHealthcare Services, Inc. | Pharmacy, Safety Net | Pharmacies are important to several of our initiatives, since this is where patients go to pick up food and Rx, affording opportunities for nutrition counseling, medication adherence, refill reminders, etc. |
| 32 | Walgreens Co. | Pharmacy, Non Safety Net | Pharmacies are important to several of our initiatives, since this is where patients go to pick up food and Rx, affording opportunities for nutrition counseling, medication adherence, refill reminders, etc. |
| 33 | Community Care Behavioral Health | Behavioral Health Provider, Non Safety Net | Important advisory role in how to integrate PCP and BH since they |

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**[Albany Medical Center Hospital] Stakeholder and Community Engagement**

| # | Organization | Brief Description | Rationale |
|---|---|---|---|
| | | | have success in doing that. Recognized leaders in the field of BH. |
| 34 | Greene County Department of Health | Local Government Unit, Non Safety Net | We need county health department involvement for many reasons. Their expertise in public health management and prevention is valuable to several projects, including both domain 4 initiaitives. |
| 35 | Mental Health Association of Columbia-Greene Counties, Inc. | Local Government Unit / OMH Provider, Safety Net | We need county mental health department involvement for many reasons. Their expertise in public health management and prevention is valuable to several projects, including both domain 4 initiaitives. |
| 36 | Hudson Mohawk Area Health Education Center (AHEC) | Community Based Organization, Non Safety Net | Critical education vendor with expertise in workforce training development and redeployment. |

## Section 3.8 - Summary of CNA Findings:

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

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

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

**[Albany Medical Center Hospital] Summary of CNA Findings**

| Community Need Identification Number | Identify Community Needs | Brief Description | Primary Data Source |
|---|---|---|---|
| 1 | Address comorbid physical/behavioral conditions to focus on patient centered and integrated care | Behavioral Health drives higher admission, readmission, and ED rates. Medicaid and Uninsured patients with Behavioral Health needs have much higher utilization rates than those without. In the AMC PPS, 1667 unique recipients accounted for 5941 total IP admissions for a BH diagnosis; additionally 1,905 unique recipients accounted for 3,506 ED visits with a BH primary care diagnosis. Many times these concerns can be addressed in the primary care setting before reaching the level of a hospital visit but through consumer survey and focus groups, it was made clear that these patients do not feel they have sufficient services available to them in | SPARCS data, NYSDOH DSRIP Medicaid Dashboards, Salient and Consumer Surveys |

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**[Albany Medical Center Hospital] Summary of CNA Findings**

| Community Need Identification Number | Identify Community Needs | Brief Description | Primary Data Source |
|---|---|---|---|
| | | both the BH and primary care realm. 38.6% of attributed lives have a BH diagnosis. Of these, 23.9% also have a tobacco use disorder, 23.9% are diagnosed with unspecified essential hypertension, and 14.6% have unspecified asthma. These comorbid conditions exponentially increase potentially avoidable hospital utilization if patients were routinely tracked by a primary care physician. Medicaid Primary Care visit rates are lower in 4 of the 5 counties vs NYS. The AMC PPS area has fewer mental health providers per 100,000 than the State average with the lowest percentages in Saratoga and Greene Counties. | |
| 2 | Target high impact interventions on high need population | Targeting the high utilizers and high needs patients in the AMC PPS will have the greatest impact on overall ED visit and IP admission rates. 7.6% of attributed patients account for 18.7% of inpatient admissions within the AMC PPS. 31.2% of these admissions become readmissions and the majority is for potentially avoidable conditions. Of patients with a BH diagnosis, 23.9% also have an ED or IP diagnosis relating to tobacco use, 23.9% for hypertension, and 14.6% for asthma. 5.3% of attributed patients had >4 ED visits accounting for 46% of total ED visits within the PPS. 4% of recipients in our PPS had >2 admissions accounting for 49% of IP admissions. Compared to the other areas, the PPS has a higher ED utilization among those who use the ED more than 2X a year (16.9% vs 12%) and a high proportion of extreme utilizers (0.7% vs. 0.5%). | SPARCS data, NYSDOH DSRIP Medicaid Dashboards, Salient and Consumer Surveys, EBRFSS, NYSDOH Community Health Indicator Reports, CAHPS Survey |
| 3 | Reduce avoidable ED Visits by providing alternative resources | The emergency department is currently a major source of care for Medicaid beneficiaries as well as for the uninsured and therefore there is a greater need for access to primary care services within this demographic. The preventable ED visit rate ,for the AMC PPS, is above the NYS benchmark. The PPV rates are number of visits are especially high in Columbia vs. NYS rate 36 for Medicaid, 23.5 for all payor. There are a total of almost 60,000 Potentially Preventable ED Visits within our PPS. Consumer survey of Medicaid enrollees showed that 29% of respondents used the emergency room as their usual place to receive healthcare services as it was the most convenient for them at the time of needing care. 59% of those used the ED three or more times in the last year. Medicaid primary care visits are lover than the NYS average in 4 out of 5 counties in the AMC PPS Region. Of the 52,002 ER visits within the AMC PPS, over 13% were classified as preventable. | HealthData NY, NYSDOH DSRIP Dashboards, Salient, Consumer Surveys |
| 4 | Reduce avoidable hospital admissions and save resources | The majority of preventable admissions are for beneficiaries with chronic conditions. Preventable admissions would decrease with greater integration | HealthData NY, NYSDOH DSRIP Dashboards, Salient, Consumer |

# Albany Medical Center Hospital (PPS ID:1)

**[Albany Medical Center Hospital] Summary of CNA Findings**

| Community Need Identification Number | Identify Community Needs | Brief Description | Primary Data Source |
|---|---|---|---|
| | | of services. The total Medicaid inpatient admission gap based on the AHRQ PQI measures in the chart-books is 1,183 for adults (PQI), primarily in Albany County (680=57%). Rates are over the benchmark of 129.4 in Columbia County. Two chronic conditions that showed significant gaps providing opportunity for improvement were cardiovascular and respiratory conditions. There were 326 Asthma PQIs and 37 PDIs calculated; similarly, the 5 county service area experienced an average of 206 Medicaid circulatory composite PQIs per year in comparison to the NYS rate of 42.2/10,000 Medicaid recipients. 2 of the 5 counties fell into the 4th or 5th quartile for adult hypertension, asthma and adult heart failure. It is suggested that reduction in PQIs will ultimately conserve resources. | Surveys |
| 5 | Cost Savings | Over time, health care system expenses have rarely gone down. The current system is unaffordable and unsustainable. Reduction of unnecessary ER utilization and preventable IP admissions will reduce the cost of care over time. The top 3 diagnosis of patients with 10-15 IP admissions per year are BH/Substance abuse related. These account for 26.5% of admissions. Of the 52,002 ED visits in the last year, 13% were classified as avoidable. Further, BH diagnoses in aggregate, account for 56% of ER visits. Care is neither integrated nor coordinated within the 5 county service area. Care coordination among PCP and Specialists in the BH field is suggested in order to reduce avoidable ED visits as well as preventable IP admissions. | NYSDOH DSRIP Dashboards, Salient data |
| 6 | Increase cultural compentency and health literacy across the region | 2011 SAHIE census estimates there were 57,000 uninsured individuals (9.2%) in the 5 county AMC PPS. The largest number of uninsured are located in Albany (25,196) followed by Saratoga (15,575). Our CNA consumer survey of Medicaid enrollees showed 6% reported as being uninsured, 50% reported not knowing where to get health insurance & many reported problems with losing insurance after leaving the service area. Access to health services for the uninsured is limited, with some providers not serving these patients & some serving a disproportionate share. Our CNA found 9% of provider patients as uninsured which is higher than the general population & 17% not accepting new uninsured patients. There are almost 60,000 PPVâ€™s to Medicaid recipients in the AMC service area. NYS had a PPV rate of 36/100 Medicaid recipients. All 5 counties had rates higher than NYS, with Albany (58) & Columbia (55), in the 4th or 5th quartile. There were approximately 1,184 adult PQI hospitalizations per year in the Medicaid population residing in the AMC PPS area. NYS had an overall PQI composite rate of 184.8 per 10,000 Medicaid | NYSDOH DSRIP Medicaid dashboards, CBO Surveys, Focus Groups, Listening Sessions, HealthDataNY PPV |

# Albany Medical Center Hospital (PPS ID:1)

**[Albany Medical Center Hospital] Summary of CNA Findings**

| Community Need Identification Number | Identify Community Needs | Brief Description | Primary Data Source |
|---|---|---|---|
| | | recipients. Albany (189.9) had rates higher than NYS. Greater understanding & better access to more culturally sensitive primary care will reduce the number of ED visits. Engaging with & understanding this populationâ€™s socio-demographic drivers of unnecessary hospital use will build trust & define the best levers for improving health. | |
| 7 | Utilize existing infrastructure for new delivery models | There is a great need in the AMC PPS region to utilize existing infrastructure in order to create a new delivery model of health care. Based on thorough analysis and review of excess nursing home space and occupancy rates there is available space that is outdated or unutilized. There are 4135 certified beds in the AMC PPS territory. Regional forecasts of certified beds shows a decrease of 1.2% over the next 5 years. This decrease will allow for existing infrastructure to convert to alternative uses. Infrastructure has been identified as a need in the PPS region and the SNF participants is where the existing space is. | Salient Data, NYSDOH DOH Nursing Home and Assisted Living Profiles |

**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 |
|---|---|---|
| 1_SEC038_AMC PPS CNA Report.pdf | 12/22/2014 12:03:39 PM | Comprehensive 10 county community needs assessment completed in partnership with Ellis Hospital |

## Albany Medical Center Hospital (PPS ID:1)

## 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: **Alb Med_Section4_Text_1.4 DSRIP Project Plan Application _ Section 4 Part I(text) 12_22_14_Final.docx**

**Description of File**

The AMC PPS Project applications for eleven projects.

File Uploaded By: brookse1

File Uploaded On: 12/22/2014 03:33 PM

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

Currently Uploaded File: **Alb Med_Section4_ScopeAndScale_AMC dsrip_pps_scale_and_speed.xlsx**

**Description of File**

Draft speed and scale spreadsheet.

File Uploaded By: mcintyc

File Uploaded On: 12/22/2014 01:35 PM

# Albany Medical Center Hospital (PPS ID:1)

## 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.

Workers will be impacted by health system transformation. All workers will need to be trained in order to understand the changes and how their roles may be modified within an integrated delivery system. Staff will require training on cultural competency. All health and social service staff funded either directly or indirectly will receive mandatory annual cultural competency training. Selected staff will also receive training regarding health literacy. Clinical staff will receive training on revisions to protocols, care management guidelines, patient documentation and data collection, that will vary by project. All DSRIP project staff in all sites will receive training regarding their roles and responsibilities in terms of data elements and how they are collected, entered and reported; data quality assurance, precision and completeness of all required elements; milestone reporting, including their roles and responsibilities insuring all pertinent due dates are

## Albany Medical Center Hospital (PPS ID:1)

met and that data is securely managed to protect health information.
Projects directly connected to the hospitals are the most likely to create shifts in workforce, whereas other projects that focus on transformation of the system may have less of an impact. Reductions in admissions and emergency department utilization will require fewer staffing resources in these settings. The hospitals included in AMCH's PPS anticipate relatively small staff redeployment from these changes, certainly less than 4% of the hospital's workforce. The four participating hospitals have a combined workforce of over 15,000 employees, including both inpatient and outpatient staff. Impacts to the workforce will primarily present as opportunities to hire new staff and to retrain existing workers with new skill sets to facilitate redeployment or retraining. The projects that AMC has selected will require additional workers in primary care settings where care coordination will become more important.
The AMC PPS has had discussions with regional and local Area Health Education Centers (AHEC) and 1199SEIU Training Fund, regarding the need to develop curricula or utilize existing curricula for training and retraining workers as needed. We have discussed the need to proactively develop training opportunities and identify emerging needs as the DSRIP projects unfold. Existing workers and new hires will be able to access training at no cost.
The PPS will identify representatives from labor, workers, organizations, and the workforce development vendor to create a Workforce Coordination Council (WCC). The WCC will serve as a multidisciplinary body to coordinate the efforts of the providers, their workers, and labor representation. AMCH's PPS has discussed with neighboring PPSs the feasibility of pooling resources to share curricula, training resources and potentially vendors, to make more efficient use of available dollars.
AMC PPS believes that the participating hospitals will need to redeploy selected staff. We estimate the total impacted staff to be relatively small over the life of the DSRIP Project. Of these, the vast majority will be registered nurses. Our best estimates using available data are provided in the tables of this section. We remain committed that no staff will be laid off. Redeployment, retraining, or hiring will happen in all categories of worker including technicians, radiology techs, phlebotomists, other direct care providers, administrative and patient care and clerical staff. In terms of unionized workers, there is variation in terms of union representation across the participating hospitals and, therefore, some of the employees who may be redeployed are likely to be union members.

***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.

Input from labor representatives and training organizations highlighted the need for the PPS to provide intensive ongoing support to the workforce. We will do this by working with our PPS members to track changes in the workforce and create opportunities to share job posting information across the PPS, as well as working with neighboring and overlapping PPSs to find opportunities to leverage the strengths of our existing workforce to adapt to the new environment. This will be done with a website maintained by the PPS listing job and training opportunities. We will facilitate training that will be available across the PPS and in collaboration with neighboring PPS organizations. As an academic health center committed to training and education, AMCH will ensure that training improves workforce competence by focusing on knowledge, skills and abilities.
Recruiting will be needed in several areas. Our projects will rely heavily on care coordinators and navigators. We have also identified a shortage of qualified behavioral health providers. This will be addressed directly with the organizations that train these professions. We have begun working with Albany Medical College to find opportunities to expand training for psychiatrists, psychologists and allied mental health professionals to address this identified gap.

We have identified workforce shortages in two discrete areas: behavioral health and care coordination/navigation. The identified gap in behavioral health was consistent with results from the community forums and focus group sessions and in surveying our PPS membership. We have begun discussions with Albany Medical College's Department of Psychiatry to expand training within this specialty. We have also discussed this issue with the University at Albany. Their School of Social Welfare and Department of Psychology both train masters and doctoral level clinicians, licensed to provide individual and group psychotherapy and counseling services. We have collaborated with them for many years to provide post-doctoral fellowship training and opportunities for graduate level field placements. The second identified shortage in care coordination/navigation is due to care coordination being relatively new. We have not traditionally utilized care navigators. As a result, we anticipate the need to develop this workforce. We have participated in discussions with several vendors who offer intensive training for peer navigators. We believe that creating job opportunities for current Medicaid beneficiaries benefits everyone. We will continue to work with vendors to develop the needed curriculum to train these workers. It will be essential to close these gaps for us to achieve the goals of DSRIP.

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***Strategy 3:**

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

| Workforce Implication | Percent of Employees Impacted |
|---|---|
| Redeployment | 2.4% |
| Retrain | 7% |
| 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.

The first priority in retraining the workforce will be to workers who voluntarily wish to advance their skills and accept new responsibility. Retraining will be developed in collaboration with our workforce development vendor and the Workforce Coordination Council who will assist us in monitoring gaps and opportunities within the developing workforce. Training will be integral in helping workers transition to better opportunities. This training will be available to workers at no cost to them. The cost will be shared among participating providers across the system and will be an eligible and appropriate expense of Medicaid redesign. Our workforce vendor will deploy training on a regular basis at locations across our region. These trainings will be proactively deployed in anticipation of changes to workforce needs as each project develops.

Primarily limited to the participating hospitals, job functions will be identified as either "emerging" or "declining". Individual workers currently employed in job functions that are declining will be given priority in training for job functions that are identified as emerging. This will allow workers to develop new skill sets voluntarily helping them more easily transition to a new position at the same or higher pay, although compensation generally requires calculation of other factors like night and weekend shifts, ability to earn overtime, etc. As already mentioned, emerging opportunities will be communicated to the workforce through a PPS hosted web portal. This portal will serve as a central location for both workers and organizations to seek out the right people for the right jobs.

Processes involved in communicating with the workers will include job fairs, coordinated recruitment efforts, and management and worker training to make certain the communication about changing workforce needs is adequately communicated. We remain committed to avoiding involuntary termination and expect that with turnover, new hires and outpatient growth opportunities, no employees will be terminated due to job reductions.

Due to the significant redesign of the delivery system, it is not likely all jobs will be able to be preserved in their current form. Aggressive steps will be taken to make retraining voluntary. We will work closely with representatives from labor and workers to clearly communicate when jobs have been identified as declining and put resources in place to make retraining opportunities as attractive as possible to urge voluntary participation in the retraining effort. These efforts will include job fairs, training, and one-on-one coaching to ensure workers are provided the best opportunities. No one will be forced to participate in retraining. We will urge all participating providers in our PPS to support this effort by providing administrative leave with pay for training purposes. We will also support other training initiatives, like AMCH's innovative "grow your own" program that provides tuition support to eligible staff who want to improve their long term career prospects by taking college level courses in a matriculated degree program. We will also coordinate with other regional educational institutions to offer credit bearing courses on our campus as a way of encouraging the pursuit of education for staff, as appropriate. We

expect that similar programs will be created and supported at Saratoga Hospital and Columbia-Memorial Hospital in Hudson.

***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.

Our retraining approach will focus on the worker and matching his/her needs with the needs of the emerging delivery system. Training workers and developing their skills will prepare them, as best as possible, to accept new positions in the developing system at the same or higher rates of pay. We will work with workforce development vendors and the Workforce Coordination Council to monitor changes to the workforce including positions gained, lost, and rates of pay. While the PPS will not directly employ the workers, we will demonstrate leadership in the development of affected staff by facilitating training and creating a transparent workplace. We will insure that compensation is fair and is in line with collective bargaining agreements in organizations that are unionized. Important compensation and benefit decisions are made by every employer wishing to attract and retain the best workforce possible, and market forces guide these decisions.

***Retraining 3:**

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

As described previously, some jobs will ultimately change. The PPS is committed to aggressively working with our performing providers to make similar positions available to anyone who is displaced. Extensive training and communication efforts will communicate these changes proactively. We will make changes to the workforce as required as the projects roll out, thus avoiding sudden changes in the workforce. While we are committed to avoiding any forced employee reductions, employees always have the choice of deciding to accept or decline reassignments. Job coaches and unemployment specialists will advise employees refusing a reassignment in terms of their rights and responsibilities.

***Retraining 4:**

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

The PPS will work collaboratively with our workforce development vendor, the Workforce Coordination Council, and labor representatives where appropriate to make sure the retraining plan meets the needs of workers and is compatible with previously negotiated collective bargaining agreements. It is not the intent of the PPS to interject into collective bargaining negotiations but rather serve as a resource to the workers, employers, and labor representatives to ensure a smooth transition within the workforce. Labor representatives will have important input on the current status of the workforce and will be part of our Workforce Coordinating Council. Our workforce development sub-committee, including representation from the Civil Service Employees Association, New York State Nurses Association and 1199 Service Employees International Union, has had several meetings, including candid conversations about the role that labor representatives expect to play in terms of retraining efforts.

***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 | 95% |
| Partial Placement | 5% |

## 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.

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Similar to retraining, redeployment of the workforce will be made available first to workers who voluntarily wish to advance their skills and accept new responsibility. Planned redeployment will be done in collaboration with our workforce development vendor who will assist us in monitoring gaps and opportunities within the evolving workforce. Training will be integral in helping workers transition to better opportunities. This training will be available to workers at no cost to them. The cost will be shared among participating providers across the system. Our workforce vendor will deploy training on a regular basis at locations across our region in order to assist workers that are in the process of redeployment. These trainings will be proactively deployed in anticipation of changes to workforce needs as each project advances, and in collaboration with organizations and workers.
Job functions will be identified as either "emerging" or "declining". Redeployment positions will be focused in the areas of emerging workforce opportunities. Individual workers currently employed in organizations where redeployment is an option will be given priority in training for jobs functions that are identified as emerging. This will allow workers to voluntarily develop new skill sets that help them more easily redeploy to new positions at the same or higher rate of pay. Emerging opportunities will be communicated to the workforce through a PPS hosted web portal. This portal will serve as a central location for both workers and organizations to seek out the right people for the right jobs.
Processes involved in communicating with the workers will include job fairs, coordinated recruitment efforts, and management and worker training to make certain the communication about changing workforce needs is adequately communicated sufficiently in advance to minimize negative impacts and provide greatest opportunity to the workforce.

***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.

Our approach will be focused on the worker and matching the needs of the worker with the needs of the emerging delivery system. By retraining workers, we anticipate that they will be prepared to embrace their new positions in the developing system at the same or better pay. We will work with our workforce development vendor and the Workforce Coordinating Council to monitor changes to the workforce particularly with regards to positions gained, lost, and rates of pay. While the PPS will not directly employ the workers we will demonstrate leadership in the development of the workforce by facilitating training and creating a more transparent workplace. Our approach will be developed in consultation with HR departments at the participating hospitals during DY1. As mentioned previously, no employees will be involuntarily terminated. We will endeavor, wherever possible, to avoid reductions in salary or benefits for all existing employees. Classification and compensation is a complex HR area that takes into consideration regional rates of pay, education, experience, and salary history. It is subject to Department of Labor regulatory review. We will be in full compliance.

***Redeployment 3:**

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

Some employees adapt better to change than others. Workers have the right to refuse redeployment. It is likely that some existing employees will. We will work with these employees by providing job coaches, job fairs and unemployment advisors to counsel them about their rights and benefits as well as their obligations should they decline a reassignment. Employees make decisions about where and who they work for based on numerous factors, including location, reputation, opportunities for advancement, alternative options and compensation. We will work with employees to try and influence the decision, but recognize it is their decision to make.

***Redeployment 4:**

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

The PPS will work collaboratively with our workforce development vendor and labor representatives where appropriate to make sure any redeployment plan meets the needs of workers and is compatible with previously negotiated collective bargaining agreements. It is not the intent of the PPS to interject into collective bargaining negotiations but rather serve as a resource to the workers, employers, and labor representatives to ensure a smooth transition within the workforce. Labor representatives will have important input on the current status of the workforce and will be part of our Workforce Coordinating Council. Our workforce development sub-committee, including representation from the Civil Service Employees Association, New York State Nurses Association and 1199 Service Employees International Union, has had several meetings, including candid conversations about the role that labor representatives expect to play in terms of retraining efforts.

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## Section 5.4 – WORKPLACE RESTRUCTURING - NEW HIRES :

**Description:**
Please outline expected additions to the workforce. Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

***New Hires:**
Briefly describe the new jobs that will be created as a result of the implementation of the DSRIP program and projects.

The transformation of the healthcare delivery system will create new jobs as well as provide resources to expand the availability or demand for additional positions in existing roles. The PPS will create new jobs in Care Management. These jobs will be new to the PPS region although similar jobs currently exist, the new care management jobs that the PPS will create will have an expanded scope as they begin to manage care across the continuum of care and in a coordinated interdisciplinary way. Workers in these jobs will require training and the PPS will work with our proven workforce vendor to develop new curricula for training in these roles. New jobs will also be created as new facilities are developed in relation to project 2.a.v. The creation of Medical Villages will require staffing in newly repurposed facilities. Jobs created in this project will include Physician, mid-level, nursing, medical technologists, health and peer navigators, as well as administrative and clerical staff. Project 2.b.iii - ED triage project will also create jobs that have not existed in the healthcare industry in this region previously. Healthcare navigators will be employed to guide Medicaid beneficiaries through a complicated healthcare system. Much like care coordinators these positions will require training that will be developed collaboratively with our workforce development vendor using new or existing curricula. These navigators will be utilized in several of our projects, like asthma, crisis stabilization, and behavioral health integration as navigators will be employed to help patients access care and services in the most appropriate setting. Project 2.d.i will also require a new type of worker. The Patient Activation Model requires that individuals be hired and trained to engage low, and non-utilizers of the health care system as well as the uninsured to access appropriate levels of healthcare. These CBO based new hires will be community enrollment specialists and will be expected to understand how to engage and activate patients in care. Other new hires will come from areas where shortages in staffing are identified such as behavioral health. AMC PPS will continue to work with regional and local AHECs as well as Albany Medical College to expand the training programs and to the extent possible the capacity to train the needed resources to close the shortages within the PPS.

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 | 337 |
| Physician | 80 |
| Mental Health Providers Case Managers | 165 |
| Social Workers | 112 |
| IT Staff | 93 |
| Nurse Practitioners | 109 |
| Other | 87 |

## 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 | 613,996 | 908,221 | 908,221 | 830,950 | 492,746 | 3,754,134 |
| Redeployment | 78,793 | 75,768 | 75,768 | 56,450 | 47,543 | 334,322 |
| Recruiting | 59,475 | 56,450 | 56,450 | 56,450 | 28,225 | 257,050 |
| Other | 126,750 | 253,500 | 253,500 | 253,500 | 125,750 | 1,013,000 |

## Section 5.6 – State Program Collaboration Efforts:

***Collaboration 1:**

**NYS Confidentiality – High**

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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.

The AMC PPS has begun to explore opportunities to expand capacity in our system by utilizing and expanding existing relationships with our Area Health Education Centers and training curriculum that may be available through Health Workforce Retraining Initiative awards in New York State. Our WCC will continue to explore opportunities with existing state programs some of which have suffered during recent years from a lack of funding. There are significant opportunities to recruit additional physicians, particularly psychiatrists, to address gaps in the current provider network. Recruitment efforts in the capital district suffer due to proximity to New York City. We have begun discussions with the AMC Department of Psychiatry to develop ways to increase training through fellowships, residency program expansion, and other steps to address this gap. We hope to be able to collaborate with existing state programs to enhance efforts in this area. The Healthy Capital District Initiative (HCDI) was recently awarded PHIP funding by NYS DOH components of that public health grant include training and assistance with workforce issues. As a founding organizational member AMCH will continue to work with HCDI regarding the state's prevention and public health agendas. AMCH is the recipient of CDC and NIH grants supporting workforce training and development through a recent award we are able to support provider training to encourage practitioners to counsel their patients about tobacco cessation. Through the variety of trainings offered by the medical college, many of which bear continuing education credit, we are able to assist in re-training the current workforce and training tomorrows providers.

## Section 5.7 - Stakeholder & Worker Engagement:

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

***Engagement 1:**
Outline the steps taken to engage stakeholders in developing the workforce strategy.

The AMC PPS strategy for stakeholder engagement has been open and transparent. Our subcommittees were populated initially by open invitation to the PAC. PAC members were invited to volunteer and recommend members to participate in the committees. No volunteer was turned away from participation in any functioning committee. After initial committees were set we identified committees that needed broader input. We then actively sought the participation of workers, labor, and training organizations for the development of our workforce strategy approach. The workforce subcommittee met in person or via conference call on multiple occasions, and will serve as the impetus for the formation of our Workforce Coordinating Council (WCC). Participants in the process are identified in the next question.

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

Organizations that have participated thus far in the process are: Workers from AMC, leadership from Eastern Regional and local Area Health Education Centers (AHEC), representative from 1199 Training, representative from New York State Nursing Association, Representatives from 1199 SEIU.
We anticipate more participation from a wider array of workers and organizations as we enter the detailed work plan phase of the DSRIP initiative

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

The PPS will engage frontline workers and include them in the WCC. Organizations will be asked to identify potential participants to ensure effective and broad representation. Through the efforts of our WCC we will maintain a representative body that both understands and reflects the needs of our changing work force. Members may be elected or nominated as appropriate in accordance with organizational rules.

***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.

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The WCC will serve as the primary body to coordinate the efforts of the PPS with regard to workforce development. The PPS will continually review membership of the council and encourage participation from workers, organizations, and labor representation as appropriate. The Council will work to identify structural barriers to workforce development, and be given sufficient resources through its budget to address those barriers.

### 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.

AMCH adapted Montefiore's language, with our partner's permission, to align efforts on these requirements. To enable real-time data sharing, we will increase the number of providers sharing data with the local RHIO. In our 5-county area, HIXNY is the platform for data sharing. Nearly 40% of our PPS have HIXNY participation agreements. We will increase connectivity and data exchange by DY3. While Montefiore is working with HealthlinkNY, they have experience in working with 2 RHIOs and will facilitate what is needed in HIXNY. AMCH/Montefiore will take 3 steps to ensure data sharing: 1ADT integration & secure DIRECT messaging as a stepping stone to meet SHIN-NY/RHIO integration and e-prescribing requirements by DY 3; 2 facilitate EHR adoption for partners & educate them on EHR system alternatives; 3 increase the exchange of patient information until universal RHIO integration by determining a level set for information exchange & bringing all participants up to Stage 2 Meaningful Use.

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

AMCH will ensure data security and privacy in the following ways:
Sign Participation Agreement, Business Associate Agreement (CFR 164.504(e)) and Data Use Agreement (for scope of data use, and additional safety regulations) with partners.
Hold webinars to ensure all partners are aware of and comply with HIPAA Privacy and Security Rules, and fair data sharing practices set forth in the Nationwide Privacy and Security Framework.
Montefiore to host reporting and performance tracking systems on its data center, and the facility has been certified as a 'SOC II Secure Facility for Hosting'.
HIXNY also will offer training on consent, privacy and security to each PPS participant as their connections to the RHIO are made.
Montefiore's Leadership Steering Committee and IT&HIE Transformation Team will have oversight of overall strategy and collective implementation. AMCH's DSRIP compliance officer will also have responsibility for ensuring data sharing milestones are met and protocols enforced.

***Confidentiality 3:**

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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.

To date, over 70% of AMCH's PPS providers have made the transition to EHR. We see this as a critical enabler for real-time data sharing and universal integration to RHIO. HIXNY will enable our partners to receive real time alerts at time of admission and discharge and is working to increase the collection and exchange of core data elements of clinical quality measures, in a way that is compliant with relevant privacy protocols. We will also encourage our partners to leverage DIRECT to enable secure messaging between PPS partners.

In addition to the data exchange that will be enabled through HIXNY, Montefiore is exploring options for a common, integrated care management platform that will allow multiple providers to access a this platform, and will provide more advanced alerts to facilitate implementation of the care plan. This system will ideally interface with the RHIO and other tools necessary to facilitate reporting and data sharing.

To track our progress toward these goals, and to ensure appropriate patient privacy protocols are in place, we will collect data from our PPS partners and provide technical assistance for partners lagging behind DSRIP goals.
AMCH also believes that SHIN-NY consent will be a critical enabler to accelerate data exchange between partners.
While increasing connectivity is a primary objective, we recognize an interim solution will be required to support reporting and data sharing in DSRIP Years 1 & 2. As such, AMCH plans, under the direction of Montefiore, to leverage their experience with data collection and reporting (through Pioneer ACO and Health Homes) to launch a portal that will enable partners to share important information to inform overall PPS performance, and allow AMCH and Montefiore to share back performance reports and other important data to inform care delivery.

## 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.

AMCH performance management efforts will be directed by Montefiore and by our Clinical, Financial, Data and Project Teams in collaboration with our PACs. The teams will be directed by Montefiore, with participation from AMCH's PAC to insure that local operation and management issues are coordinated and addressed. These teams provide input to the Montefiore's Leadership Steering Committee (LSC) and AMCH's Executive Committee, the governing teams that have responsibility for ensuring we are on track and meeting performance goals.
Committees will drive change by covering all critical elements: Creating a performance driven culture for continuous improvement, taking immediate action, awarding success, and sharing best practices; clear divisions of roles and responsibilities, and making sure processes and incentives are aligned with the goals and objectives of DSRIP.
Montefiore and AMCH will ensure partners understand requirements, and take action to meet the goals. This will be done by a reporting and performance tracking web portal developed and managed by Montefiore, who will make sure that collected data is analyzed and results are sent to all PPS partners to inform care decisions.

***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

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- Conduct population-based activities to improve the health of the targeted population.

Data will be collected from multiple sources and integrated into Montefiore's Enterprise Data Warehouse, which creates potential for cross-domain analytics (e.g. claims, care processes, outcomes, patient satisfaction, healthcare utilization and cost). These analytics, combined with continued updates to the CNA will help AMCH's PPS understand the health needs of the community and design activities that improve health care. Patient stratification will be a critical tool to meet this goal. AMCH will leverage Montefiore's current experience and capabilities within the Care Management Organization to stratify the population based on level of need and potential risk factors. This will enable targeted outreach and communication to emphasize primary and preventive care, linked with community prevention services. AMCH will also work to integrate systems as appropriate with managed care plans, building off Montefiore's experience through the CMO, to enable regular data exchange and reporting.

***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).

Summary dashboards and reports will be made available for regular (e.g., quarterly or monthly) performance reviews. Collective performance against targets will be overseen by Montefiore and the compliance function with the DSRIP office.
Results and ways to improve performance will be discussed at committee meetings. Montefiore will hold webinars upon receipt of results and feedback from the State. These webinars ensure that activities of the different workgroups progress towards DSRIP goals, remain aligned with one another, and that each group is clear on actions and deliverables. Montefiore will also continue to explore other web and software tools to facilitate communication and collaboration among PPSs and other stakeholders. AMCH will assist these efforts in convening meetings, serving as a conduit for communications, providing local technical and other assistance as needed and providing IT leadership and expertise to Montefiore, as necessary and appropriate.

***RCE 4:**

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

AMCH, in partnership with Montefiore, will build a highly functioning PPS by leveraging Rapid Cycle Evaluation (RCE) through:

Immediate action and correction: RCE will help AMCH to address improvement opportunities while identifying best practices and success cases. Success will spread across the PPSs by having superior performing partners play a role in coaching partners that are lagging behind.

Claims-based analytics with real time inputs: AMCH will leverage the claims data provided by DOH and any available clinical and patient data to perform patient risk stratification and provider performance analytics in Y1 and Y2, and transition to advanced performance analytics across PPSs afterwards.

Continuous improvement: RCE will help AMCH to quickly determine whether an intervention is effective, and enable program administrators to continuously improve their programs by experimenting with different interventions.

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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 CNA demonstrated what many of us knew – that disparities exist between whites and non-whites in terms of health outcomes. AMCH and its PPS remain committed to providing sensitive, culturally competent services as a means to reducing these disparities. There are both real and perceived challenges that must be addressed. In terms of perceptions, a consistent message from our focus groups informed us that many patients have a general mistrust of the medical system. This affects their interest and ability to access appropriate medical care. Patients believe that doctors are not using good judgment. Others feel victims of "Medicaid stigma", receiving substandard care and being treated differently. Some question the effectiveness of generic drugs and believe that medical tests are ordered based on reimbursement rate rather than need. Most cannot afford the co-pays. They also believe that obesity and smoking are socially acceptable cultural norms that cannot ever be eradicated. These findings are supported by clinical data from our CNA. Other unhealthy lifestyle choices involve lack of exercise, alcohol and drug use, and high costs of healthy foods. Many will not see a medical provider until it is convenient to do so. Because the ED is seen as a place to be served regardless of ability to pay, the cultural norm of going to the ED as the "default" place to seek medical care is a practice utilized among the working poor, poor, and those living in poverty.

This is especially relevant to the 16% (139,000) of non-white patients, and to 100,000 homeless individuals, 7% (60,000) foreign-born individuals, 50,000 individuals where English is not spoken at home, and 24,000 illegal immigrants residing in the 5-county area. In addition, there are 12% of individuals in the service area who live in poverty, who have never accessed the medical system.

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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.

Providers in our PPS service area are spread between 5 counties in various communities. However, most do not have the resources necessary to provide professional development staff trainings.
Thus, as an incentive to learn, Albany Med will provide cultural competency trainings at no cost for providers and staff. Trainings will be tailored to meet provider needs in addressing diverse communities. Our PPS providers will also be trained in adopting the national standards for Culturally and Linguistically Appropriate Services (CLAS). Albany Med will identify and contract with a training organization, and with other experts to develop and deliver trainings to our PPS partners. Training modalities will include: Webinars, independent learning, didactic and small group education, distance learning, and focused technical assistance sessions. Trainings will be delivered to front line, executive and medical provider staff, and will include topics on cultural competency (historical underpinnings, cultural norms, and standards of care) as well as best practices and lessons learned. In addition, pre-tests and post-tests will be administered and tracked in order to identify learning gaps and track process goals.
All efforts will be made to hire and train staff that reflects the patient population, as well as other experts who have experience and skills in gaining trust in working with diverse populations.
Ongoing processes will include tracking and monitoring data outcomes for various risk groups, monitoring progress in reducing disparities, and publishing and presenting on key findings and best practices via poster sessions and papers at conferences and in professional publications. Consistent with information presented in workforce development regarding training needs and in section 10 regarding bonus points we will utilize the cultural expertise afforded by Montefiore Medical Center's and Area Health Education Consortium (AHEC) to facilitate the training.

***Competency 3:**

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

AMCH and Montefiore are committed to utilizing the expertise possessed by many CBOs who understand the unique cultural issues faced by their clientele. They represent a rich racial and ethnic heritage that we will draw on in transforming the healthcare system to be more culturally inclusive representative and diverse. In the process we will reduce disparities solely based on race, age, sexual orientation, ethnicity, marital status, country of origin, disability, or other distinguishing characteristics that result in inequalities. While we do not know at this time which CBOs will be contracted with to assist in addressing cultural competence, between AMCH and Montefiore we have a number of qualified organizations to choose from. While several of them are members of our PPS we will not limit our use of CBOs to only those who are participating organizations. Recommendations in terms of appropriate CBOs for consideration will be sought from the workforce development subcommittee, and the consumer affairs subcommittee. Based on identified qualifications required suitable and appropriate CBOs will be asked to prepare and submit written proposals in terms of scope of services and associated expenses. This bidding process will be open and transparent.

### Section 7.2 – Approach to Improving Health Literacy:

**Description:**

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

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

***Literacy:**

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

- Describe the PPS plan to improve and reinforce the health literacy of patients served.

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

In the AMHC service area, there are over 80,000 non-English speaking residents. Over 73,000 residents were foreign-born. The National Institute of Literacy estimates that 32 million adults can't read (14% of population), that 21% of U.S. adults read below a 5th grade level, and 19% of high school graduates cannot read above a 6th grade reading level. This represents 14% of American adults demonstrating a "below basic" literacy level and 29% exhibiting a "basic" reading level, with 55% of high school graduates and 12% of English speaking adults, overall, possessing proficient health literacy skills. In our 5-county catchment area, graduation rates varied from 71% in Albany City Schools to over 91% in numerous suburban school districts. In addition, education beyond high school graduation including vocational training and college ranged from 19% in rural and poor communities to 75% in higher per capita income areas, largely being wealthy suburban areas surrounding the larger cities. Focus group participants voiced their ability to access assistance with health literacy only through either community navigators or trusted neighborhood leaders. In addition, because of reading ability (including font size), disadvantaged patients do not understand the health care system, available medical options, medical adherence, and community resources. Thus, access to health care suffers, including unnecessary ED visits, poorer health outcomes, higher costs, unnecessary preventable hospitalizations, prescription errors, medication non-compliance, adherence issues, and mortality. (National Minority AIDS Council 2014 Report). Through effective cultural competency and staff training, we will: measure integration of best practices, track provision of technical assistance about best practices, evaluate utilization of health navigators in the community, and measure optimum use of language line patient translation services, through CQI and other evaluation efforts.
To support providers, we will: provide training on best practices; utilize training vendors and expert consultants as needed; offer technical assistance about best methods to engage with disadvantaged community members struggling with health literacy; assist in creating tools to effectively access health literacy in their respective agencies; create comprehensive forms and assist in whatever means necessary to streamline processes required to complete complicated forms; utilize the language line interpretation system to help meet their translation needs; collaborate with a numerous community groups to improve health literacy; hire and train staff who represent the service area and who have experience and trust working with the population; adopt and measure progress of implementing CLAS standards; work to Improve data collection systems; interpret data to better track health care disparities and make appropriate changes with AMHC and with its collaborating partners. These efforts will help us to assess health literacy of individual patients and understanding of their health needs allowing us to be patient centered.

AMHC will identify and contract with one vendor in order to achieve and maintain health literacy through the DSRIP program. This vendor will be responsible for training needs, as well as assessment, data collection and technical assistance. Through training and support of best practices with our collaborative community based partners, it is anticipated that language, readability, understanding, and literacy levels will be addressed, tracked, measured and evaluated. In addition, self-assessment tools, including CLAS standards implementation, will be utilized and adjusted as appropriate on an on-going basis. It is expected that AMHC and the collaborating partners will also integrate DSRIP and CLAS standards into their own existing CQI structures for review and evaluation.

### 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 Finance Committee in consultation with the PMO established a funds flow plan. The budget consists of five categories: Project implementation, New & expanded services, Earned Bonuses, Revenue Stabilization, and Other costs not anticipated. The percentage of funds dedicated to the categories will change over time and will be managed by the finance committee and approved by the Executive Committee and PAC. Funds will be distributed in a way that motivates participating organizations to achieve the goals of DSRIP. Bonuses will be the largest category of expense, and will be earned by organizations achieving the goals established in the project plans. Revenue stabilization will be allocated as transitional funding to offset changes in volume created by DSRIP, and may assist organizations deemed fragile during the transition to a value based purchasing system.

The distribution of funds will be driven by project specific performance measures, and provides for the distribution of funds across the entire continuum of care including all participating organizations and specialties. Funds will not flow to organizations that do not achieve the goals and milestones established in the project plans. Project implementation will consume a significant portion of the budget, but beyond implementation costs the funds flow will be driven primarily by formulaic calculations driven by the project implementation budgets as well as the established metrics and milestones. Primary care will receive larger percentages of the funds due to the size of their involvement in multiple extensive redesign projects. Lesser funds will be provided to organizations that are involved in fewer projects. Ultimately sufficient funds will be committed to achieve the desired changes in organizational behavior. Safety net providers will be majority recipients.

The flow of funds is under the direction of the finance committee which reports to the Executive committee of the PAC. The funds flow plan will be managed by the finance committee and overseen by the Executive Committee. Changes to the plan will be considered and upon their approval will be forwarded to the entire PAC for approval. This process will be transparent and any formulas, calculations, or bonuses will be clearly defined and communicated to the PAC. This process will ensure transparency within the PAC. The changing needs of the PAC will be reflected in the makeup of the Executive Committee. This committee will be able to give direction to the finance committee as

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needed as circumstances direct. The finance committee will present financial updates at each meeting of the PAC or Executive committee.

The AMC PPS approach to the flow of funds is flexible enough to meet the changing needs of the PAC as projects evolve and goals are achieved. With an engaged PAC, Executive Committee, and Finance committee, the funds will be directed to their best use driving changes within the system, ultimately reducing hospital and ED utilization, and providing care in the most appropriate setting. By allocating sufficient funds to the Earned Bonus category and focusing those funds on the achievement of measurable goals and objectives the PPS will be well positioned to make significant progress towards DSRIP goals. Additional bonus funds will be available to the highest performing organizations. The budget categories are expected to fluctuate over the life of DSRIP. Project implementation costs for example are anticipated to be a larger portion of expense, however as the project evolves payments will be more connected to outcomes and less associated with process implementation. Costs for services that are currently not covered by Medicaid will be included, but as the project matures the costs for these services will begin to be included in the new reimbursement models that the DSRIP project is designed to create.

### Section 8.2 – Budget Methodology:

***Budget 2:**
To summarize the methodology, please identify the percentage of payments the PPS intends to distribute amongst defined budget categories. Budget categories must include (but are not limited to):

- Cost of Project Implementation: the PPS should consider all costs incurred by the PPS and its participating providers in implementing the DSRIP Project Plan.
- Revenue Loss: the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such as a reduction in bed capacity, closure of a clinic site, or other significant changes in existing business models.
- Internal PPS Provider Bonus Payments: the PPS should consider the impact of individual providers in the PPS meeting and exceeding the goal of the PPS' DSRIP Project Plan.

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

| # | Budget Category | Percentage (%) |
|---|---|---|
| 1 | Cost of Project Implementation | 25% |
| 2 | Revenue Loss | 10% |
| 3 | Internal PPS Provider Bonus Payments | 40% |
| 4 | New or Expaned Services not currently covered | 20% |
| 5 | Other Costs - Not anticipated | 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.

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

## DSRIP PPS Organizational Application

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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.

AMCH completed a financial survey of our PPS providers. The survey respondents provided financial data with respect to liquidity, profitability and leverage as well as statistics related to payer mix. In addition, AMCH reviewed data available on public web sites for our largest members. Although we have not yet achieved a 100% response rate, approximately 68% of our members currently exceed defined thresholds for liquidity, profitability and leverage. In addition, the vast majority of our members have Medicaid utilization in excess of 40%.
We are using a Sensitivity Analysis, applied to our largest and most fragile providers to model the financial impact that reductions of 10%, 15% and 25% in the provider's DSRIP targeted utilization would have on their financial stability. The PPS finance committee will regularly review the financial health of the PPS and its members and will continue to project and assess sensitivity to change. The finance committee will define the elements to be contained in financial remediation plans to be implmented at a provider level as deemed necessary.
The oversight and monitoring functions to be provided via our governance will enable us to maintain appropriate financial controls, stability and predictability with the ultimate goal of sustaining program efforts beyond the five year term of the project. Obviously beyond the goals of the targeted initiatives, other systematic factors will impact the financial health of participating organizations and will be a consideration in the ongoing financial reviews. This is to help ensure service continuity to these targeted populations through alternative service options.
We continue to work toward a merger of our PPS with HVC, led by Montefiore Medical Center and have shared our financial survey findings and other pertinent information with them for their consideration and input. AMCH has the formal approval of our PPS and PAC to

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provide this and other information to Montefiore.

***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.

Hospitals, nursing homes and other inpatient-focused providers could be negatively impacted by the DSRIP goals of reducing avoidable admissions and emergency room visits. The DSRIP project goals will have a greater negative impact on those providers who are unable to implement timely changes in their strategies as well as their business and operating models as part of transitioning into an integrated delivery network as intended by the implementation of DSRIP.

There are at least eight ways that the DSRIP projects could potentially impact providers, including but not limited to the following:

1. Reductions in inappropriate admissions and ED volumes could impact acute care providers depending upon the overall demand for their services vs. capacity, the flexibility or inflexibility of their cost structures and their current payor mix.

2. Reduction in cash flow due to the loss of patient volume or loss of support payments (where applicable) and/or due to the lower levels of reimbursement for the same volume (i.e. in the case of disproportionate share providers).

3. Requirements to reduce or eliminate services could result in losses of revenue without a corresponding reduction in costs. Such eliminations will also generate significant challenges/pressures within the service market.

4. Reductions in utilization of certain levels or types of services could be offset by increases in levels of care by some providers within the PPS. However, the costs related to such a shift (i.e. retraining and redeploying staff, capital investments) may have a negative impact and may not be sustainable depending upon volumes.

5. A failure or inability of a provider to meet DSRIP requirements for the reduction in services and expenses.

6. The impact of timing differences could be material – i.e. timing of incurring costs. vs. timing of receiving DSRIP funds, timing of implementing changes vs. timing of reaping any benefits of efficiencies/freed capacities.

7. The majority of DSRIP providers will require upfront startup costs for implementation of new project activities. Depending on final implementation plans, especially in terms of speed and scale, more funds may be needed upfront than will be available.

8. Many of the projects will require capital funding, in addition to operating needs. It is not clear that capital funding will be provided and if provided, whether it will be adequate and received when needed.

AMCH and the PPS Finance Committee are attempting to identify, quantify (estimate) and address such risks in the budget and funds flow plan of the projects. Until project implementation details are developed and approved, it is difficult to quantify the total financial impact. In Section 8, Budget and Funds Flow, we provide estimates of the amount of funds that may be required in terms of revenue loss. Based on carefully developed assumptions and coversations with Montefiore Medical Center, we estimate that 10% of funds will be needed to address revenue loss. We are not yet able to quantify capital funding needs, which will be substantial and critical to the success of implmentation of every project.

AMCH will propose to the DOH that the PPS we lead be allowed to merge with Montefiore's Hudson Valley Collaborative. While it is unclear what form this will take and whether it will be approved, merging our efforts in terms of financial sustainability will require planning and consideration on everyone's part. We believe it is the proper thing to do and will continue to pursue this strategy. The combined financial strengths of Albany Med and Montefiore will help the larger network of regional providers efficiently transform to new payment models and health care realities.

### Section 9.2 – Path to PPS Financial Sustainability:

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**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.

AMCH will develop a Financial Stability Plan (FSP) during the initial implementation and startup of the PPS. The FSP will be developed under the oversight of the Finance Committee and presented to the PAC's Executive Committee for approval during the first quarter of 2015. AMCH will select key financial and statistical metrics with which to assess the financial health of the PPS members. In addition, the FSP will outline key operational and financial milestones against which each Phase of the project will be measured to assess the progress of the PPS in meeting our DSRIP goals. The FSP will define the process and form with which to monitor and report actual results compared to the metrics. The FSP will specifically identify providers whose financial strength is deemed critical to the overall strength of the PPS as well as those providers that are deemed particularly fragile – both of these groups of providers will be addressed in the monitoring and reporting process outlined in the FSP. The FSP will also identify potential remediation plans to be executed by fragile providers – i.e. expense reduction plans, debt restructure, and/or re-alignment of services to meet DSRIP goals. At this time we have no information to suggest that the financial status of any providers will have a material negative impact on the ability of the provider to participate in the PPS but as stated above will continue to monitor the status of all providers. We continue to discuss these imporant issues with our partner, Montefiore Medical Center. We have agreed to align our efforts and strategies, with the near-term goal being a merger of our PPSs into a single, larger regional entity.

***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 PPS Finance Committee will monitor the financial sustainability and will make choices with respect to DSRIP funds flows depending upon each provider's achievement of metrics as well as their ability to demonstrate the reasonableness of their financial needs during transitional periods. The Finance Committee will identify and assess any negative financial trends. If such trends are indicative of continued, diminishing financial stability, a remediation plan will be developed by the PPS under the supervision of the Finance Committee which will be implemented by the provider.

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

During the DSRIP period, AMCH will focus on defining and developing the types of performance-based programs that will best serve the overall healthcare delivery system from a financial standpoint while greatly enhancing the quality of care provided to our patient populations. AMCH will assist our PPS providers with developing programs that reinforce the provider and patient roles in quality based population health management. We believe that during the DSRIP period the continuum of services provided by our PPS and the coordination thereof, will help establish a healthcare services market with providers who are transitioning into population and disease management organizations that are much more responsive to quality and outcomes models under a value based reimbursement system. This will further enable our provider to mature into financially sustainable organizations who have shifted their business models and cost profiles to continue the pursuit of efficient, high quality, outcomes based healthcare.

## 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.

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Meaningful and lasting payment reform, closely correlated to our DSRIP goals and objectives, will be critical to ensure that our project initiatives are sustainable during and beyond the 5 year period.
An effective value based payment model must be transparent, fair, result in improved quality of the health services provided by our PPS, and therefore must reward high performance. In order for our PPS to effectively implement and adopt to such a payment model, it must be scalable and flexible so as to allow all of our providers -who are currently operating at various infantile stages in payment reform - to transition via a multi-year glide path.
As mentioned previously, AMCH's PPS will propose to merge with Montefiore's PPS, the Hudson Valley Collaborative. Our PAC and the PAC's Executive Committee have already endorsed this merger. If approved, it will require closer alignment of some of our financial strategies. Part of the rationale for us pursuing this alternative transformative model is that we would benefit from the extensive knowledge and expertise that Montefiore possesses in moving to value based reimbursement methodolgies. That specific expertise is currently lacking among all providers in our regional area.

***Strategy 2:**

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

We believe that our projects will drive down (re)admissions and other avoidable complication related costs so that at the total cost of care and therefore the total amount of current Medicaid payments per patient will be reduced. Initially, the resulting reductions in our provider's income will be compensated by DSRIP income. However, over time, the resulting changes in the care and cost model should drive a much more efficient, effective and sustainable health care delivery system that will benefit all providers, including the most fragile.

Rather than opting for a total capitation model (effectively only transferring insurance risk on to the providers), we would prefer models in which we realize shared savings and we our paid for performance - in particular for those services on which we have focused our DSRIP program.

The PPS will continue to operate in a hybrid world of fee for service, as well as Value based payment methods. Thus, the PPS models need to be flexible enough to satisfy the finance demands of various payment methods. Not a dissimilar circumstance to how all health care providers must survive for the foreseeable future.

### 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.

AMC PPS will contract with Montefiore Medical Center who also leads HVC, and ultimately hopes to merge with HVC into a single PPS. Montefiore brings population management capabilities that are unique in New York, and among the most advanced nationally. The PPS will use these capabilities to develop a more integrated and patient-centered system.
Montefiore is expert at structuring value-based arrangements (VBAs). Montefiore launched its first VBA in the 1990s, and established early relationships with Medicaid payers. Montefiore has VBAs across lines of business, including payers in the Hudson Valley, and has started discussions with major Medicaid payers. Montefiore has developed an Integrated Provider Network with 3,400 providers, including 1,500 in private practice. Montefiore will use its infrastructure and expertise to accelerate adoption of VBAs.
Montefiore has established one of the nation's most successful approaches to managing care. A critical component is Montefiore Care Management, supporting nearly 300,000 beneficiaries, approximately 40% of which are Medicaid recipients, is poised to serve our region's needs while building capacity within partner organizations like AMC PPS. Montefiore provides essential wraparound services, integrated with on-site clinical care. These resources are services that assess patient needs, navigate across settings, work closely with physicians, support patients between visits, and are integrated with social services. The network Montefiore manages includes independent providers. Montefiore has successfully collaborated with community partners.
Montefiore has developed a strong IT infrastructure, with robust data analytics, operations support, EMR implementation and data warehousing. Montefiore is at the forefront of innovation, including as a lead Health Home, and operates the state's first free-standing ED. Notably, Montefiore is New York State's only Pioneer ACO, and was top performing nationally two years running.

**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.

AMCH has worked diligently through its workforce subcommittee to develop a functional strategy that will adapt to the needs of the workforce as DSRIP projects are implemented. As part of that committee we identified three potential workforce vendors. AMCH will contract with a combination of these providers to ensure that the training and workforce needs of the PPS are met in a culturally appropriate way. Vendors identified include Area Health Education Centers, including the Eastern Regional AHEC, Hudson Mohawk (HM) AHEC and Catskill Hudson AHEC. HM AHEC has reached over 16,000 participants with Pipeline and other Preparation Programming, and close to 10,000 participants through professional education. HM AHEC has also placed close to 300 Community Based Clinical Rotations with over 75 preceptors. Catskill Hudson AHEC has funded hundreds of innovative and educational health professions programs since 2003. To date, thousands of medical, nursing and health professions students were placed with hundreds of teachers at community-based training sites. Tens of thousands of young people, ages 10-17, received exposure to healthcare careers and health professionals through the fun and interactive activities of health career youth programs. Thousands of health professionals have participated in Catskill Hudson AHEC sponsored continuing education programs. Another potential vendor is 1199 Training Fund. The Training Fund has constructed a career and educational ladder that has enabled thousands of nursing home workers to improve their basic academic skills, achieve high school diplomas, prepare for college, earn college degrees, and move into new jobs as LPNs, RNs and a variety of other professions. All three organizations are certified proven workforce strategy vendors. AMCH will contract with a

## Albany Medical Center Hospital (PPS ID:1)

combination of these or other vendors to facilitate our workforce strategy and ensure any negative impacts to the workforce as a result of the DSRIP projects are mitigated.

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

## Albany Medical Center Hospital (PPS ID:1)

### 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 Albany Medical Center Hospital that all information provided on this Project Plan Applicant is true and accurate to the best of my knowledge.***

Primary Lead Provider Name: ALBANY MEDICAL CTR HOSPITAL
Secondary Lead Provider Name:

| | |
|---|---|
| Lead Representative: | George Clifford |
| Submission Date: | 12/22/2014 03:57 PM |

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